NEW GENERATION ATI COMPREHENSIVE HESI EXAMS 2023 | REAL EXAMS WITH CORRECT ANSWERS

1.ID: 383711499
Enalapril maleate (Vasotec) is prescribed for a hospitalized client. Which assessment does the nurse perform as a priority before administering the medication?

- Checking the client's blood pressure
- Correct Checking the client's peripheral
- pulses Checking the most recent
- potassium level

Checking the client's intake-and-output record for the last 24 hours
Rationale: Enalapril maleate is an angiotensin-converting enzyme (ACE) inhibitor used to treat hypertension. One common side effect is postural hypotension. Therefore the nurse would check the client's blood pressure immediately before administering each dose. Checking the client's peripheral pulses, the results of the most recent potassium level, and the intake and output for the previous 24 hours are not specifically associated with this mediation.

2.ID: 383744011
A client is scheduled to undergo an upper gastrointestinal (GI) series, and the nurse provides instructions to the client about the test. Which statement by the client indicates a need for further instruction?

- "The test will take about 30 minutes."
- "I need to fast for 8 hours before the test."
- "I need to drink citrate of magnesia the night before the test and give myself a Fleet enema on the morning of the test." Correct
- "I need to take a laxative after the test is completed, because the liquid that I'll have to drink for the test can be constipating."

Rationale: An upper GI series involves visualization of the esophagus, duodenum, and upper jejunum by means of the use of a contrast medium. It involves swallowing a contrast medium (usually barium), which is administered in a flavored milkshake. Films are taken at intervals during the test, which takes about 30 minutes. No special preparation is necessary before a GI series, except that NPO status must be maintained for 8 hours before the test. After an upper GI series, the client is prescribed a laxative to hasten elimination of the barium. Barium that remains in the colon may become hard and difficult to expel, leading to fecal impaction.

3.ID: 383705015
A nurse on the evening shift checks a physician's prescriptions and notes that the dose of a prescribed medication is higher than the normal dose. The nurse calls the physician's answering service and is told that the physician is off for the night and will be available in the morning. The nurse should:

- Call the nursing supervisor

Ask the answering service to contact the on-call physician Correct

- Withhold the medication until the physician can be reached in the morning
- Administer the medication but consult the physician when he becomes available

Rationale: The nurse has a duty to protect the client from harm. A nurse who believes that a physician's prescription may be in error is responsible for clarifying the prescription before carrying it out. Therefore the nurse would not administer the medication; instead, the nurse would withhold the medication until the dose can be clarified. The nurse would not wait until the next morning to obtain clarification. It is premature to call the nursing supervisor.

4. ID: 383708500
An emergency department (ED) nurse is monitoring a client with suspected acute myocardial infarction (MI) who is awaiting transfer to the coronary intensive care unit. The nurse notes the sudden onset of premature ventricular contractions (PVCs) on the monitor, checks the client's carotid pulse, and determines that the PVCs are not resulting in perfusion. The appropriate action by the nurse is:

- Documenting the findings
- Asking the ED physician to check the client
- Correct Continuing to monitor the client's cardiac status Informing the client that PVCs are expected after an MI

Rationale: PVCs are a result of increased irritability of ventricular cells. Peripheral pulses may be absent or diminished with the PVCs themselves because the decreased stroke volume of the premature beats may in turn decrease peripheral perfusion. Because other rhythms also cause widened QRS complexes, it is essential that the nurse determine whether the premature beats are resulting in perfusion of the extremities. This is done by palpating the carotid, brachial, or femoral artery while observing the monitor for widened complexes or by auscultating for apical heart sounds. In the situation of acute MI, PVCs may be considered warning dysrhythmias, possibly heralding the onset of ventricular tachycardia or ventricular fibrillation. Therefore the nurse would not tell the client that the PVCs are expected.
Although the nurse will continue to monitor the client and document the findings, these are not the most appropriate actions of those provided. The most appropriate action would be to ask the ED physician to check the client.

