1. A nurse is caring for a client who is receiving total parenteral nutrition (TPN). The pharmacy is delayed in supplying the client's next container of TPN. Which of the following fluids should the nurse infuse until the next container arrives?

   A. Dextrose 5% in water

      Rationale: TPN contains high concentrations of certain nutrients. Infusing dextrose 5% in water could cause rapid shifts in serum levels of some substances.

   B. 0.9% sodium chloride

      Rationale: TPN contains high concentrations of certain nutrients. Infusing 0.9% sodium chloride could cause rapid shifts in serum levels of some substances.

   C. Dextrose 10% in water

      Rationale: TPN contains high concentrations of dextrose and proteins. To avoid hypoglycemia, the nurse should infuse dextrose 10% or 20% in water until the next container of TPN solution arrives.

   D. Lactated Ringer's solution

      Rationale: TPN contains high concentrations of certain nutrients. Infusing lactated Ringer's solution could cause rapid shifts in serum levels of some substances.

2. A nurse is providing discharge teaching for a client who has chronic pancreatitis. Which of the following statements by the nurse is appropriate?

   A. "You should decrease your caloric intake when abdominal pain is present."

      Rationale: Clients who have chronic pancreatitis are at risk for malnutrition and should increase their caloric intake in order to maintain weight.

   B. "You should increase your daily intake of protein."

      Rationale: Clients who have chronic pancreatitis should consume a diet that is high in protein.

   C. "You should increase fat intake when experiencing loose stools."

      Rationale: Clients who have chronic pancreatitis should consume a low-fat diet to prevent stimulation of the pancreas and steatorrhea.

   D. "You should limit alcohol intake to 2-3 drinks per week."

      Rationale: Clients who have chronic pancreatitis should avoid alcohol intake to prevent stimulation of the pancreas.

3. A nurse monitors for increased intracranial pressure (ICP) on a client who has a leaking cerebral aneurysm. If the client manifests increased intracranial pressure, which of the following findings should the nurse expect? (Select all that apply)

- A. Violent headache
- B. Neck pain and stiffness
- C. Slurred speech
- D. Projectile vomiting
- E. Rapid loss of consciousness

Rationale: Violent headache is correct. The client who manifests ICP should display a violent headache

Neck pain and stiffness is incorrect. The client who manifests ICP should not display neck pain and stiffness

Slurred speech is correct. The client who manifests ICP may display slurred speech.

Projectile vomiting is correct. The client who manifests ICP may display sudden onset of projectile vomiting.

Rapid loss of consciousness is correct. The client who manifests ICP may display a sudden rapid loss of consciousness.

4. A nurse is assessing an adult who has meningococcal meningitis. Which of the following is an appropriate finding by the nurse?

A. Severe headache

Rationale: The nurse should find as a sign of meningococcal meningitis severe headache due to meningeal inflammation.

B. Bradycardia

Rationale: The nurse should find as a sign of meningococcal meningitis tachycardia not bradycardia.

C. Increased muscle tone

Rationale: The nurse should find as a sign of meningococcal meningitis decreased not increased muscle tone.

D. Oriented to time, person, place

Rationale: The nurse should find as a sign of meningococcal meningitis disorientation not orientation to time, person, and place.

5. A nurse admits a client who has a concussion for overnight observation. Alert and oriented on admission, the client reports a headache along with neck pain and generalized muscle aches. The nurse knows that a manifestation considered an early indication of increased intracranial pressure (ICP) is

A. bradycardia.

Rationale: Alterations in vital signs, including increased systolic pressure, widening pulse pressure and bradycardia may be later signs of increased ICP.

B. ipsilateral pupil dilation.

Rationale: Ipsilateral or bilateral pupil dilation occurs when increasing intracranial pressure displaces the brain against the optic nerve, but pupil dilation is not an early sign of increased ICP.

C. widening pulse pressure.

Rationale: Alterations in vital signs, including increased systolic pressure, widening pulse pressure and bradycardia may be later signs of increased ICP.

D. lethargy.

Rationale: Increased intracranial pressure is a condition in which the pressure of the cerebrospinal fluid or brain matter within the skull exceeds the upper limits for normal. An early sign of increasing ICP is lethargy.

6. A nurse is caring for a client following a CVA and observes the client experiencing severe dysphagia. The nurse notifies the provider. Which of the following nutritional therapies will likely be prescribed?

   A. NPO until dysphagia subsides

      Rationale: Making the client NPO provides no nutritional support and will not likely be prescribed.

   B. Supplements via nasogastric tube

      Rationale: Supplements via nasogastric tube provide enteral nutrition for clients who are at risk for aspiration caused by a diminished gag reflex or difficulty swallowing. This nutritional therapy will likely be prescribed.

