

# HESI MED SURG FINAL EXAM VERSION 2

## -2023

- A client who just returned from the recovery room after a tonsillectomy and adenoidectomy is restless and her pulse rate is increased. As the nurse continues the assessment, the client begins to vomit a copious amount of bright-red blood. The immediate nursing action is to:

- Notify the surgeon
- Continue the
- assessment
- Check the client's blood pressure
- Obtain a flashlight, gauze, and a curved hemostat

Rationale: Hemorrhage is a potential complication after tonsillectomy and adenoidectomy. If the client vomits a large amount of bright-red blood or the pulse rate increases and the patient is restless, the nurse must notify the surgeon immediately. The nurse should obtain a light, mirror, gauze, curved hemostat, and waste basin to facilitate examination of the surgical site. The nurse should also gather additional assessment data, but the surgeon must be contacted immediately.

Test-Taking Strategy: Focus on the data in the question. Noting the words "bright-red blood" will assist in directing you to the correct option.

Remember that the presence of bright-red blood indicates active bleeding. Review the nursing actions to be taken immediately when bleeding occurs after a tonsillectomy and adenoidectomy if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Delegating/

Prioritizing

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., p. 657). St. Louis: Saunders.

· A client who has just undergone surgery suddenly experiences chest pain, dyspnea, and tachypnea. The nurse suspects that the client has a pulmonary embolism and immediately sets about:

- Preparing the client for a perfusion scan
- Attaching the client to a cardiac monitor
- Administering oxygen by way of nasal cannula
- Ensuring that the intravenous (IV)

line is patent

Rationale: Pulmonary embolism is a life-threatening emergency. Oxygen is immediately administered nasally to relieve hypoxemia, respiratory distress, and central cyanosis, and the physician is notified. IV infusion lines are needed to administer medications or fluids. A perfusion scan, among other tests, may be performed. The electrocardiogram is monitored for the presence of dysrhythmias. Additionally, a urinary catheter may be inserted and blood for arterial blood gas determinations drawn. The immediate priority, however, is the administration of oxygen.

Test-Taking Strategy: Focus on the client's diagnosis and use the skills of prioritizing. Apply the ABCs (airway, breathing, and circulation) to find the correct option. Review the nursing actions to be taken immediately in the event of pulmonary embolism if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Delegating/

Prioritizing

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., p. 680). St. Louis: Saunders.

• A nurse is assessing a client who has a closed chest tube drainage system. The nurse notes constant bubbling in the water seal chamber. What actions should the nurse take? (Select all that apply).

Clamping the chest tube

Changing the drainage

system

Assessing the system for an external air leak

- Correct Reducing the degree of suction being applied

- ☑ Documenting assessment findings, actions taken, and client response  
Correct

Rationale: Constant bubbling in the water seal chamber of a closed chest tube drainage system may indicate the presence of an air leak. The nurse would assess the chest tube system for the presence of an external air leak if constant bubbling were noted in this chamber. If an external air leak is not present and the air leak is a new occurrence, the physician is notified immediately, because an air leak may be present in the pleural space. Leakage and trapping of air in the pleural space can result in a tension pneumothorax. Clamping the chest tube is incorrect.

Additionally, a chest tube is not clamped unless this has been specifically prescribed in the agency's policies and procedures. Changing the drainage system will not alleviate the problem. Reducing the degree of suction being applied will not affect the bubbling in the water seal chamber and could be harmful. The nurse would document the assessment findings and interventions taken in the client's medical record.

Test-Taking Strategy: Use the process of elimination and your knowledge regarding the priority actions in the care of a closed chest tube drainage system. Focus on the data in the question, noting that there is bubbling in the water seal chamber.

Recalling that this may indicate an air leak will direct you to the correct options. Review the nursing actions to be taken immediately in the event that complications of a closed chest tube drainage system occur if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

## Implementation Content Area: Adult Health/

### Respiratory

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 648, 649). St. Louis: Saunders.