5. ID: 383704545
NPO status is imposed 8 hours before the procedure on a client scheduled to undergo electroconvulsive therapy (ECT) at 1 p.m. On the morning of the procedure, the nurse checks the client's record and notes that the client routinely takes an oral antihypertensive medication each morning. The nurse should:

- Administer the antihypertensive with a small sip of water
- Correct Withhold the antihypertensive and administer it at bedtime Administer the medication by way of the intravenous (IV) route
- Hold the antihypertensive and resume its administration on the day after the ECT

Rationale: General anesthesia is required for ECT, so NPO status is imposed for 6 to 8 hours before treatment to help prevent aspiration. Exceptions include clients who routinely receive cardiac medications, antihypertensive agents, or histamine (H2) blockers, which should be administered several hours before treatment with a small sip of water. Withholding the antihypertensive and administering it at bedtime and withholding the antihypertensive and resuming administration on the day after the ECT are incorrect actions, because antihypertensives must be administered on time; otherwise, the risk for

rebound hypertension exists. The nurse would not administer a medication by way of a route that has not been prescribed.

6. ID: 383706660
A client who recently underwent coronary artery bypass graft surgery comes to the physician's office for a follow-up visit. On assessment, the client tells the nurse that he is feeling depressed. Which response by the nurse is therapeutic?

- "Tell me more about what you're feeling." Correct
- "That's a normal response after this type of surgery."
- "It will take time, but, I promise you, you will get over this depression."
- "Every client who has this surgery feels the same way for about a month."

Rationale: When a client expresses feelings of depression, it is extremely important for the nurse to further explore these feelings with the client. In stating, "This is a normal response after this type of surgery" the nurse provides false reassurance and avoids addressing the client's feelings. "It will take time, but, I promise you, you will get over the depression" is also a false reassurance, and it does not encourage the expression of feelings. "Every client who has this surgery feels the same way for about a month" is a generalization that avoids the client's feelings.

7. ID: 383705009
A client in labor experiences spontaneous rupture of the membranes. The nurse immediately counts the fetal heart rate (FHR) for 1 full minute and then checks the amniotic fluid. The nurse notes that the fluid is yellow and has a strong odor. Which of the following actions should be the nurse's priority?

- Contacting the physician Correct Documenting the findings Checking the fluid for protein
- Continuing to monitor the client and the FHR

Rationale: The FHR is assessed for at least 1 minute when the membranes rupture. The nurse also checks the quantity, color, and odor of the amniotic fluid. The fluid should be clear (often with bits of vernix) and have a mild odor. Fluid with a foul or strong odor, cloudy appearance, or yellow coloration suggests chorioamnionitis and warrants notifying the physician. A large amount of vernix in the fluid suggests that the fetus is preterm. Greenish, meconium-stained fluid may be seen in cases of postterm gestation or placental insufficiency. Checking the fluid for protein is not associated with the data in the question.
Although the nurse would continue to monitor the client and the FHR and would document the findings, contacting the physician is the priority.

8. ID: 383705011

A nurse has assisted a physician in inserting a central venous access device into a client with a diagnosis of severe malnutrition who will be receiving parenteral nutrition (PN). After insertion of the catheter, the nurse immediately plans to:

- Call the radiography department to obtain a chest x-ray Correct
- Check the client's blood glucose level to serve as a baseline measurement

- Hang the prescribed bag of PN and start the infusion at the prescribed rate
- Infuse normal saline solution through the catheter at a rate of 100 mL/hr to maintain patency Rationale: One major complication associated with central venous catheter placement is pneumothorax, which may result from accidental puncture of the lung. After the catheter has been placed but before it is used for infusions, its placement must be checked with an x-ray. Hanging the prescribed bag of PN and starting the infusion at the prescribed rate and infusing normal saline solution through the catheter at a rate of 100 mL/hr to maintain patency are all incorrect because they could result in the infusion of solution into a lung if a pneumothorax is present. Although the nurse may obtain a blood glucose measurement to serve as a baseline, this action is not the priority.

9. ID: 383705041
A rape victim being treated in the emergency department says to the nurse, "I'm really worried that I've got HIV now." What is the appropriate response by the nurse?
- "HIV is rarely an issue in rape victims."
- "Every rape victim is concerned about
- HIV."
- "You're more likely to get pregnant than to contract HIV."
- "Let's talk about the information that you need to determine your risk of contracting HIV." Correct Rationale: HIV is a concern of rape victims. Such concern should always be addressed, and the victim should be given the information needed to evaluate his or her risk. Pregnancy may occur as a result of rape, and pregnancy prophylaxis can be offered in the emergency department or during follow-up, once the results of a pregnancy test have been obtained. However, stating, "You're more likely to get pregnant than to contract HIV" avoids the client's concern. Similarly, "HIV is rarely an issue in rape victims" and "Every rape victim is concerned about HIV" are generalized responses that avoid the client's concern.

