HESI PN EXIT EXAM V3 110 QUESTIONS AND ANSWER(S)

1. An adult client experiences a gasoline tank fire when riding a motorcycle and is admitted to the emergency department (ED) with full thickness burns to all surfaces of both lower extremities. What percentage of body surface area should the nurse document in the electronic medical record (EMR)?
    - 9 %
    - 18 %
    - **36 %**
    - 45 %
    - Rational: according to the rule of nines, the anterior and posterior surfaces of one lower extremity is designated as 18 %of total body surface area (TBSA), so both extremities equals 36% TBSA, other options are incorrect.
2. A client with hyperthyroidism is receiving propranolol (Inderal). Which finding indicates that the medication is having the desired effect?
    - Decrease in serum T4 levels
    - Increase in blood pressure
    - **Decrease in pulse rate**
    - Goiter no longer palpable
3. An older male client with type 2 diabetes mellitus reports that has experiences legs pain when walking short distances, and that the pain is relieved by rest. Which client behavior indicates an understanding of healthcare teaching to promote more effective arterial circulation?
    - Consistently applies TED hose before getting dressed in the morning.
    - Frequently elevated legs thorough the day.
    - Inspect the leg frequently for any irritation or skin breakdown
    - **Completely stop cigarette/ cigar smoking.**
    - Rationale: Stopping cigarette smoking helps to decrease vasoconstriction and improve arterial circulation to the extremity.

4. A community health nurse is concerned about the spread of communicable diseases among migrant farm workers in a rural community. What action should the nurse take to promote the success of a healthcare program designed to address this problem?

    - **Establish trust with community leaders and respect cultural and family values**

5. The nurse performs a prescribed neurological check at the beginning of the shift on a client who was admitted to the hospital with a subarachnoid brain attack (stroke). The client's Glasgow Coma Scale (GCS) score is 9. What information is most important for the nurse to determine?

    - **The client's previous GCS score**
    - When the client's stroke symptoms started
    - If the client is oriented to time
    - The client's blood pressure and respiration rate
    - Rationale: The normal GCS is 15, and it is most important for the nurse to determine if it abnormal score a sign of improvement or a deterioration in the client's condition

6. The charge nurse in a critical care unit is reviewing clients' conditions to determine who is stable enough to be transferred. Which client status report indicates readiness for transfer from the critical care unit to a medical unit?

    - **Chronic liver failure with a hemoglobin of 10.1 and slight bilirubin elevation**

7. Based on principles of asepsis, the nurse should consider which circumstance to be sterile?

    - One inch- border around the edge of the sterile field set up in the operating room
    - A wrapped unopened, sterile 4x4 gauze placed on a damp table top.
    - **An open sterile Foley catheter kit set up on a table at the nurse waist level**
    - Sterile syringe is placed on sterile area as the nurse riches over the sterile field.
    - Rationale: A sterile package at or above the waist level is considered sterile. The edge of sterile field is contaminated which include a 1-inch border (A). A sterile objects become contaminated by capillary action when sterile objects become in contact with a wet contaminated surface.

8. An unlicensed assistive personnel (UAP) reports that a client's right hand and fingers spasms when taking the blood pressure using the same arm. After confirming the presence of spams what action should the nurse take?

    - Ask the UAP to take the blood pressure in the other arm

- Tell the UAP to use a different sphygmomanometer.
- **Review the client's serum calcium level**
- Administer PRN antianxiety medication.
- Rationale: Trousseau's sign is indicated by spasms in the distal portion of an extremity that is being used to measure blood pressure and is caused by hypocalcemia (normal level 9.0-10.5 mg/dl, so C should be implemented.

