1.
Which assessment is most important for the nurse to perform on a client who is hospitalized for Guillain-Barre syndrome that is rapidly progressing?

- Respiratory effort.
- Unsteady gait.
- Intensity of pain.
- Ability to eat.

Guillain-Barre syndrome causes paralysis or weakness that typically starts at the feet and progresses upwards. As the condition progresses, the nurse must ensure that the client is able to breathe effectively.

Heuther, Understanding Pathophysiology, 6th ed. p. 412

2.
A male client comes into the clinic with a history of penile discharge with painful, burning urination. Which action should the nurse implement?

- Collect a culture of the penile discharge.
- Palpate the inguinal lymph nodes gently.
- Observe for scrotal swelling and redness.
- Express the discharge to determine color.

Penile discharge with painful urination is commonly associated with gonorrhea. The nurse should collect a culture of the penile discharge to determine the cause of these symptoms. The cause must be determined or confirmed through culture to identify the organism and ensure effective treatment.

Jarvis Physical Examination and Health Assessment, 6th edition

3.
A client with history of atrial fibrillation is admitted to the telemetry unit with sudden onset of shortness of breath. The nurse observes a new irregular heart rhythm and should perform which assessment at this time?

- Check for a pulse deficit.
- Palpate the apical impulse.
- Inspect jugular vein pulse.
- Examine for a carotid bruit.

A client with a past history of atrial fibrillation may return to that rhythm. Any signs of atrial fibrillation, such as sudden onset shortness of breath, requires further investigation. The nurse should assess this client for a pulse deficit because this condition occurs with atrial fibrillation.

Jarvis. (2016); Physical Examination and Health Assessment, (Chap 19) 7th ed., p. 481

4.
Which client should be further assessed for an ectopic pregnancy?

- A 24-year-old with shoulder and lower abdominal quadrant pain.
- A 33-year-old with intermittent lower abdominal cramping.
- A 20-year-old with fever and right lower abdominal colic.
- A 40-year-old with jaundice and right lower abdominal pain.

A 24-year-old with sudden onset of lower abdominal quadrant pain should be assessed for an ectopic pregnancy. The pain can also be referred to the shoulder and may be associated with vaginal bleeding.

Health Assessment for Nursing Practice, Wilson and Giddens. p.269

5.
Which dietary assessment finding is most important for the nurse to address when caring for a client with diabetic nephropathy?

- Drinks a six pack of beer every day.
- Enjoys a hamburger once a month.
- Eats fortified breakfast cereal daily.
- Consumes beans and rice every day.

Drinking six beers every day is the dietary assessment finding most important for the nurse to address when caring for a client with diabetic nephropathy. The usual can of beer is 12 ounces (355 mL). Clients with diabetes are recommended to drink no more than 12 ounces of beer per day because beer contains carbohydrates that can create unhealthy fluctuations in blood glucose and promote poor glucose control. Nephropathy is exacerbated by poor blood glucose control.
6.
Which assessment finding is of greatest concern to the nurse who is caring for a client with stomatitis?

- Cough brought on by swallowing.
- Sore throat caused by speaking.
- Painful and dry oral cavity.
- Unintended weight loss.

A cough brought on by swallowing is a sign of dysphagia, which is a finding of particular concern in a client with stomatitis. Dysphagia can cause numerous problems, including airway obstruction, and should be reported to the healthcare provider immediately.

Ignatavicius, (2016). Medical-surgical nursing: Patient-centered collaborative care, eight edition., Ch. 53, p. 1100.

7.
The nurse is teaching a client diagnosed with peripheral arterial disease. Which genitourinary system complication should the nurse include in the teaching?

- Altered sexual response.
- Sterility.
- Urinary incontinence.
- Decreased pelvic muscle tone.

Peripheral arterial disease (PAD) is a cardiovascular condition characterized by narrowing of the arteries and reduced blood flow to the extremities. PAD is known to alter the blood flow to the male's penis and is associated with erectile dysfunction in men.

Ignatavicius,. (2016). Medical-surgical nursing: Patient-centered collaborative care, eight edition., Ch. 69, p. 1452.