   C. Initiation of total parenteral nutrition

      Rationale: Total parenteral nutrition is initiated when the GI tract cannot be used for the ingestion, digestion, and absorption of essential nutrients. This nutritional therapy will not likely be prescribed.

   D. Soft residue diet

      Rationale: A soft residue diet would place the client at risk for aspiration due to difficulty swallowing solids; therefore, this nutritional therapy will not likely be prescribed.

7. A nursing is caring for a client who has aphasia following a stroke. A family member asks the nurse how she should communicate with the client. Which of the following is an appropriate response by the nurse?

   A. "Incorporate nonverbal cues in the conversation."

      Rationale: Nonverbal cues enhance the client's ability to comprehend and use language.

   B. "Ask multiple choice questions as part of the conversation."

      Rationale: Simple questions requiring yes/no responses are better understood by the client.

   C. "Use a higher-pitched tone of voice when speaking."

      Rationale: Tone of voice is understood by clients with aphasia, unless they have a hearing impairment.

   D. "Use simple child-like statements when speaking."

      Rationale: It is important to respect the client and use age-appropriate communication.

8. A nurse is caring for a client in liver failure with ascites who is receiving spironolactone (Aldactone). Which of the following outcomes should the nurse expect from this client's medication therapy?

A. Increased sodium excretion

Rationale: The primary action of spironolactone is to increase sodium excretion in the urines.

B. Decreased urinary output

Rationale: Spironolactone is a diuretic, thus it should increase urine output.

C. Increased potassium excretion

Rationale: Spironolactone is potassium-sparing.

D. Decreased chloride excretion

Rationale: Spironolactone promotes the excretion of chloride in the urine.

9. A nurse is caring for a client who has meningitis, a temperature of 39.7° C (103.5° F), and is prescribed a hypothermia blanket. While using this therapy, the nurse should know that the client must carefully be observed for which of the following complications?

A. Dehydration

Rationale: Dehydration is not considered a complication of the hypothermia blanket therapy.

B. Seizures

Rationale: Seizures are not considered a complication of the hypothermia blanket therapy.

C. Burns

Rationale: Burns are associated with the improper use of heating pads, not a hypothermia blanket.

D. Shivering

Rationale: The hypothermia (cooling) blanket, if used improperly (at inappropriately low temperatures, or without skin protection), can cause the client to cool too fast, leading to shivering. To prevent heat loss from the skin, the body becomes peripherally vasoconstricted in an attempt to reduce heat loss. The body will also try to increase heat production by shivering, which can increase the metabolic rate by two to five times and in doing so greatly raise oxygen consumption.

10. An acute care nurse is caring for an adult client who is undergoing evaluation for a possible brain tumor. When performing a neurological examination, which of following is the most reliable indicator of cerebral status?

A. Pupil response

Rationale: The nurse should include pupil response as part of a neurological examination; however, it is not the most reliable indicator of cerebral status.

B. Deep tendon reflexes

Rationale: The nurse should include deep tendon reflexes as part of a neurological examination; however, it is not the most reliable indicator of cerebral status.

C. Muscle strength

Rationale: The nurse should include muscle strength as part of a neurological examination; however, it is not the most reliable indicator of cerebral status.

D. Level of consciousness

Rationale: The nurse should examine the client's level of consciousness as the most reliable indicator of cerebral status.

11. A nurse in the antepartum unit is caring for a client who is at 36 weeks of gestation and has pregnancy-induced hypertension. Suddenly, the client reports continuous abdominal pain and vaginal bleeding. The nurse should suspect which of the following complications?

A. Placenta previa

Rationale: Placenta previa occurs with painless vaginal bleeding.

B. Prolapsed cord

Rationale: With a prolapsed umbilical cord, there is no bleeding or pain. There may be changes in the fetal heart tracing, and the cord might also become visible.

C. Ruptured ovarian cysts

Rationale: A rupture of an ovarian cyst can cause sudden pelvic pain, but it does not commonly cause vaginal bleeding.

D. Abruptio placentae

Rationale: The cardinal signs and symptoms of abruptio placentae include a rigid board-like abdomen, severe pain, and heavy vaginal bleeding.

12. A nurse is caring for a client who is receiving total parenteral nutrition (TPN) via a peripherally inserted central catheter (PICC) line. When assessing the client, the nurse notes that the client's arm seems swollen above the PICC insertion site. Which of the following actions should the nurse take first?

A. Measure the circumference of both upper arms.

Rationale: The first action to take if the client's arm appears to be swollen is to measure the arm and compare it to the circumference of the other arm. If the arm is swollen, it is appropriate to notify the provider who inserted the PICC line. Swelling could indicate formation of a clot above the site.