9. A 56-years-old man shares with the nurse that he is having difficulty making decision about terminating life support for his wife. What is the best initial action by the nurse?
    - **Provide an opportunity for him to clarify his values related to the decision**
    - Encourage him to share memories about his life with his wife and family
    - Advise him to seek several opinions before making decision
    - Offer to contact the hospital chaplain or social worker to offer support.
    - Rationale: When a client is faced with a decisional conflict, the nurse should first provide opportunities for the client to clarify values important in the decision. The rest may also be beneficial once the client as clarified the values that are important to him in the decision-making process.
10. A client is being discharged home after being treated for heart failure (HF). What instruction should the nurse include in this client's discharge teaching plan?
    - **Weigh every morning**
    - Eat a high protein diet
    - Perform range of motion exercises
    - Limit fluid intake to 1,500 ml daily
11. A woman just learned that she was infected with Heliobacter pylori. Based on this finding, which health promotion practice should the nurse suggest?
    - **Encourage screening for a peptic ulcer**
12. A client who recently underwear a tracheostomy is being prepared for discharge to home. Which instructions is most important for the nurse to include in the discharge plan?
    - **Teach tracheal suctioning techniques**
13. A child with heart failure is receiving the diuretic furosemide (Lasix) and has serum potassium level 3.0 mEq/L. Which assessment is most important for the nurse to obtain?
    - **Cardiac rhythm and heart rate.**
    - Daily intake of foods rich in potassium.

- Hourly urinary output
- Thirst ad skin turgor.

14. The nurse note a depressed female client has been more withdrawn and non-communicative during the past two weeks. Which intervention is most important to include in the updated plan of care for this client?
    - Encourage the client's family to visit more often
    - Schedule a daily conference with the social worker
    - Encourage the client to participate in group activities
    - **Engage the client in a non-threatening conversation.**
    - Rationale: Consistent attempts to draw the client into conversations which focus on non-threatening subjects can be an effective means of eliciting a response, thereby decreasing isolation behaviors. There is not sufficient data to support the effectiveness of A as an intervention for this client. Although B may be indicated, nursing interventions can also be used to treat this client. C is too threatening to this client.
15. A client with rheumatoid arthritis (RA) starts a new prescription of etanercept (Enbrel) subcutaneously once weekly. The nurse should emphasize the importance of reporting problem to the healthcare provider?
    - Headache
    - Joint stiffness
    - **Persistent fever**
    - Increase hunger and thirst
    - Rationale: Enbrel decrease immune and inflammatory responses, increasing the client's risk of serious infection, so the client should be instructed to report a persistent fever, or other signs of infection to the healthcare provider.
16. The nurse is assessing an older adult with type 2 diabetes mellitus. Which assessment finding indicates that the client understands long- term control of diabetes?
    - The fating blood sugar was 120 mg/dl this morning.
    - Urine ketones have been negative for the past 6 months
    - **The hemoglobin A1C was 6.5g/100 ml last week**
    - No diabetic ketoacidosis has occurred in 6 months.
    - Rationale: A hemoglobin A1C level reflects he average blood sugar the client had over the previous 2 to 3 month, and level of 6.5 g/100 ml suggest that the client

understand long-term diabetes control. Normal value in a diabetic patient is up to 6.5 g/100 ml.

17. An older male client is admitted with the medical diagnosis of possible cerebral vascular accident (CVA). He has facial paralysis and cannot move his left side. When entering the room, the nurse finds the client's wife tearful and trying unsuccessfully to give him a drink of water. What action should the nurse take?

    - **Ask the wife to stop and assess the client's swallowing reflex**

18. A 13 years-old client with non-union of a comminuted fracture of the tibia is admitted with osteomyelitis. The healthcare provider collects home aspirate specimens for culture and sensitivity and applies a cast to the adolescent's lower leg. What action should the nurse implement next?

    - Administer antiemetic agents
    - Bivalve the cast for distal compromise
    - Provide high- calorie, high-protein diet
    - **Begin parenteral antibiotic therapy**
    - Rationale: The standard of treatment for osteomyelitis is antibiotic therapy and immobilization. After bond and blood aspirate specimens are obtained for culture and sensitivity, the nurse should initiate parenteral antibiotics as prescribed.

19. The nurse is preparing a community education program on osteoporosis. Which instruction is helpful in preventing bone loss and promoting bone formation?

    - **Recommend weigh bearing physical activity**

20. A client with a history of chronic pain requests a nonopioid analgesic. The client is alert but has difficulty describing the exact nature and location of the pain to the nurse. What action should the nurse implement next?

    - **Administer the analgesic as requested**

21. A male client receives a thrombolytic medication following a myocardial infarction. When the client has a bowel movement, what action should the nurse implement?

    - **Send stool sample to the lab for a guaiac test**
    - Observe stool for a day-colored appearance.
    - Obtain specimen for culture and sensitivity analysis
    - Asses for fatty yellow streaks in the client's stool.