8.
A 40-year-old female client has a history of smoking. Which finding should the nurse identify as a risk factor for myocardia infarction?

- Oral contraceptives.
- Senile osteopenia.
- Levothyroxine therapy.
- Pernicious anemia.

Women older than 35 years old who smoke and take oral contraceptives have an increased risk of myocardial infarction or stroke.

Ignatavicius, (2013). Medical-surgical nursing: Patient-centered collaborative care, 7th ed.., Ch. 35, p. 694.

9.
A client has been told that there is cataract formation over both eyes. Which finding should the nurse expect when assessing the client?

- Decreased color perception.
- Presence of floaters.
- Loss of central vision.
- Reduced peripheral vision.

Decreased color perception occurs with cataract formation. Cataract formation is also associated with blurred vision and a global loss of vision so gradual that the client may not be aware of it.

Ignatavicius, (2016). Medical-surgical nursing: Patient-centered collaborative care, eight edition., Ch. 47,

10.
Which assessment finding should most concern the nurse who is monitoring a client two hours after a thoracentesis?

- New onset of coughing.
- Low resting heart rate.
- Distended neck veins.
- Decreased shallow respirations.

A pneumothorax (partial or complete lung collapse) is the potential complication of a thoracentesis. Manifestations of a pneumothorax include new onset of a nagging cough, tachycardia, and an increased shallow respiration rate.

Ignatavicius,(2016). Medical-surgical nursing: Patient-centered collaborative care, eight edition., Ch. 27, pp. 511-13.

11.
While caring for a client who has esophageal varices, which nursing intervention is most important for the registered nurse (RN) to implement?

- Monitor infusing IV fluids and any replacement blood products.
- Prepare for esophagogastroduodenoscopy (EGD).
- Maintain the client on strict bedrest.
- Insert a nasogastric tube (NGT) for intermittent suction.

Maintaining hemodynamic stability in a client with esophageal varices can precipitate a life-threatening crisis if esophageal varies leak or rupture and can result in hemorrhage. The priority is assessing and monitoring infusions of IV fluids and any replacement blood products.

12.
The registered nurse (RN) is caring for a client who developed oliguria and was diagnosed with sepsis and dehydration 48 hours ago. Which assessment finding indicates to the RN that the client is stabilizing?

- Urine output of 40 mL/hour.
- Apical pulse 100 and blood pressure 76/42.
- Urine specific gravity 1.001.
- Tented skin on dorsal surface of hands.

A decrease in urinary output is a sign of dehydration. When the urine output returns to a normal range, 40 mL/hour, the client's kidneys are perfusing adequately and indicates the client's status is stabilizing.

13.
After a liver biopsy is performed at the bedside, the registered nurse (RN) is assigned the care of the client. Which nursing intervention is most important for the RN to implement?

- Position client on left side with pillow placed under the costal margin.
- Assist the client with voiding immediately after the procedure.
- Evaluate vital signs q10 to 20 minutes for 2 hours after procedure.
- Ambulate client 3 times in first hour with pillow held at abdomen.

Vital signs should be checked every 10 to 20 minutes to assess for bleeding after biopsy of the liver, which is highly vascular. The client should be positioned on the right side with a pillow or sandbag under the costal margin and supporting the biopsy site. The client should be maintained on bedrest for several hours to decrease the risk of bleeding from the biopsy site.

14.
The registered nurse (RN) is caring for a client with aplastic anemia who is hospitalized for weight loss and generalized weakness. Laboratory values show a white blood count (WBC) of 2,500/mm 3 and a platelet count of 160,000/mm 3. Which intervention is the primary focus in the client's plan of care for the RN to implement?

- Assist with frequent ambulation.
- Encourage visitors to visit.
- Maintain strict protective precautions.
- Avoid peripheral injections.

The client should be under strict protective transmission precautions because the WBC values are low and normal WBC levels are 4,000-10,000/mm3, so the client is an increased high risk for infection.

15.
The registered nurse (RN) is caring for a young adult who is having an oral glucose tolerance tests (OGTT). Which laboratory result should the RN assess as a normal value for the two hour postprandial result?