• A nurse is helping a client with a closed chest tube drainage system get out of bed and into a chair. During the transfer, the chest tube is caught on the leg of the chair and dislodged from the insertion site. The immediate priority on the part of the nurse is:

- Contacting the physician
- Reinserting the chest tube
- Transferring the client back to
- bed

Covering the insertion site with a sterile occlusive dressing Correct

Rationale: If a chest tube is dislodged from the insertion site, the nurse immediately covers the site with sterile occlusive dressing. The nurse then performs a respiratory assessment, helps the client back into bed, and contacts the physician. The nurse does not reinsert the chest tube. The physician will reinsert the chest tube as necessary.

Test-Taking Strategy: Use the process of elimination, noting the strategic word “immediate.” Eliminate the option that involves reinsertion of the chest tube first, because a nurse is not trained to insert a chest tube. To select from the remaining options, focus on the subject, dislodgment of a chest tube from its insertion site, and recall the complications associated with this occurrence; this will direct you to the correct option. Review the nursing actions to be taken immediately in the event of complications associated

with a closed chest tube drainage system if you had difficulty with this question.

Level of Cognitive Ability: Applying  
Client Needs: Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Adult Health/

Respiratory

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 648, 649). St. Louis: Saunders.

- A nurse performing nasopharyngeal suctioning and suddenly notes the presence of bloody secretions. The nurse would first:
  - Continue suctioning to remove the blood
  - Check the degree of suction being applied Correct
  - Encourage the client to cough out the bloody secretions
  - Remove the suction catheter from the client's nose and begin vigorous suctioning through the mouth

Rationale: The return of bloody secretions is an unexpected outcome of suctioning. If it occurs, the nurse should first assess the client and then determine the degree of suction being applied. The degree of suction pressure may need to be decreased. The nurse must also remember to apply intermittent suction and perform catheter rotation during suctioning. Continuing the suctioning or performing vigorous suctioning through the mouth will result in increased trauma and therefore increased bleeding.

Suctioning is normally performed on clients who are unable to expectorate secretions. It is therefore unlikely that the client will be able to cough out the bloody secretions.

Test-Taking Strategy: Use the process of elimination. Eliminate the options of continuing the suctioning to remove the blood and removing the suction catheter from the nose to begin vigorous suctioning through the mouth, because they are comparable or alike. Next eliminate the option that involves encouraging the client to cough out the bloody secretions, because it is unlikely that the client will be able to do so. Review the nursing actions to be taken immediately in the event of a complication during suctioning if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Adult Health/

Respiratory

Reference: Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed., p. 940). St. Louis: Mosby.

- A nurse is suctioning a client through a tracheostomy tube. During the procedure, the client begins to cough, and the nurse hears a wheeze. The nurse tries to remove the suction catheter from the client's trachea but is unable to do so. The nurse would first:

• Call a code



- Contact the physician
- Administer a
- bronchodilator

Disconnect the suction source from the catheter Correct

Rationale: Inability to remove a suction catheter is a critical situation. This finding, along with the client's symptoms presented in the question, indicates the presence of bronchospasm and bronchoconstriction. The nurse immediately

disconnects the suction source from the catheter but leave the catheter in the trachea. The nurse then connects the oxygen source to the catheter. The physician is notified and will most likely prescribe an inhaled bronchodilator. The nurse also prepares for emergency resuscitation if the bronchospasm is not relieved.

**Test-Taking Strategy:** Use the process of elimination, noting the strategic word “first.” Eliminate the option of administering a bronchodilator, because this action requires a physician’s prescription. To select from the remaining options, visualize the situation presented in the question. Noting that the nurse is unable to remove the suction catheter from the client’s trachea will direct you to the correct option. Review the nursing actions to be taken immediately in the event of a complication during suctioning if you had difficulty with this question.