10. ID: 383703603
A client is taking prescribed ibuprofen (Motrin), 300 mg orally four times daily, to relieve joint pain resulting from rheumatoid arthritis. The client tells the nurse that the medication is causing nausea and indigestion. The nurse should tell the client to:
- Contact the physician
- Stop taking the medication
- Take the medication with food Correct
- Take the medication twice a day instead of four times

Rationale: Ibuprofen is a nonsteroidal antiinflammatory medication. Side effects include nausea (with or without vomiting) and dyspepsia (heartburn, indigestion, or epigastric pain). If gastrointestinal distress occurs, the client should be instructed to take the medication with milk or food. The nurse would not instruct the client to stop the medication or instruct the client to adjust the dosage of a prescribed medication; these actions are not within the legal scope of

the role of the nurse. Contacting the physician is premature, because the client's complaints are side effects that occasionally occur and can be relieved by taking the medication with milk or food.

11. ID: 383704532
A client's oral intake of liquids includes 120 mL on the night shift, 800 mL on the day shift, and 650 mL on the evening shift. The client is receiving an intravenous (IV) antibiotic every 12 hours, diluted in 50 mL of normal saline solution. The nurse empties 700 mL of urine from the client's Foley catheter at the end of the day shift. Thereafter, 500 mL of urine is emptied at the end of the evening shift and 325 mL at the end of the night shift. Nasogastric tube drainage totals 155 mL for the 24-hour period, and the total drainage from the Jackson-Pratt device is 175 mL. What is the client's total intake during the 24-hour period? Type your answer in the space provided.

Answer: _____mL

Correct Responses: "1670"

12. ID: 383704537
Lorazepam (Ativan) 1 mg by way of intravenous (IV) injection (IV push) is prescribed for a client for the management of anxiety. The nurse prepares the medication as prescribed and administers the medication over a period of:

- 3 minutes
- Correct 10 seconds
- 15 seconds
- 30 minutes

Rationale: Lorazepam is a benzodiazepine. When administered by IV injection, each 2 mg or fraction thereof is administered over a period of 1 to 5 minutes. Ten seconds and 30 seconds are brief periods. Thirty minutes is a lengthy period.

13. ID: 383706090
A nurse, conducting an assessment of a client being seen in the clinic for symptoms of a sinus infection, asks the client about medications that he is taking. The client tells the nurse that he is taking nefazodone hydrochloride (Serzone). On the basis of this information, the nurse determines that the client most likely has a history of:

- Depression Correct
- Diabetes mellitus
- Hyperthyroidism
- Coronary artery disease

Rationale: Nefazodone hydrochloride is an antidepressant used as maintenance therapy to prevent relapse of an acute depression. Diabetes mellitus, hypethyroidism, and coronary artery

disease are not treated with this medication.

14. ID: 383707982
Phenelzine sulfate (Nardil) is prescribed for a client with depression. The nurse provides information to the client about the adverse effects of the medication and tells the client to contact the physician immediately if she experiences:

- Dry mouth
- Restlessness
- Feelings of depression
- Neck stiffness or soreness Correct

Rationale: Phenelzine sulfate, a monoamine oxidase inhibitor (MAOI), is an antidepressant and is used to treat depression. Hypertensive crisis, an adverse effect of this medication, is characterized by hypertension, frontally radiating occipital headache, neck stiffness and soreness, nausea, vomiting, sweating, fever and chills, clammy skin, dilated pupils, and palpitations. Tachycardia, bradycardia, and constricting chest pain may also be present. The client is taught to be alert to any occipital headache radiating frontally and neck stiffness or soreness, which could be the first signs of a hypertensive crisis.
Dry mouth and restlessness are common side effects of the medication.

15. ID: 383703621
Risperidone (Risperdal) is prescribed for a client hospitalized in the mental health unit for the treatment of a psychotic disorder. Which finding in the client's medical record would prompt the nurse to contact the prescribing physician before administering the medication?