- 140 mg/dl.
- 160 mg/dl.
- 180 mg/dl.
- 200 mg/dl.

The two hour postprandial level should be less 140 mg/dl for a young adult client.

16.
The registered nurse (RN) is caring for an older client who recently experienced a fractured pelvis from a fall. Which assessment finding is most important for the RN to report the healthcare provider?

- Lower back pain.
- Headache of 7 on scale 1 to 10.
- Blood pressure of 140/98.
- Dyspnea.

A client with a large bone fracture is at risk for intramedullary fat leaking into the blood stream and becoming embolic. Dyspnea is an indication of fat embolism to the lungs and should be reported to the healthcare provider immediately.

17.
The registered nurse (RN) is caring for a client with tuberculosis (TB) who is taking a combination drug regimen. The client complains about taking "so many pills." What information should the RN provide to the client about the prescribed treatment?

- The development of resistant strains of TB are decreased with a combination of drugs.
- Compliance to the medication regimen is challenging but should be maintained.
- Side effects are minimized with the use of a single medication but is less effective.
- The treatment time is decreased from 6 months to 3 months with this standard regimen.

Combination therapy is necessary to decrease the development of resistant strains of TB and ensure treatment efficacy.

18.
The registered nurse (RN) is teaching a client who is newly diagnosed with emphysema how to perform pursed lip breathing. What is the primary reason for teaching the client this method of breathing?

- Decreases respiratory rate.
- Increases O 2 saturation throughout the body.
- Conserves energy while ambulating.
- Promotes CO 2 elimination.

Pursed lip breathing helps eliminate CO2 by increasing positive pressure within the alveoli increasing the surface area of the alveoli making it easier for the O2 and CO2 gas exchange to occur .

19.
The registered nurse (RN) is caring for a client with acute pancreatitis and reviews the admission laboratory results. What laboratory value should the RN anticipate being elevated with this diagnosis?

- Triglycerides.
- Amylase.
- Creatinine.
- Uric acid.

An elevated amylase level is associated with acute pancreatitis.

20.
A client in an ambulatory clinic describes awaking in the middle of the night with difficulty breathing and shortness of breath related to paroxysmal nocturnal dyspnea. Which underlying condition should the registered nurse (RN) identify in the client's history?

- Chronic bronchitis.
- Gastroesophageal reflux disease (GERD).
- Heart failure (HF).
- Chronic pancreatitis.

Paroxysmal nocturnal dyspnea is classic sign of heart failure and is secondary to fluid overload associated with heart failure which causes pulmonary edema.

21.
A client is recently diagnosed with systemic lupus erythematosus (SLE) and the registered nurse (RN) is assessing for common complications. Which symptom should the RN instruct the client to report immediately?

- Fever related to infection.
- Weight loss and anorexia.
- Depressed mood.
- Break in tissue integrity.

Secondary infections are a major concern with SLE clients due to the use of corticosteroids and chemotherapeutic agents, which suppresses the immune system, so reporting fever and infections should be reported immediately.

22.
A male client is admitted after falling from his bed. The healthcare provider (HCP) tells the family that he has an incomplete fracture of the humerus. The family ask the

RN what this means. Which explanation by the nurse accurately describes the client's fracture?

- Straight fracture line that is also a simple, closed fracture.
- Nondisplaced fracture line that wraps around the bone.
- A complete fracture that also punctures the skin.
- A fracture that bends or splinters part of the bone.

An incomplete fracture occurs when part of the bone is splintered (broken) and it has not gone completely through the thickness of the bone.

23.
The registered nurse (RN) is caring for a client who has a closed head injury from a motor vehicle collision. Which finding would indicate to the nurse that the client is at risk for diabetes insipidus (DI)?

- High fever.
- Low blood pressure.
- Muscle rigidity.
- Polydipsia.

A characteristic finding of DI is excretion of large quantities of urine (5 to 20L/day), and most clients compensate for fluid loss by drinking large amounts of water (polydipsia). DI can occur when there has been damage or injury to the pituitary gland or hypothalamus as a result of head trauma, tumor or an illness such as meningitis. This damage interrupts the ADH production, storage and release causing the excessive urination and thirst.

