HESI RN FUNDAMENTALS

1. A 20-year-old female client with a noticeable body odor has refused to shower for the last 3 days. She states, "I have been told that it is harmful to bathe during my period." Which action should the nurse take first?

A. Accept and document the client's wish to refrain from bathing.

B. Offer to give the client a bed bath, avoiding the perineal area.

C. Obtain written brochures about menstruation to give to the client.

D. Teach the importance of personal hygiene during menstruation with the client.: D

Rationale: Because a shower is most beneficial for the client in terms of hygiene, the client should receive teaching first, respecting any personal beliefs such as cultural or spiritual values. After client teaching, the client may still choose option A or B. Brochures reinforce the teaching.

2. A 65-year-old client who attends an adult daycare program and is wheelchair-mobile has redness in the sacral area. Which instruction is most important for the nurse to provide?

A. Take a vitamin supplement tablet once a day.

B. Change positions in the chair at least every hour.

C. Increase daily intake of water or other oral fluids.

D. Purchase a newer model wheelchair.: B

Rationale: The most important teaching is to change positions frequently because pressure is the most significant factor related to the development of pressure ulcers. Increased vitamin and fluid intake may also be beneficial and promote healing and reduce further risk. Option D is an intervention of last resort because this will be very expensive for the client.

3. After a needle stick occurs while removing the cap from a sterile needle, which action should the nurse implement?

A.Complete an incident report.

B.Select another sterile needle.

C.Disinfect the needle with an alcohol swab.

D.Notify the supervisor of the department immediately.: B

Rationale: After a needle stick, the needle is considered used, so the nurse should discard it and select another needle. Because the needle was sterile when the nurse was stuck and the needle was not in contact with any other person's body fluids, the nurse does not need to complete an

incident report or notify the occupational health nurse. Disinfecting a needle with an alcohol swab is not in accordance with standards for safe practice and infection control.

4. After receiving written and verbal instructions from a clinic nurse about a newly prescribed medication, a client asks the nurse what to do if questions arise about the medication after getting home. How should the nurse respond?

A. **Provide the client with a list of Internet sites that answer frequently asked questions about medications.**

B. **Advise the client to obtain a current edition of a drug reference book from a local bookstore or library.**

C. **Reassure the client that information about the medication is included in the written instructions.**

D. **Encourage the client to call the clinic nurse or health care provider if any questions arise.:** D

Rationale: To ensure safe medication use, the nurse should encourage the client to call the nurse or health care provider if any questions arise. Options A, B, and C may all include useful information, but these sources of information cannot evaluate the nature of the client's questions and the follow-up needed.

5. After the nurse tells an older client that an IV line needs to be inserted, the client becomes very apprehensive, loudly verbalizing a dislike for all health care providers and nurses. How should the nurse respond?

A. **Ask the client to remain quiet so the procedure can be performed safely.**

B. **Concentrate on completing the insertion as efficiently as possible.**

C. **Calmly reassure the client that the discomfort will be temporary.**

D. **Tell the client a joke as a means of distraction from the procedure.:** C

Rationale: The nurse should respond with a calm demeanor to help reduce the client's apprehension. After responding calmly to the client's apprehension, the nurse may implement to ensure safe completion of the procedure.

6. Based on the nursing diagnosis of risk for infection, which intervention is best for the nurse to implement when providing care for an older incontinent client?

A. Maintain standard precautions.

B. Initiate contact isolation measures.

C. Insert an indwelling urinary catheter.

D. Instruct client in the use of adult diapers.: A

Rationale: The best action to decrease the risk of infection in vulnerable clients is handwashing. Option B is not necessary unless the client has an infection. Option C increases the risk of infection. Option D does not reduce the risk of infection.

7. By rolling contaminated gloves inside-out, the nurse is affecting which step in the chain of infection?

A. Mode of transmission

B. Portal of entry

C. Reservoir

D. Portal of exit: A

Rationale: The contaminated gloves serve as the mode of transmission from the portal of exit of the reservoir to a portal of entry.

8. A client becomes angry while waiting for a supervised break to smoke a cigarette outside and states, "I want to go outside now and smoke. It takes forever to get anything done here!" Which intervention is best for the nurse to implement?