- Rationale: Thrombolytic drugs increase the tendency for bleeding. So guaiac (occult blood test) test of the stool should be evaluated to detect bleeding in the intestinal tract.

22. The mother of a child with cerebral palsy (CP) ask the nurse if her child's impaired movements will worsen as the child grows. Which response provides the best explanation?

    - **Brain damage with CP is not progressive but does have a variable course**

23. During shift report, the central electrocardiogram (EKG) monitoring system alarms. Which client alarm should the nurse investigate first?

    - **Respiratory apnea of 30 seconds**

24. In early septic shock states, what is the primary cause of hypotension?

    - Peripheral vasoconstriction
    - **Peripheral vasodilation**
    - Cardiac failure
    - A vagal response
    - Rationale: Toxins released by bacteria in septic shock create massive peripheral vasodilation and increase microvascular permeability at the site of the bacterial invasion.

25. A client diagnosed with calcium kidney stones has a history of gout. A new prescription for aluminum hydroxide (Amphogel) is scheduled to begin at 0730. Which client medication should the nurse bring to the healthcare provider's attention?

    - **Allopurinol (Zyloprim)**
    - Aspirin, low dose
    - Furosemide (lasix)
    - Enalapril (vasote)

26. A male client's laboratory results include a platelet count of 105,000/ mm3 Based on this finding the nurse should include which action in the client's plan of care?

    - Cluster care to conserve energy
    - Initiate contact isolation
    - **Encourage him to use an electric razor**
    - Asses him for adventitious lung sounds

- Rationale: This client is at risk for bleeding based on his platelet count (normal 150,000 to 400,000/ mm3). Safe practices, such as using an electric razor for shaving, should be encouraged to reduce the risk of bleeding.

27. A client is admitted to the hospital after experiencing a brain attack, commonly referred to as a stroke or cerebral vascular accident (CVA). The nurse should request a referral for speech therapy if the client exhibits which finding?
    - Abnormal responses for cranial nerves I and II
    - **Persistent coughing while drinking**
    - Unilateral facial drooping
    - Inappropriate or exaggerated mood swings
28. At 1615, prior to ambulating a postoperative client for the first time, the nurse reviews the client's medical record. Based on date contained in the record, what action should the nurse take before assisting the client with ambulation:
    - **Remove sequential compression devices.**
    - Apply PRN oxygen per nasal cannula.
    - Administer a PRN dose of an antipyretic.
    - Reinforce the surgical wound dressing.
    - Rationale: Sequential compression devices should be removed prior to ambulation and there is no indication that this action is contraindicated. The client's oxygen saturation levels have been within normal limits for the previous four hours, so supplemental oxygen is not warranted.
29. Which assessment finding for a client who is experiencing pontine myelinolysis should the nurse report to the healthcare provider?
    - **Sudden dysphagia**
    - Blurred visual field
    - Gradual weakness
    - Profuse diarrhea
30. A client is scheduled to receive an IW dose of ondansetron (Zofran) eight hours after receiving chemotherapy. The client has saline lock and is sleeping quietly without any restlessness. The nurse caring for the client is not certified in chemotherapy administration. What action should the nurse take?
    - Ask a chemotherapy-certified nurse to administer the Zofran
    - **Administer the Zofran after flushing the saline lock with saline**

- Hold the scheduled dose of Zofran until the client awakens
- Awaken the client to assess the need for administration of the Zofran.
- Rationale: Zofran is an antiemetic administered before and after chemotherapy to prevent vomiting. The nurse should administer the antiemetic using the accepter technique for IV administration via saline lock. Zofran is not a chemotherapy drug and does not need to be administered by a chemotherapy- certified nurse.