**Level of Cognitive Ability:**

**Applying Client Needs:**

**Physiological Integrity**

**Integrated Process: Nursing Process/**

**Implementation Content Area: Adult Health/**

**Respiratory**

**Reference:** Potter, P., & Perry, A. (2009). *Fundamentals of nursing* (7th ed., p. 939). St. Louis: Mosby.

- A nurse assesses the closed chest tube drainage system of a client who underwent lobectomy 24 hours ago. The nurse notes that there has been no chest tube drainage for the past hour. The nurse first:

○ **Contacts the physician**

- Checks for kinks in the drainage system
- Correct Checks the client's blood pressure and heart rate
- Connects a new drainage system to the client's chest tube

Rationale: If a chest tube is not draining, the nurse must first check for a kink or clot in the chest drainage system. The nurse also observes the client for signs of respiratory distress or mediastinal shift; and if such signs are noted, the physician is notified. Checking the heart rate and blood pressure is not directly related to the lack of chest tube drainage. Connecting a new drainage system to the client's chest tube is done once the fluid drainage chamber is full. A specific procedure is followed when a new drainage system is connected to a client's chest tube.

Test-Taking Strategy: Use the process of elimination, noting the strategic word "first." Focusing on the subject, a lack of chest tube drainage, will direct you to the correct option. Review unexpected outcomes and related interventions in the care of a chest tube drainage system if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Adult Health/

Respiratory

Reference: Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed., p. 952). St. Louis: Mosby.

Awarded 0.0 points out of 1.0 possible points.

9.ID: 383740435

A nurse is assessing a postoperative client on an hourly basis. The nurse notes that the client's urine output for the past hour was 25 mL. On the basis of this finding, the nurse first:

- Calls the physician
- Increases the rate of the IV infusion
- Checks the client's overall intake and output record
- Correctly administers a 250-mL bolus of normal saline solution (0.9%)

Rationale: Clients are at risk for becoming hypovolemic after surgery, and often

the first sign of hypovolemia is decreasing urine output. However, the nurse needs additional data to make an accurate interpretation. Neither an increase in the rate of the IV infusion nor administration of a 250-mL bolus of normal saline (0.9%) would be implemented without a prescription from the physician. The physician is called once the nurse has gathered all necessary assessment data, including the overall fluid status and vital signs.

Test-Taking Strategy: Note the strategic word "first." Try to visualize the situation and use the steps of the nursing process to answer the question. The correct option addresses the process of assessment. Eliminate increasing the rate of the IV infusion and administering a 250-mL bolus of normal saline (0.9%), because each requires a physician's prescription. In this situation, the nurse needs to gather additional information before contacting the physician. Review unexpected outcomes after surgery and priority nursing interventions in the event of such outcomes if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Perioperative

Care

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., p. 290). St. Louis: Saunders.

Awarded 0.0 points out of 1.0 possible points.

10.ID: 383740623

A nurse is getting a client out of bed for the first time since surgery. The nurse raises the head of the bed, and the client complains of dizziness. Which of the following actions should the nurse take first?

- Checking the client's blood pressure
- Checking the oxygen saturation level
- Having the client take some deep
- breaths

Lowering the head of the bed slowly until the dizziness is relieved Correct

Rationale: Dizziness or a feeling of faintness is not uncommon when a client is positioned upright for the first time after surgery. If this occurs, the nurse lowers the head of the bed slowly until the dizziness is relieved. The nurse then checks the client's pulse and blood pressure. Because the problem is circulatory, not respiratory, checking the oxygen saturation level and having the client take some deep breaths are not the first actions to be taken.

Test-Taking Strategy: Use the process of elimination, noting the strategic word "first." Note the relationship between the subject of the question (the client becomes dizzy) and the correct answer. Review unexpected outcomes after

surgery and the priority nursing interventions in the event of such outcomes if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Delegating/

Prioritizing

Reference: Black, J., & Hawks, J. (2009). Medical-surgical nursing: Clinical management for positive outcomes (8th ed., p. 195). St. Louis: Saunders.

Awarded 0.0 points out of 1.0 possible points.

11.ID: 383738719

A nurse is preparing for intershift report when a nurse's aide pulls an emergency call light in a client's room. Upon answering the light, the nurse finds a client who returned from surgery earlier in the day experiencing tachycardia and tachypnea. The client's blood pressure is 88/60 mm Hg. Which action should the nurse take first?

