HESI RN FUNDAMENTALS ACTUAL EXAM QUESTIONS AND ANSWERS WITH RATIONALES FOR NGN LATEST 2023

The nurse observes that a male client has removed the covering from an ice park applied to his knee. What action should the nurse take first?

- Observe the appearance of the skin under the ice pack.
- Instruct the client regarding the need for the covering.
- Reapply the covering after filling with fresh ice.
- Ask the client how long the ice was applied to the skin.

Observe the appearance of the skin under the ice pack (The first action taken by the nurse should be toassess the skin for any possible thermal injury. If no injury to the skin has occurred, the nurse can take the other actions.)

The nurse mixes 50 mg of Nipride in 250 mL of D5W and plans to administer the solution at a rate of 5 mcg/kg/min to a client weighting 182 lbs. Using a drip factor of 60 gtt/mL, how many drops per minuteshould the client receive?

124 gtt/min

The healthcare provider prescribes an IV infusion of 1000 ml of Ringer's Lactate w/ 30 units of Pitocin torun in over 4 hours for a client who has just delivered a 10 pound infant by cesarean section. The tubinghas been changed to a 20 gtt/ml administration set. The nurse plans to set the flow rate at how many gtt/min?

83 gtt/min

Which assessment data provides the most accurate determination of proper placement of a nasogastric tube?

Examining a chest x-ray obtained after the tubing was inserted

Three days following a surgery, a male client observes his colostomy for the first time. He becomes quiteupset and tells the nurse that it is much bigger than he expected. What is the best response by the nurse?

- Reassure the client that he will become accustomed to the stoma appearance in time.
- Instruct the client that the stoma will become much smaller when the initial swelling diminishes.
- Offer to contact a member of the local ostomy support group to help him with his concerns.
- Encourage the client to handle the stoma equipment to gain confidence with the procedure.

B. Instruct the client that the stoma will become smaller when the initial swelling diminishes (Postoperative swelling causes enlargement of the stoma. The nurse can teach the client that the stomawill become smaller when swelling is diminished (B). This will help reduce the client's anxiety and promote acceptance of the colostomy. (A) does not provide helpful teaching or support. (C) is a useful action, and may be taken after the nurse provides pertinent teaching. The client is not yet demonstrating readiness to learn colostomy care. (D)

A female client with a nasogastric tube attached to low suction states that she is nauseated. The nurseassesses that there has been no drainage through the nasogastric tube in the last two hours. What action should the nurse take first?

- Irrigate the nasogastric tube with sterile normal saline.
- Reposition the client on her side.
- Advance the nasogastric tube an additional five centimeters.
- Administer an intravenous antiemetic prescribed for PRN use.

B. Reposition the client on her side. (The immediate priority is to determine if the tube is functioning correctly, which would then relieve the client's nausea. The least invasive intervention (B) should be attempted first, followed by (A and C), unless either of these interventions is contraindicated. If thesemeasures are unsuccessful, the client may require an antiemetic (D))

A hospitalized male client is receiving nasogastric tube feedings via a small-bore tube and a continuous pump infusion. He reports that he had a bad bout of severe coughing a few minutes ago, but feels finenow. What action is best for the nurse to take?

- Record the coughing incident. No further action is required at this time.
- Stop the feeding, explain to the family why it is being stopped, and notify the HCP.
- After clearing the tube with 30 ml of air, check the pH of fluid withdrawn from the tube.
- Inject 30 ml of air into the tube while auscultating the epigastrium for gurgling.

C. After clearing the tube with 30 ml of air, check the pH of fluid withdrawn from the tube.

A male client tells the nurse that he does not know where he is or what year it is. What data should thenurse document that is most accurate?

- demonstrates loss of remote memory
- exhibits expressive dysphasia
- has a diminished attention span
- is disoriented to place and time

D. is disoriented to place and time (The client is exhibiting disorientation (D). (A) refers to memory of thedistant past. The client is able to express himself without difficulty (B), and does not demonstrate diminished attention span. (C).

A client with chronic kidney disease (CKD) selects a scrambled egg for his breakfast. What action shouldthe nurse take?

- Commend the client for selecting a high biologic value protein.
- Remind the client that protein in the diet should be avoided.
- Suggest that the client also select orange juice, to promote absorption.
- Encourage the client to attend classes on dietary management of CKD.

A. Commend the client for selecting a high biologic value protein. (Foods such as eggs and milk (A) are high biologic proteins which are allowed because they are complete proteins and supply the essential amino acids that are necessary for growth and cell repair. Orange juice is rich in potassium and shouldnot be encouraged. The client has made a good diet choice so (D) is not necessary.)

When assisting an 82 year old client to ambulate, it is important for the nurse to realize that the centerof gravity for an elderly person is the--

Upper torso (The center of gravity for adults is the hips. However, as the person grows older, a stoopedposture is common because of the changes from osteoporosis and normal bone degeneration, and the knees, hips, and elbows flex. This stooped posture results in the upper torso becoming the center of gravity for older persons.)

In developing a plan of care for a client with dementia, the nurse should remember that confusion in theelderly

- is to be expected, and progresses with age
- often follows relocation to new surroundings
- is a result of irreversible brain pathology
- can be prevented with adequate sleep

B. often follows relocation to new surroundings (Relocation (B) often results in confusion among elderlyclients-- moving is stressful for anyone. (A) is stereotypical judgement. Stress in the elderly often manifests itself as confusion, so (C) is wrong. Adequate sleep is not a prevention (D) for confusion.)

