HESI EXIT EXAM- LATEST 2021 COMPLETE QUESTIONS & ANSWERS.

1. A nurse is evaluating care of an immobilized patient. Which action will the nurse take?

a. Focus on whether the interdisciplinary team is satisfied with the care.

b. Compare the patient’s actual outcomes with the outcomes in the care plan.

c. Involve primarily the patient’s family and health care team to determine goal achievement.

d. Use objective data solely in determining whether interventions have been successful.

ANS: B

From your perspective as the nurse, you are to evaluate outcomes and response to nursing care and compare the patient’s actual outcomes with the outcomes selected during planning. Ask if the patient’s expectations (subjective data) of care are being met, and use objective data to determine the success of interventions. Just as it was important to include the patient during the assessment and planning phase of the care plan, it is essential to have the patient’s evaluation of the plan of care, not just the patient’s family and health care team.

2. A nurse is supervising the logrolling of a patient. To which patient is the nurse **most** likely providing care?

a. A patient with neck surgery

b. A patient with hypostatic pneumonia

c. A patient with a total knee replacement

d. A patient with a Stage IV pressure ulcer

ANS: A

A nurse supervises and aids personnel when there is a health care provider’s

order to logroll a patient. Patients who have suffered from spinal cord injury or are recovering from neck, back, or spinal surgery often need to keep the spinal column in straight alignment to prevent further injury. Hypostatic pneumonia, total knee replacement, and Stage IV ulcers do not have to be logrolled.

3. The nurse is providing teaching to an immobilized patient with impaired skin integrity about diet. Which diet will the nurse recommend?

a. High protein, high calorie

b. High carbohydrate, low fat

c. High vitamin A, high vitamin E

d. Fluid restricted, bland

ANS: A

Because the body needs protein to repair injured tissue and rebuild depleted protein stores, give the immobilized patient a high-protein, high-calorie diet. A high-carbohydrate, low-fat diet is not beneficial for an immobilized patient. Vitamins B and C are needed rather than A and E. Fluid restriction can be detrimental to the immobilized patient; this can lead to dehydration. A bland diet is not necessary for immobilized patients.

4. The nurse is caring for a patient who has had a stroke causing total paralysis of the right side. To help maintain joint function and minimize the disability from contractures, passive ROM will be initiated. When should the nurse begin this therapy?

a. After the acute phase of the disease has passed

b. As soon as the ability to move is lost

c. Once the patient enters the rehab unit

d. When the patient requests it

ANS: B

Passive ROM exercises should begin as soon as the patient’s ability to move the extremity or joint is lost. The nurse should not wait for the acute phase to end. It may be some time before the patient enters the rehab unit or the patient requests it, and contractures could form by then.

5. The nurse is admitting a patient who has been diagnosed as having had

a stroke. The health care provider writes orders for “ROM as needed.” What should the nurse do **next**?

a. Restrict patient’s mobility as much as possible.

b. Realize the patient is unable to move extremities.

c. Move all the patient’s extremities.

d. Further assess the patient.

ANS: D

Further assessment of the patient is needed to determine what the patient is able to perform. Some patients are able to move some joints actively, whereas the nurse passively moves others. With a weak patient, the nurse may have to support an extremity while the patient performs the movement. In general, exercises need to be as active as health and mobility allow.

6. A nurse is assessing pressure points in a patient placed in the Sims’ position. Which areas will the nurse observe?

a. Chin, elbow, hips

b. Ileum, clavicle, knees

c. Shoulder, anterior iliac spine, ankles

d. Occipital region of the head, coccyx, heels

ANS: B

In the Sims’ position pressure points include the ileum, humerus, clavicle, knees, and ankles. The lateral position pressure points include the ear, shoulder, anterior iliac spine, and ankles. The prone position pressure points include the chin, elbows, female breasts, hips, knees, and toes. Supine position pressure points include the occipital region of the head, vertebrae, coccyx, elbows, and heels.

7. The patient is admitted to a skilled care unit for rehabilitation after the surgical procedure of fixation of a fractured left hip. The patient’s nursing diagnosis is *Impaired physical mobility related to musculoskeletal impairment from surgery and pain with movement.* The patient is able to use a walker but needs assistance ambulating and transferring from the bed

to the chair. Which nursing intervention is **most** appropriate for this patient?

a. Obtain assistance and physically transfer the patient to the chair.

b. Assist with ambulation and measure how far the patient walks.

c. Give pain medication after ambulation so the patient will have a clear mind.

d. Bring the patient to the cafeteria for group instruction on ambulation.

ANS: B

Assist with walking and measure how far the patient walks to quantify progress. The nurse should allow the patient to do as much for self as possible. Therefore, the nurse should observe the patient transferring from the bed to the chair using the walker and should provide assistance as needed. The patient should be encouraged to use adequate pain medication to decrease the effects of pain and to increase mobility. The patient should be instructed on safe transfer and ambulation techniques in an environment with few distractions, not in the cafeteria.