Calling the physician

- Checking the hourly urine
- output Checking the IV site for infiltration
- Placing the client in a modified Trendelenburg position Correct

Rationale: The client is exhibiting signs of shock and requires emergency intervention. The first action is to place the client in a modified Trendelenburg position to increase blood return from the legs, which in turn increases venous return and subsequently the blood pressure. The nurse calls the physician, verifies the client's blood volume status by assessing urine output, and ensures that the IV infusion is proceeding without complications.

Test-Taking Strategy: Note the strategic word "first." Use your knowledge of the ABCs (airway, breathing, circulation). The correct option addresses the client's circulatory status. Review the nursing interventions to be taken immediately in the event of postoperative shock if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Delegating/

Prioritizing

References: Black, J., & Hawks, J. (2009). Medical-surgical nursing: Clinical management for positive outcomes (8th ed., p.



2173). St. Louis: Saunders. Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., p. 833). St. Louis: Saunders.

Awarded 0.0 points out of 1.0 possible

points.12.ID: 383739342

A nurse is assessing the chest tube drainage system of a postoperative client who has undergone a right upper lobectomy. The closed drainage system contains

300 mL of bloody drainage, and the nurse notes intermittent bubbling in the water seal chamber. One hour after the initial assessment, the nurse notes that the bubbling in the water seal chamber is now constant, and the client appears dyspneic. On the basis of these findings, the nurse should first assess:

- The client's vital signs
- The amount of
- drainage
- The client's lung sounds

The chest tube connections Correct

Rationale: The client's dyspnea is most likely related to an air leak caused by a loose connection. Other causes might be a tear or incision in the pulmonary pleura, which requires physician intervention. Although the interventions identified in the other options should also be taken in this situation, they should be performed only after the nurse has tried to locate and correct the air leak. It only takes a moment to check the connections, and if a leak is found and corrected, the client's symptoms should resolve.

Test-Taking Strategy: Note the strategic word "first" and focus on the data in the question. Recalling that a constant bubbling in the water seal chamber could indicate a leak in the system will direct you to the correct option.

Review care of the client with a closed chest tube drainage system if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Delegating/

Prioritizing

Reference: Black, J., & Hawks, J. (2009). Medical-surgical nursing: Clinical management for positive outcomes (8th ed., p. 1623). St. Louis: Saunders.

Awarded 0.0 points out of 1.0 possible

points.13.ID: 383737774

A client recovering from surgery has a large abdominal wound. Which of the following foods, high in vitamin C, should the nurse encourage the client to eat as a means of promoting wound healing?

- Steak
- Veal
- Chees
- e

Oranges Correct

Rationale: Citrus fruits and juices are especially high in vitamin C. Other sources are potatoes, tomatoes, and other fruits and vegetables. Meats and dairy products are not especially high in vitamin C. Meats are high in protein. Dairy products are high in calcium.

Test-Taking Strategy: Note the strategic word "high" in the question.

Eliminate steak and veal first because they are comparable or alike in that they are meats. To select from the remaining options, recall that cheese is high in calcium, not vitamin C; this will direct you to the correct option. If you are unfamiliar with foods high in vitamin C, review this content.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

## Integrated Process: Teaching and Learning

Content Area: Perioperative Care

References: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., p. 486). St. Louis: Saunders.

Nix, S. (2009). Williams' basic nutrition and diet therapy (13th ed., p. 437). St. Louis: Mosby.

Awarded 0.0 points out of 1.0 possible

points.14.ID: 383739328

A nurse is caring for a client who has just regained bowel sounds after undergoing surgery. The physician has prescribed a clear liquid diet for the client. Which of the following items does the nurse ensure is available in the client's room before allowing the client to drink?

- Straw
- Napki
- n
- Suction equipment
- CorrectOxygen
- saturation monitor

Rationale: Aspiration is a concern when fluids are offered to a client who has just

undergone surgery. It is possible that the swallow reflex is still impaired as an effect of anesthesia. The nurse checks the gag and swallow reflexes before offering fluids to the client, but suction equipment still must be available. An oxygen saturation monitor is unnecessary when fluids are being administered, nor is a napkin or straw necessary; in fact, the straw could contribute to the formation of flatus, resulting in gastrointestinal discomfort.