A postoperative client will need to perform daily dressing changes after discharge. Which outcome statement best demonstrates the client's readiness to manage his wound care after discharge? Theclient

- asks relevant questions regarding the dressing change
- states he will be able to complete the wound care regimen
- demonstrates the wound care procedure correctly
- has all the necessary supplies for wound care

C. demonstrates the wound care procedure correctly
(A return demonstration of a procedure (C) provides an objective assessment of the client's ability to perform a task, while (A and B) are subjective measures. (D) is important, but is less of a priority thanthe the nurse's assessment of the client's ability to complete wound care.)

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A client who is 5 '5" tall and weighs 200 pounds is scheduled for surgery the next day. What question ismost important for the nurse to include during the preoperative assessment?

- What is your daily calorie consumption?
- What vitamin and mineral supplements do you take?"
- "Do you feel that you are overweight?"
- "Will a clear liquid diet be okay after surgery?"

B. "What vitamin and mineral supplements do you take?"
(Vitamin and mineral supplements (B) may impact medications used during the operative period. (A and C) are appropriate questions for long-term dietary counseling. The nature of the surgery and anesthesiawill determine the need for a clear liquid diet (D), rather than the client's preference.)

During the initial morning assessment, a male client denies dysuria but reports that his urine appearsdark amber. Which intervention should the nurse implement?

- Provide additional coffee on the client's breakfast tray.

- Exchange the client's grape juice for cranberry juice.
- Bring the client additional fruit at mid-morning.
- Encourage additional oral intake of juices and water.

D. Encourage additional oral intake of juices and water.

Which intervention is most important for the nurse to implement for a male client who is experiencingurinary retention?

- Apply a condom catheter
- Apply a skin protectant
- Encourage increased fluid intake
- Assess for bladder distention

D. Assess the bladder for distention (Urinary retention is the inability to void all urine collected in the bladder, which leads to uncomfortable bladder distention (D). (A and B) are useful actions to protect theskin of a client with urinary incontinence. (C) may worsen the bladder distention.)

A client with acute hemorrhagic anemia is to receive four units of packed RBCs as rapidly as possible.Which intervention is most important for the nurse to implement?

- Obtain the pre-transfusion hemoglobin level.
- Prime the tubing and prepare a blood pump set-up
- Monitor vital signs q 15 min for the first hour.
- Ensure the accuracy of the blood type match.

D. Ensure the accuracy of the blood type match.
(ALL interventions should be implemented prior to administering blood, but (D) has the highest priority.Any time blood is administered the nurse should ensure the accuracy of the blood type match in order to prevent a possible hemolytic reaction.)

A male client being discharged with a prescription for the bronchodilator theophylline tells the nurse that he understands he is to take three doses of the medication each day. Since, at the time of discharge, time-released capsules are not available, which dosing schedule should the nurse advise theclient to follow?

8 AM, 4 PM, and midnight
(Theophylline should be administered on a regular around the clock schedule to provide the bestbronchodilating effect and reduce the potential for adverse effects.)

A client is to receive 10 mEq of KCl diluted in 250 mL of normal saline over 4 hours. At what rate shouldthe nurse set the client's intravenous infusion pump?

63 mL/hr

When evaluating a client's plan of care, the nurse determines that a desire outcome was not achieved.Which action should the nurse implement first?

- Establish a new nursing diagnosis.
- Note which actions were not implemented.
- Add additional nursing orders to the plan.
- Collaborate with the HCP to make changes.

B. Note which actions were not implemented.
(First, the nurse should review which actions in the original plan were not implemented (B) in order to determine why the original plan did not produce the desired outcome. Appropriate revisions can then be made, which may include revising the expected outcome, or identifying a new nursing diagnosis (A).
(C) may be needed if the nursing actions were unsuccessful, or were unable to be implemented.
(D)other members of the healthcare team may be necessary to collaborate changes once the nurse determines why the original plan did not produce the desired outcome.

Which snack food is best for the nurse to provide a client with myasthenia graves who is at risk foraltered nutritional status?
- chocolate pudding
- graham crackers
- sugar free gelatin
- apple slices

A. chocolate pudding
(The client with myasthenia graves is at high risk for altered nutrition because of fatigue and muscle weakness resulting in dysphagia. Snacks that are semisolid, such as pudding (A) are easy to swallow andrequire minimal chewing effort, and provide calories and protein. (C) does not provide any nutritional value. (B and D) require energy to chew and are more difficult to swallow than pudding.)

The nurse is instructing a client with high cholesterol about diet and life style modification. Whatcomment from the client indicates that the teaching has been effective?
- "If I exercise at least two times weekly for one hour, I will lower my cholesterol."
- "I need to avoid eating proteins, including red meat."
- "I will limit my intake of beef to 4 ounces per week."
- "My blood level of low density lipoproteins needs to increase."

C. "I will limit my intake of beef to 4 ounces per week."
(Limiting saturated fat from animal food sources to no more than 4 ounces per week (C) is an important diet modification for lowering cholesterol. To be effective in reducing cholesterol, the client should exercise 30 minutes per day, or at least 4 to 6 times per week (A). Red meat and all proteins do not needto be eliminated (B) to lower cholesterol, but should be restricted to lean cuts of red meat and smaller portions (2-ounce servings). The low density lipoproteins (D) need to decrease rather than increase.)

An obese male client discusses with the nurse his plans to begin long-term weight loss regimen. In addition to dietary changes, he plans to begin an intensive aerobic exercise program 3 to 4 times a weekand to take stress management classes. After praising the client for his decision, which instruction is most important for