- The client has a history of cataracts.
- The client has a history of hypothyroidism.
- The client takes a prescribed antihypertensive.
- Correct The client is allergic to acetylsalicylic acid (aspirin).

Rationale: Risperidone is an antipsychotic medication. Contraindications to the use of risperidone include cardiac disorders, cerebrovascular disease, dehydration, hypovolemia, and therapy with antihypertensive agents. Risperidone is used with caution in clients with a history of seizures. History of cataracts, hypothyroidism, or allergy to aspirin does not affect the administration of this medication.

16. ID: 383707984
A client who has been undergoing long-term therapy with an antipsychotic medication is admitted to the inpatient mental health unit. Which of the following findings does the nurse, knowing that long-term use of an antipsychotic medication can cause tardive dyskinesia, monitor in the client?

- Fever
- Diarrhea
-
-

Hypertensio

n

Tongue protrusion Correct

Rationale: Tardive dyskinesia is a severe reaction associated with long-term use of antipsychotic medications. The clinical manifestations include abnormal movements (dyskinesia) and involuntary

movements of the mouth, tongue ("flycatcher tongue"), and face. In its most severe form, tardive dyskinesia involves the fingers, arms, trunk, and respiratory muscles. When this occurs, the medication is discontinued. Fever, diarrhea, and hypertension are not characteristics of tardive dyskinesia.

17. ID: 383706064
A nurse is reviewing the record of a client scheduled for electroconvulsive therapy (ECT). Which of the following diagnoses, if noted on the client's record, would indicate a need to contact the physician who is scheduled to perform the ECT?

- Recent stroke
- Correct
- Hypothyroidism
- History of glaucoma
- Peripheral vascular disease

Rationale: Several conditions pose risks in the client scheduled for ECT. Among them are recent myocardial infarction or stroke and cerebrovascular malformations or intracranial lesions. Hypothyroidism, glaucoma, and peripheral vascular disease are not contraindications to this treatment.

18. ID: 383712440
A client scheduled for suprapubic prostatectomy has listened to the surgeon's explanation of the surgery. The client later asks the nurse to explain again how the prostate is going to be removed. The nurse tells the client that the prostate will be removed through:

- A lower abdominal incision
- Correct An upper abdominal incision
- An incision made in the perineal area
- The urethra, with the use of a cutting wire

Rationale: A lower abdominal incision is used in suprapubic or retropubic prostatectomy. An upper abdominal incision is not used to remove the prostate. An incision between the scrotum and anus is made when a perineal prostatectomy is performed. Transurethral resection is performed through the urethra; an instrument called a resectoscope is used to cut the tissue by means of a high-frequency current.

19. ID: 383707954
A nurse is preparing a poster for a health fair booth promoting primary prevention of skin cancer. Which of the following recommendations does the nurse include on the poster? Select all that apply.

- Seek medical advice if you find a skin lesion.
-
-

Correct Use sunscreen with a low sun protection factor (SPF). Avoid sun exposure before 10 a.m. and after 4 p.m.

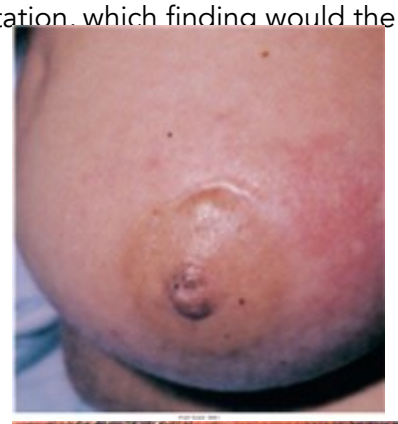
Wear a hat, opaque clothing, and sunglasses when out in the sun. Correct

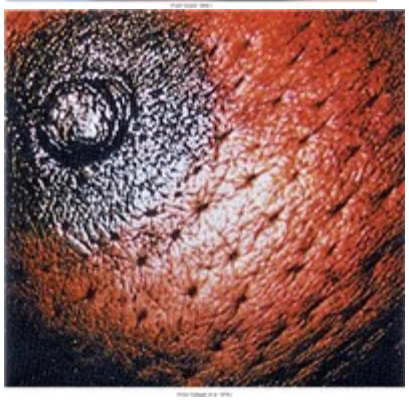
Examine the body every 6 months for possibly cancerous or precancerous lesions.