24.
The registered nurse (RN) is assisting the healthcare provider (HCP) with the removal of a chest tube. Which intervention has the highest priority and should be anticipated by the RN after the removal of the chest tube?

- Prepare the client for chest x-ray at the bedside.
- Review arterial blood gases after removal.
- Elevate the head of bed to 45 degrees.
- Assist with disassembling the drainage system.

A chest x-ray should be performed immediately after the removal of a chest tube to ensure lung expansion has been maintained after its removal.

25.
A client with chest pain, dizziness, and vomiting for the last 2 hours is admitted for evaluation for Acute Coronary Syndrome (ACS). Which cardiac biomarker should the registered nurse (RN) anticipate to be elevated if the client experienced myocardial damage?

- Creatine Kinase (CK-MB).
- Serum troponin.
- Myoglobin.
- Ischemia modified albumin.

Troponin is the most sensitive and specific test for myocardial damage. Troponin elevation is more specific than CK-MB.

26.
A female client is recently diagnosed with Sarcoidosis. The client tells the registered nurse (RN) that she does not understand why she has this. When teaching the client, the RN should include that sarcoidosis most commonly occurs with which ethnic group of women?

- African American women.
- Caucasian women.
- Asian women.
- Hispanic women.

Sarcoidosis, an autoimmune inflammatory disease affecting multiple organs and has shown familial tendency due to multiple genes that together increase the susceptibility of developing the disease. In research studies it occurs more commonly in African American women (10-80 out of 100,000); compare to Caucasian women of the United States (8 out of 100,000).

27.
The registered nurse (RN) is evaluating a client who presents with symptoms of viral gastroenteritis. Which assessment finding should the RN report to the healthcare provider?

- Dry mucous membranes and lips.
- Rebound abdominal tenderness over right lower quadrant.
- Dizziness when client ambulates from a sitting position.
- Poor skin turgor over client's wrist.

Right lower quadrant (RLQ) rebound abdominal tenderness may be related to acute appendicitis and should be reported to the healthcare provider.

28.
The registered nurse (RN) is caring for a client with peptic ulcer disease (PUD). What assessment should the RN identify and document that is consistent with PUD? (Select all that apply).

- Hematemesis.
- Gastric pain on an empty stomach.
- Colic-like pain with fatty food ingestion.

- Intolerance of spicy foods.
- Diarrhea and steatorrhea.

Manifestations of PUD include hematemesis, gastric pain, and spicy food intolerance.

29.
The registered nurse (RN) recognizes which client group is at the greatest risk for developing a urinary tract infection (UTI)? (Rank from highest risk to lowest risk.)

1	Older males.
2	School-age female.
3	Older females.
4	Adolescent males.

Correct
- Older females.
- School-age female.
- Older males.
- Adolescent males.

Hypoestrogenism and alkalotic urine are other age-related factors put older women at the highest risk for UTIs. School age girls (6 to 12 years) are at risk for UTIs due to a higher prevalence to taking baths instead of showers, but these risks can be controlled in this population as well as hypoestrogenism and alkalotic urine. Older men are at risk due to possible obstruction of the bladder due to benign prostatic hypertrophy (BPH). Adolescent males (12 to 19 years) are the lowest at risk for a UTI.
All individuals regardless of gender and/or age are at risk if the following conditions exist: vesicoureteral reflux, neuromuscular conditions, like Parkinson's disease, previous brain attacks, or the use of anticholinergic medications can all cause incomplete bladder emptying which can create bacterial overgrowth. Fecal and urinary incontinence contributes to poor perineal hygiene and bacterial growth.

30.
A female client admitted with abdominal pain is diagnosed with cholelithiasis. The client asks the registered nurse (RN) what she should expect as a common treatment. What recommended plan of care should the nurse provide the client?
- Rest with liquid diet only.
- Drugs such as ursodiol.
- Cholecystectomy via laparoscopy.
- LaVeen vena caval shunt.