B. Notify the provider who inserted the PICC line.

Rationale: It may be necessary to notify the provider, but this is not the first action the nurse should take.

C. Remove the PICC line.

Rationale: It may be necessary to remove the PICC line, but this is not the first action the nurse should take.

D. Apply a cold pack to the client's upper arm.

Rationale: It may be necessary to apply a cold pack to the client's upper arm, but this is not the first action the nurse should take.

13. A nurse is planning care for a client who has a GI bleed. Which of the following actions should the nurse take first?

A. Assess orthostatic blood pressure.

Rationale: The first action the nurse should take using the nursing process is to assess the client; therefore, assessing the orthostatic blood pressure is the first priority to determine if the client is hypovolemic.

B. Explain the procedure for an upper GI series.

Rationale: The nurse should explain the procedure for an upper GI series, but this is not the priority.

C. Administer pain medication.

Rationale: The nurse should administer pain medication as needed, but this is not the priority.

D. Test the emesis for blood.

Rationale: The nurse should test the emesis for blood if the client vomits, but this is not the priority.

14. A nurse is providing discharge teaching for a client who has acute pancreatitis and has a prescription for fat-soluble vitamin supplements. The nurse should instruct the client to take a supplement for which of the following?

A. Vitamin A

Rationale: The nurse should instruct the client that fat-soluble vitamins include vitamins A, D, E, and K.

B. Vitamin B1

Rationale: itamin B1 is not a fat-soluble vitamin.

C. Vitamin C

Rationale: Vitamin C is not a fat-soluble vitamin.

D. Vitamin B12

Rationale: Vitamin B12 is not a fat-soluble vitamin.

15. A nurse is caring for a client who has acute pancreatitis. After the client's pain has been addressed, which of the following is the next intervention to include in the plan of care?

A. Monitor respiratory status every 8 hr.

Rationale: Monitoring respiratory status is an appropriate intervention, but it is not the next intervention.

B. Encourage a side-lying position with knees flexed.

Rationale: Encouraging a side-lying position with knees flexed status is an appropriate intervention, but it is not the next intervention.

C. Provide frequent oral hygiene.

Rationale: Providing frequent oral hygiene status is an appropriate intervention, but it is not the next intervention.

D. Maintain NPO status.

Rationale: To rest the pancreas and reduce secretion of pancreatic enzymes, oral fluids and food are withheld during the acute phase of pancreatitis. This is the next intervention to be included in the plan of care.

16. A nurse is caring for a client at a rehabilitation center 3 weeks after a cerebrovascular accident (CVA). Because the client's CVA affected the left side of the brain, which of the following goals should the nurse anticipate including in the client's rehabilitation program?

A. Establish the ability to communicate effectively.

Rationale: A CVA is an interruption of the blood supply to any part of the brain, resulting in damaged brain tissue. The left hemisphere is usually dominant for language. Because this client had a left-side CVA, the nurse should anticipate the client will have some degree of aphasia and will require speech therapy to establish communication.

B. Have a regular, formed stool at least every other day.

Rationale: This goal is not specific to the client's impairment.

C. Learn to control impulsive behavior.

Rationale: A client with a right-side lesion is likely to be impulsive. Clients with left-side lesions are typically cautious.

D. Improve left-side motor function.

Rationale: A client with a left-side lesion will demonstrate hemiplegia of the right side due to the fact that the pyramidal pathway crosses over at the base of the brain.

17. A client comes to the emergency department reporting nausea and vomiting that worsens when he lies down. Antacids do not help. The provider suspects acute pancreatitis. Which of the following laboratory test results should the nurse expect to see if the client has acute pancreatitis?

A. Decreased WBC

Rationale: With acute pancreatitis, WBC is generally elevated.

B. Increased serum amylase

Rationale: With acute pancreatitis, serum amylase rises within 24 hr of the start of the client’s symptoms.

C. Decreased serum lipase

Rationale: With acute pancreatitis, serum lipase is generally elevated.

D. Increased serum calcium

Rationale: Hypocalcemia is common with acute pancreatitis.

18. A nurse is caring for a client who has an acute respiratory illness. The nurse should monitor the client for which of the following manifestations of impending airway obstruction. (Select all that apply.)

- A. Tachycardia
- B. Nausea
- C. Retractions
- D. Muscle tremors
- E. Restlessness

Rationale: Tachycardia is correct. Increases in pulse and respiratory rates are indications of impending airway obstruction.

Nausea is incorrect. Gastrointestinal upset is not an indication of impending airway obstruction.

Retractions is correct. Substernal, suprasternal, and intercostal retractions and flaring nares are indications of impending airway obstruction.

Muscle tremors is incorrect. Muscle tremors are not an indication of impending airway obstruction.

Restlessness is correct. Restlessness is an indication of impending airway obstruction.