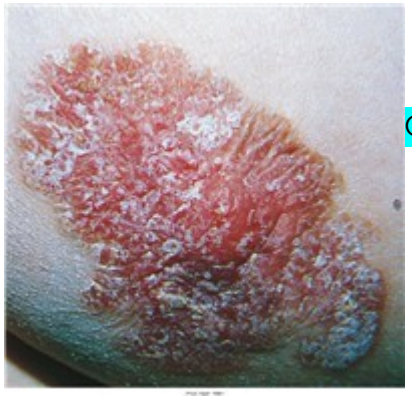
Rationale: Measures to prevent skin cancer include avoiding sun exposure between 10 a.m. and 4 p.m.; using sunscreen with a high SPF; wearing a hat, opaque clothing, and sunglasses when out in the sun; and examining the body every month for possibly cancerous or precancerous lesions. The client should also seek medical advice if any changes in a skin lesion are noted.

20. ID: 383702969

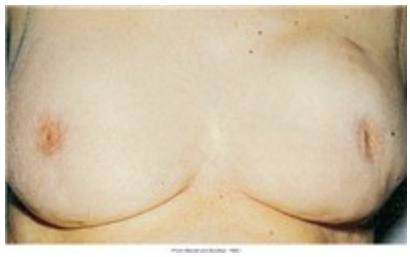
A nurse reviewing the medical record of a client with a diagnosis of infiltrating ductal carcinoma of the breast notes documentation of the presence of peau d'orange skin. On the basis of this notation, which finding would the nurse expect to note on assessment of the client's breast?







Correct



Rationale: Peau d'orange (French for "orange peel") is the term used to describe skin dimpling, resembling the skin of an orange, at the location of a breast mass. This change, along with increased vascularity, nipple retraction, or ulceration, may indicate advanced disease. Erythema, or reddening, of the breast indicates inflammation such as that resulting from cellulitis or a breast abscess. Paget's disease is a rare type of breast cancer that is manifested as a red, scaly nipple; discharge; crusting lasting more than a few weeks. In nipple retraction, the nipple is pointed or pulled in an abnormal direction. It is suggestive of malignancy.

21. ID: 383702971

The mother of an adolescent with type 1 diabetes mellitus tells the nurse that her child is a member of the school soccer team and expresses concern about her child's participation in sports. The nurse, after providing information to the mother about diet, exercise, insulin, and blood glucose control, tells the mother:

- To always administer less insulin on the days of soccer games
- That it is best not to encourage the child to participate in sports activities
- That the child should eat a carbohydrate snack about a half-hour before each soccer game
- Correct To administer additional insulin before a soccer game if the blood glucose level is 240 mg/dL or higher and ketones are present

Rationale: The child with diabetes mellitus who is active in sports requires additional food intake in the form of a carbohydrate snack about a half-hour before the anticipated activity. Additional food will need to be consumed, often as frequently as every 45 minutes to 1 hour, during prolonged periods of activity. If the blood glucose level is increased (240 mg/dL or more) and ketones are present before planned exercise, the activity should be postponed until the blood glucose has been controlled. Moderate to high ketone values should be reported to the physician. There is no reason for the child to avoid participating in sports.

22. ID: 383705039

A client with chronic renal failure who will require dialysis three times a week for the rest of his life says to the nurse, "Why should I even bother to watch what I eat and drink? It doesn't really matter what I do if I'm never going to get better!" On the basis of the client's statement, the nurse determines that the client is experiencing which problem?

- Anxiety
- Powerlessness
- Correct Ineffective

coping

Disturbed body image

Rationale: Powerlessness is present when a client believes that he or she has no control over the situation or that his or her actions will not affect an outcome in any significant way. Anxiety is a vague uneasy feeling of apprehension. Some factors in anxiety include a threat or perceived threat to physical or emotional integrity or self-concept, changes in role function, and a threat to or change in socioeconomic status. Ineffective coping is present when the client exhibits impaired adaptive abilities or behaviors in meeting the demands or roles expected. Disturbed body image is diagnosed when there is an alteration in the way the client perceives his or her own body image.

23. ID: 383710055

A nurse is providing morning care to a client in end-stage renal failure. The client is reluctant to talk and shows little interest in participating in hygiene care. Which statement by the nurse would be therapeutic?