31. When providing diet teaching for a client with cholecystitis, which types of food choices the nurse recommend to the client?
    - High protein
    - **Low fat**
    - Low sodium
    - High carbohydrate.
    - Rationale: A client with cholecystitis is at risk of gall stones that can be move into the biliary tract and cause pain or obstruction. Reducing dietary fat decrease stimulation of the gall bladder, so bile can be expelled, along with possible stones, into the biliary tract and small intestine.
32. A client with a history of cirrhosis and alcoholism is admitted with severe dyspnea and ascites. Which assessment finding warrants immediate intervention by the nurse?
    - Jaundice skin tone
    - **Muffled heart sounds**
    - Pitting peripheral edema
    - Bilateral scleral edema
    - Rationale: Muffled heart sounds may indicative fluid build-up in the pericardium and is life- threatening. The other one are signs of end stage liver disease related to alcoholism but are not immediately life- threatening.
33. When entering a client's room, the nurse discovers that the client is unresponsive and pulseless. The nurse initiate CPR and Calls for assistance. Which action should the nurse take next?
    - Prepare to administer atropine 0.4 mg IVP
    - Gather emergency tracheostomy equipment
    - Prepare to administer lidocaine at 100 mg IVP
    - **Place cardiac monitor leads on the client's chest.**

- Rationale: Before further interventions can be done, the client's heart rhythm must be determined. This can be done by connecting the client to the monitor. A or C are not a first line drug given for any of the life threatening, pulses dysrhythmias

34. A client with a history of dementia has become increasingly confused at night and is picking at an abdominal surgical dressing and the tape securing the intravenous (IV) line. The abdominal dressing is no longer occlusive, and the IV insertion site is pink. What intervention should the nurse implement?

    - Replace the IV site with a smaller gauge.
    - **Redress the abdominal incision**
    - Leave the lights on in the room at night.
    - Apply soft bilateral wrist restraints.
    - Rationale: The abdominal incision should be redressed using aseptic-techniques. The IV site should be assessed to ensure that it has not been dislodged and a dressing reapplied, if need it. Leaving the light on at night may interfere with the client's sleep and increase confusion. Restraints are not indicated and should only be used as a last resort to keep client from self-harm.

35. An adult male client is admitted to the emergency room following an automobile collision in which he sustained a head injury. What assessment data would provide the earliest that the client is experiencing increased intracranial pressure (ICP)?

    - **Lethargy**
    - Decorticate posturing
    - Fixed dilated pupil
    - Clear drainage from the ear.
    - Rationale: Lethargy is the earliest sign of ICP along with slowing of speech and response to verbal commands. The most important indicator of increase ICP is the client's level or responsiveness or consciousness. B and C are very late signs of ICP.

36. In preparing a diabetes education program, which goal should the nurse identify as the primary emphasis for a class on diabetes self-management?

    - Prepare the client to independently treat their disease process
    - Reduce healthcare costs related to diabetic complications
    - **Enable clients to become active participating in controlling the disease process**
    - Increase client's knowledge of the diabetic disease process and treatment options.

- Rationale: The primary goal of diabetic self- management education is to enable the client to become an active participant in the care and control of disease process, matching levels of self- management to the abilities of the individual client. The goal is to place the client in a cooperative or collaborative role with healthcare professional rather than (A)

37. To reduce staff nurse role ambiguity, which strategy should the nurse manager implemented?
    - Confirm that all the staff nurses are being assigned to equal number of clients.
    - **Review the staff nurse job description to ensure that it is clear, accurate, and recurrent.**
    - Assign each staff nurse a turn unit charge nurse on a regular, rotating basis.
    - Analyze the amount of overtime needed by the nursing staff to complete assignments.
    - Rationale: Role ambiguity occurs when there is inadequate explanation of job descriptions and assigned tasks, as well as the rapid technological changes that produce uncertainty and frustration. A and D may be implemented if the nurse manager is concerned about role overload, which is the inability to accomplish the tasks related to one's role. C is not related to ambiguity.

38. The nurse is assisting a new mother with infant feeding. Which information should the nurse provide that is most likely to result in a decrease milk supply for the mother who is breastfeeding?
    - **Supplemental feedings with formula**
    - Maternal diet high in protein
    - Maternal intake of increased oral fluid
    - Breastfeeding every 2 or 3 hours.
    - Rationale: Infant sucking at the breast increases prolactin release and proceeds a feedback mechanism for the production of milk, the nurse should explain that supplemental bottle formula feeding minimizes the infant's time at the breast and decreases milk supply. B promotes milk production and healing after delivery. C support milk production. C is recommended routine for breast feeding that promote adequate milk supply.

39. Which assessment is more important for the nurse to include in the daily plan of care for a client with a burned extremity?
    - Range of Motion
    - **Distal pulse intensity**