Test-Taking Strategy: The subject of the question is protecting the client's gag and swallow reflexes. Use your knowledge of the ABCs (airway, breathing, and

circulation) to answer this question. The correct option helps maintain airway clearance. If you had difficulty with this question, review care of the client who

has recently undergone surgery.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Planning Content Area: Perioperative

Care

References: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 290, 291). St. Louis: Saunders. Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed., p. 1103). St. Louis: Mosby.

Awarded 0.0 points out of 1.0 possible

points. 15.ID: 383737758

A client in the postanesthesia care unit has an as-needed prescription for ondansetron (Zofran). Which of the following occurrences would prompt the nurse to administer this medication to the client?

- Paralytic
- ileus
- Incisional
- pain Urine retention



## Nausea and vomiting Correct

Rationale: Ondansetron is an antiemetic that is used in the treatment of postoperative nausea and vomiting, as well as nausea and vomiting associated with chemotherapy. This medication is not used to treat any of the problems identified in the other options.

Test-Taking Strategy: To answer this question accurately, it is necessary to know the classification of this medication. Focusing on the clinical setting identified in the question should narrow your choices to nausea and vomiting and incisional pain. To correctly select from these two options, it is necessary to know that ondansetron is an antiemetic. Review the action of this medication if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Pharmacology

Reference: Hodgson, B., & Kizior, R. (2010). Saunders nursing drug handbook 2010 (p. 850). St. Louis: Saunders.

Awarded 0.0 points out of 1.0 possible

points. 16.ID: 383737778

A nurse administers scopolamine as prescribed to a client in preparation for surgery. For which side effect of this medication does the nurse monitor the client?

- Pupil constriction
- Increased urine output
- Complaints of dry mouth
- Correct Complaints of feeling

sweaty

Rationale: Scopolamine, an anticholinergic medication, often causes the side effects of dry mouth, urine retention, decreased sweating, and pupil dilation. The

other options are incorrect.

**Test-Taking Strategy:** Note the words “in preparation for surgery” and use the process of elimination. Recalling that this medication dries body secretions will direct you to the correct option. Review the expected side effects of this medication if this question was difficult for you.

**Level of Cognitive Ability:**

**Analyzing Client Needs:**

**Physiological Integrity**

**Integrated Process: Nursing Process/**

**Assessment Content Area: Pharmacology**

**Reference:** Hodgson, B., & Kizior, R. (2010). Saunders nursing drug handbook 2010 (p. 1027). St. Louis: Saunders.

Awarded 0.0 points out of 1.0 possible

points. 17.ID: 383740631

A nurse is preparing a client for transfer to the operating room. Which of the following actions should the take in the care of this client at this time?

- Ensuring that the client has voided
- Correct Administering all daily
- medications Practicing postoperative
- breathing exercises

Verifying that the client has not eaten for the last 24 hours

Rationale: The nurse should ensure that the client has voided if a Foley catheter is not in place. The nurse does not administer all daily medications just before sending a client to the operating room. Rather, the physician writes a specific

prescription outlining which medications may be given with a sip of water. The client is usually prescribed to have nothing by mouth for 8 hours before surgery, not 24 hours. The time of transfer to the operating room is not the time to practice breathing exercises. This should have been done earlier.

Test-Taking Strategy: Note the words “at this time.” Eliminate the option that involves administering all daily medications because of the close-ended word “all.” Eliminate the option that involves verifying that the client has not eaten for the last 24 hours because of the words “last 24 hours.” To select from the remaining options, focus on the words “at this time”; this will direct you to the correct option. Remember that the client is likely to be anxious at this time, meaning that it would be inappropriate to practice breathing exercises. Review preoperative client care measures if you had difficulty with this question.

Level of Cognitive Ability:

Applying Client Needs:

Physiological Integrity

Integrated Process: Nursing Process/

Implementation Content Area: Perioperative

Care

Reference: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: Patient-centered collaborative care (6th ed., pp. 260, 261). St. Louis: Saunders.

Awarded 0.0 points out of 1.0 possible

points. 18.ID: 383739360