"What are your feelings right now?"

Correct "Why don't you feel like washing up?"

"You aren't talking today. Cat got your tongue?"

"You need to get yourself cleaned up. You have company coming today."

Rationale: Asking, "What are your feelings right now?" encourages the client to identify his or her emotions or feelings, which is a therapeutic communication technique. In stating, "Why don't you feel like washing up?" the nurse is requesting an explanation of feelings and behaviors for which the client may not know the reason. Requesting an explanation is a nontherapeutic communication technique. "You aren't talking today. Cat got your tongue?" is a nontherapeutic cliché. The statement "You need to get yourself cleaned up. You have company coming today" is demanding, demeaning to the client, and nontherapeutic.

Test-Taking Strategy: Use your knowledge of therapeutic communication techniques to answer the question. Remembering to focus on the client's feelings will direct you to the correct option. Review therapeutic communication techniques if you had difficulty with this question.

References: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 1600, 1601). St. Louis: Saunders.
Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed., pp. 352-357). St. Louis:

Mosby. Cognitive Ability: Applying

Client Needs: Psychosocial Integrity
Integrated Process: Communication and

Documentation Content Area: Adult Health/Renal

Awarded 0.0 points out of 1.0 possible points.

24. ID: 383704543

Empyema develops in a client with an infected pleural effusion, and the nurse prepares the client for thoracentesis. What characteristics of the fluid removed during thoracentesis should the nurse, assisting the physician with the procedure, expect to note?

- Clear and yellow
- Thick and opaque Correct
- White and odorless
- Clear, with a foul odor

Rationale: Empyema is the accumulation of pus in the pleural space. Empyema fluid is thick, opaque, exudative, and intensely foul-smelling. Clear and yellow, white and odorless, and clear and foul-smelling are incorrect descriptions of the fluid that occurs in this disorder.

Test-Taking Strategy: Use the process of elimination. Focusing on the words "empyema" and "infected pleural effusion" will assist in directing you to the correct option. In this disorder, the fluid is not clear or odorless. Review the characteristics of empyema if you had difficulty with this question.

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., p. 674). St. Louis: Saunders.

Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/

Analysis

Content Area: Adult Health/Respiratory
Awarded 0.0 points out of 1.0 possible
points.
25. ID: 383706054
An emergency department nurse is told that a client with carbon monoxide poisoning resulting from a suicide attempt is being brought to the hospital by emergency medical services. Which intervention will the nurse carry out as a priority upon arrival of the client?

- Administering 100% oxygen
- Correct Having a crisis counselor
- available

  Instituting suicide precautions for the client
- Obtaining blood for determination of the client's carboxyhemoglobin level

Rationale: A client with carbon monoxide poisoning is treated with inhalation of 100% oxygen to shorten the half-life of carbon monoxide to around an hour. Hyperbaric oxygen may be required to reduce the half-life to minutes by forcing the carbon monoxide off the hemoglobin

molecule. Because the poisoning occurred as a result of a suicide attempt, a crisis counselor should be consulted, but this is not the priority. Suicide precautions should be instituted once emergency interventions have been completed and the client has been admitted to the hospital. The diagnosis is confirmed with a measurement of the carboxyhemoglobin level in the client's blood. Obtaining a blood specimen in which measure the carboxyhemoglobin level is a priority; however, the nurse would immediately administer 100% oxygen to the client.

Test-Taking Strategy: Note the strategic word "priority" and use the ABCs — airway, breathing, and circulation. This will direct you to the correct option. Review care of the client with carbon monoxide poisoning and care after a suicide attempt if you had difficulty with this question.

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 529-530). St. Louis: Saunders.

Cognitive Ability: Applying

Client Needs: Physiological Integrity
Integrated Process: Nursing Process/Implementation

Content Area: Critical Care

Awarded 0.0 points out of 1.0 possible points.
26. ID: 383703691
A nurse is caring for a client with sarcoidosis. The client is upset because he has missed work and worried about how he will care financially for his wife and three small children. On the basis of the client's concern, which problem does the nurse identify?