A. Encourage the client to use a nicotine patch.

B. Reassure the client that it is almost time for another break.

C. Have the client leave the unit with another staff member.

D. Review the schedule of outdoor breaks with the client.: D

Rationale: The best nursing action is to review the schedule of outdoor breaks and provide concrete information about the schedule. Option A is contraindicated if the client wants to continue smoking. Option B is insufficient to encourage a trusting relationship with the client. Option C is preferential for this client only and is inconsistent with unit rules.

9. A client has a nasogastric tube connected to low intermittent suction. When administering medications through the nasogastric tube, which action should the nurse do first?

A. **Clamp the nasogastric tube.**

B. **Confirm placement of the tube.**

C. **Use a syringe to instill the medications.**

D. **Turn off the intermittent suction device.:** D

Rationale: The nurse should first turn off the suction and then confirm placement of the tube in the stomach before instilling the medications. To prevent immediate removal of the instilled

medications and allow absorption, the tube should be clamped for a period of time before reconnecting the suction.

10. A client has a nursing diagnosis of Altered sleep patterns related to nocturia. Which client instruction is important for the nurse to provide?

A. Decrease intake of fluids after the evening meal.

B. Drink a glass of cranberry juice every day.

C. Drink a glass of warm decaffeinated beverage at bedtime.

D. Consult the health care provider about a sleeping pill.: A

Rationale: Nocturia is urination during the night. Option A is helpful to decrease the production of urine, thus decreasing the need to void at night. Option B helps prevent bladder infections. Option C may promote sleep, but the fluid will contribute to nocturia. Option D may result in urinary incontinence if the client is sedated and does not awaken to void.

11. A client in a long-term care facility reports to the nurse that he has not had a bowel movement in 2 days. Which intervention should the nurse implement first?

A. Instruct the caregiver to offer a glass of warm prune juice at mealtimes.

B. Notify the health care provider and request a prescription for a large-volume enema.

C. Assess the client's medical record to determine the client's normal bowel pattern.

D. Instruct the caregiver to increase the client's fluids to five 8-ounce glasses per day.: C

Rationale: This client may not routinely have a daily bowel movement, so the nurse should first assess this client's normal bowel habits before attempting any intervention. Option A, B, or D may then be implemented, if warranted.

12. A client's blood pressure reading is 156/94 mm Hg. Which action should the nurse take first?

A. Tell the client that the blood pressure is high and that the reading needs to be verified by another nurse.

B. Contact the health care provider to report the reading and obtain a prescription for an antihypertensive medication.

C. Replace the cuff with a larger one to ensure an ample fit for the client to increase arm comfort.

D. Compare the current reading with the client's previously documented blood pressure readings.: D

Rationale: Comparing this reading with previous readings will provide information about what is normal for this client; this action should be taken first. Option A might unnecessarily alarm the client. Option B is premature. Further assessment is needed to determine if the reading is abnormal for this client. Option C could falsely decrease the reading and is not the correct procedure for obtaining a blood pressure reading.

13. A community hospital is opening a mental health services department. Which document should the nurse use to develop the unit's nursing guidelines?

A. Americans with Disabilities Act of 1990

B. ANA Code of Ethics with Interpretative Statements

C. ANA's Scope and Standards of Nursing Practice

D. Patient's Bill of Rights of 1990: C

Rationale: The ANA Scope of Standards of Practice for Psychiatric-Mental Health Nursing serves to direct the philosophy and standards of psychiatric nursing practice. Options A and D define the client's rights. Option B provides ethical guidelines for nursing.

14. During a clinic visit, the mother of a 7-year-old reports to the nurse that her child is often awake until midnight playing and is then very difficult to awaken in the morning for school. Which assessment data should the nurse obtain in response to the mother's report?

A. The occurrence of any episodes of sleep apnea

B. The child's blood pressure, pulse, and respirations

C. Length of rapid eye movement (REM) sleep that the child is experiencing

D. Description of the family's home environment: D

Rationale: School-age children often resist bedtime. The nurse should begin by assessing the environment of the home to determine factors that may not be conducive to the establishment of bedtime rituals that promote sleep. Option A often causes daytime fatigue rather than resistance

to going to sleep. Option B is unlikely to provide useful data. The nurse cannot determine option C.

15. During a routine assessment, an obese 50-year-old female client expresses concern about her sexual relationship with her husband. Which is the best response by the nurse?

A. Reassure the client that many obese people have concerns about sex.

B. Remind the client that sexual relationships need not be affected by obesity.

C. Determine the frequency of sexual intercourse.

D. Ask the client to talk about specific concerns.: D