- Anxiety Correct
- Powerlessness
- Disruption of thought processes
- Inability to maintain health

Rationale: Anxiety is a vague, uneasy feeling of apprehension. Some related factors include a threat or perceived threat to physical or emotional integrity or self-concept, changes in function in one's role, and threats to or changes in socioeconomic status. The client experiencing powerlessness expresses feelings of having no control over a situation or outcome. Disruption of thought processes involves disturbance of cognitive abilities or thought. Inability to maintain health is being incapable of seeking out help needed to maintain health.

Test-Taking Strategy: Use the process of elimination. Focusing on the data in the question and noting the words "upset" and "worried" will direct you to the correct option. Review the defining characteristics of anxiety if you had difficulty with this question.

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 638, 639). St. Louis: Saunders.

Cognitive Ability: Analyzing

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process/

Analysis

Content Area: Adult Health/Respiratory
Awarded 0.0 points out of 1.0 possible points.

27. ID: 383709211
A nurse, performing an assessment of a client who has been admitted to the hospital with suspected silicosis, is gathering both subjective and objective data. Which question by the nurse would elicit data specific to the cause of this disorder?

- "Do you chew tobacco?"
- "Do you smoke cigarettes?"
- "Have you ever worked in a mine?" Correct
- "Are you frequently exposed to paint products?"

Rationale: Silicosis is a chronic fibrotic disease of the lungs caused by the inhalation of free crystalline silica dust over a long period. Mining and quarrying are each associated with a high incidence of silicosis. Hazardous exposure to silica dust also occurs in foundry work, tunneling, sandblasting, pottery-making, stone masonry, and the manufacture of glass, tile, and bricks. The finely ground silica used in soaps, polishes, and filters also presents a risk. The assessment questions noted in the other options are unrelated to the cause of silicosis.

Test-Taking Strategy: Use the process of elimination. Eliminate the options that are comparable or alike in that they are related to the use of tobacco. To select correctly from the remaining options, it is necessary to recall that silicosis is caused by exposure to dust. Review the causes of silicosis if you had difficulty with this question.

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., p. 640). St. Louis: Saunders.

Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Assessment

Content Area: Adult Health/Respiratory
Awarded 0.0 points out of 1.0 possible
points.
28. ID: 383706004
A physician prescribes a dose of morphine sulfate 2.5 mg stat to be administered intravenously to a client in pain. The nurse preparing the medication notes that the label on the vial of morphine sulfate solution for injection reads “4 mg/mL.” How many milliliters (mL) must the nurse draw into a syringe for administration to the client? Type the answer in the space provided.

Answer: _____
mL Incorrect

Correct Responses: "0.625, .625,
1" Awarded 0.0 out of 1.0 possible
points.
29. ID: 383708582
A client undergoing therapy with carbidopa/levodopa (Sinemet) calls the nurse at the clinic and reports that his urine has become darker since he started taking the medication. The nurse should tell the client:

- To call his physician
- That he needs to drink more fluids
- That this is an occasional side effect of the medication
- Correct That this may be a sign of developing toxicity of the medication

Rationale: Carbidopa/levodopa, an antiparkinson agent, may cause darkening of the urine or sweat. The client should be reassured that this is a harmless side effect of the medication and that the medication's use should be continued. Although fluid intake is important, telling the client that he needs to drink more fluid is incorrect and unnecessary. Telling the client that the darkening of his urine may signal developing medication toxicity is incorrect and might alarm the client unnecessarily. There is no need for the client to call the physician.

Test-Taking Strategy: Use the process of elimination. Eliminate first the options that are comparable or alike (i.e., if toxicity is developing, the physician would need to be notified). To select from the remaining options, recall the side effects of carbidopa/levodopa therapy, which will direct you to the correct option. Review the side effects of this medication if you had difficulty with this question.

Reference: Kee, J., Hayes, E., & McCuistion, L. (2009). Pharmacology: A nursing process approach (6th ed., p. 336). Philadelphia: Saunders.

Cognitive Ability: Applying

Client Needs: Physiological Integrity
Integrated Process: Nursing Process/Implementation

Content Area: Pharmacology

Awarded 0.0 points out of 1.0 possible
points. 30.ID: 383703617
A client with myasthenia gravis is taking neostigmine bromide (Prostigmin). The nurse determines that the client is gaining a therapeutic effect from the medication after noting:

- Bradycardia
- Increased heart rate
- Decreased blood pressure
- Improved swallowing function Correct

Rationale: Neostigmine bromide, a cholinergic medication that prevents the destruction of acetylcholine, is used to treat myanthenia gravis. The nurse would monitor the client for a therapeutic response, which includes increased muscle strength, an easing of fatigue, and improved chewing and swallowing function. Bradycardia, increased heart rate, and decreased blood pressure are signs of an adverse reaction to the medication.

Test-Taking Strategy: Note the strategic words "a therapeutic effect." Focusing on the client's diagnosis and recalling the pathophysiology associated with this disorder will direct you to the correct option.
Review the therapeutic and adverse effects of this medication if you had difficulty with this question.

Reference: Lehne, R. (2010). Pharmacology for nursing care (7th ed., pp. 133, 137, 138). St. Louis: Saunders.

Cognitive Ability: Evaluating

Client Needs: Physiological Integrity
Integrated Process: Nursing Process/

Evaluation Content Area: Pharmacology

Awarded 0.0 points out of 1.0 possible points.
31. ID: 383703637
A nurse is assessing a client who has been taking amantadine hydrochloride (Symmetrel) for the treatment of Parkinson's disease. Which finding from the history and physical examination would cause the nurse to determine that the client may be experiencing an adverse effect of the medication?

- Insomnia
- Rigidity and akinesia
- Bilateral lung wheezes Correct
- Orthostatic hypotension

Rationale: Amantadine hydrochloride is an antiparkinson agent that potentiates the action of dopamine in the central nervous system (CNS). The medication is used to treat rigidity and akinesia. Insomnia and orthostatic hypotension are side effects of the medication. Adverse effects include congestive heart failure (evidenced by bilateral lung wheezes), leukopenia, neutropenia, hyperexcitability, convulsions, and ventricular dysrhythmias.

Test-Taking Strategy: Use the process of elimination and focus on the subject, an adverse effect. Recalling that the medication is used to treat rigidity and akinesia will assist you in eliminating this option. To select from the remaining options, use the ABCs — airway, breathing, and circulation. Review the adverse effects of amantadine hydrochloride if you had difficulty with this question.

Reference: Lehne, R. (2010). Pharmacology for nursing care (7th ed., pp. 194, 1083). St. Louis:

Saunders. Cognitive Ability: Evaluating

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Evaluation

Content Area: Adult Health/Neurological
Awarded 0.0 points out of 1.0 possible
points.
32. ID: 383703669
A nurse who will be staffing a booth at a health fair is preparing pamphlets containing

information regarding the risk factors for osteoporosis. Which of the following risk factors does the nurse include in the pamphlet? Select all that apply.

- [ ] Smoking Correct
- [ ] A high-calcium diet
- [ ] High alcohol intake Correct
- [ ] White or Asian ethnicity
- [ ] Correct

Participation in physical activities that promote flexibility and muscle strength

Rationale: Osteoporosis is a chronic metabolic disease in which bone loss results in decreased density and sometimes fractures. Risk factors include being 65 years or older in women, 75 years or older in men, family history of the disorder, history of fracture after age 50, white or Asian ethnicity, low body weight and slender build, chronically low calcium intake, a history of smoking, high alcohol intake, and lack of physical exercise or prolonged immobility.

Test-Taking Strategy: Focus on the subject, a risk factor. Recalling that this disorder involves bone loss resulting in decreased density and sometimes fractures will direct you to the correct options. Review the risk factors for osteoporosis if you are not familiar with them.

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 1153, 1154, 1157). St. Louis: Saunders.

Cognitive Ability: Applying

Client Needs: Health Promotion and Maintenance

Integrated Process: Teaching and Learning

Content Area: Adult Health/Musculoskeletal
Awarded 0.0 points out of 1.0 possible
points.

33. ID: 383706656

A nurse is providing instruction to a client with osteoporosis regarding appropriate foods to include in the diet. The nurse tells the client that one food item high in calcium is:

- Corn
- Cocoa
- Peache
- s
- Sardines Correct

Rationale: Osteoporosis is a chronic metabolic disease in which bone loss results in decreased density and sometimes fractures. Foods high in calcium include milk and milk products, dark-green leafy vegetables, tofu and other soy products, sardines, and hard water. Corn, cocoa, and peaches do not contain appreciable amounts of calcium.