2023/2024 ALL HESI FUNDAMENTALS EXAM TEST BANK UPDATED QUESTION WITH RATIONALES AND ANSWERS LATEST UPDATED *HESI FUNDAMENTALS EXAM, ANSWERED*

An elderly client with a fractured left hip is on strict bedrest. Which nursing measure is essential to the client's nursing care?

A. Massage any reddened areas for at least five minutes.

B. Encourage active range of motion exercises on extremities.

C. Position the client laterally, prone, and dorsally in sequence.

D. Gently lift the client when moving into a desired position. - To avoid shearing forces when repositioning, the client should be lifted gently across a surface (D). Reddened areas should not be massaged (A) since this may increase the damage to already traumatized skin. To control pain and muscle spasms, active range of motion (B) may be limited on the affected leg. The position described in (C) is contraindicated for a client with a fractured left hip.

Correct Answer: D

The nurse is administering medications through a nasogastric tube (NGT) which is connected to suction. After ensuring correct tube placement, what action should the nurse take next?

A. Clamp the tube for 20 minutes.

B. Flush the tube with water.

C. Administer the medications as prescribed.

D. Crush the tablets and dissolve in sterile water. - The NGT should be flushed before, after and in between each medication administered (B). Once all medications are administered, the NGT should be clamped for 20 minutes (A). (C and D) may be implemented only after the tubing has been flushed.

Correct Answer: B

A client who is in hospice care complains of increasing amounts of pain. The healthcare provider prescribes an analgesic every four hours as needed. Which action should the nurse implement?

A. Give an around-the-clock schedule for administration of analgesics.

B. Administer analgesic medication as needed when the pain is severe.

C. Provide medication to keep the client sedated and unaware of stimuli.

D. Offer a medication-free period so that the client can do daily activities. - The most effective management of pain is achieved using an around-the-clock schedule that provides analgesic medications on a regular basis (A) and in a timely manner. Analgesics are less effective if pain persists until it is severe, so an analgesic medication should be administered before the client's pain peaks (B). Providing comfort is a priority for the client who is dying, but sedation that impairs the client's ability to interact and experience the time before life ends should be minimized (C). Offering a medication-free period allows the serum drug level to fall, which is not an effective method to manage chronic pain (D).

Correct Answer: A

When assessing a client with wrist restraints, the nurse observes that the fingers on the right hand are blue. What action should the nurse implement first?

A. Loosen the right wrist restraint.

B. Apply a pulse oximeter to the right hand.

C. Compare hand color bilaterally.

D. Palpate the right radial pulse. - The priority nursing action is to restore circulation by loosening the restraint (A), because blue fingers (cyanosis) indicates decreased circulation. (C and D) are also important nursing interventions, but do not have the priority of (A). Pulse oximetry (B) measures the saturation of hemoglobin with oxygen and is not indicated in situations where the cyanosis is related to mechanical compression (the restraints).

Correct Answer: A

The nurse is assessing the nutritional status of several clients. Which client has the greatest nutritional need for additional intake of protein?

A. A college-age track runner with a sprained ankle.

B. A lactating woman nursing her 3-day-old infant.

C. A school-aged child with Type 2 diabetes.

D. An elderly man being treated for a peptic ulcer. - A lactating woman (B) has the greatest need for additional protein intake. (A, C, and D) are all conditions that require protein, but do not have the increased metabolic protein demands of lactation.

Correct Answer: B

A client is in the radiology department at 0900 when the prescription levofloxacin (Levaquin) 500 mg IV q24h is scheduled to be administered. The client returns to the unit at 1300. What is the best intervention for the nurse to implement?

A. Contact the healthcare provider and complete a medication variance form.

B. Administer the Levaquin at 1300 and resume the 0900 schedule in the morning.

C. Notify the charge nurse and complete an incident report to explain the missed dose.

D. Give the missed dose at 1300 and change the schedule to administer daily at 1300. - To ensure that a therapeutic level of medication is maintained, the nurse should administer the missed dose as soon as possible, and revise the administration schedule accordingly to prevent dangerously increasing the level of the medication in the bloodstream (D). The nurse should document the reason for the late dose, but (A and C) are not warranted. (B) could result in increased blood levels of the drug.

Correct Answer: D

While instructing a male client's wife in the performance of passive range-of-motion exercises to his contracted shoulder, the nurse observes that she is holding his arm above and below the elbow. What nursing action should the nurse implement?

A. Acknowledge that she is supporting the arm correctly.

B. Encourage her to keep the joint covered to maintain warmth.

C. Reinforce the need to grip directly under the joint for better support.

D. Instruct her to grip directly over the joint for better motion. - The wife is performing the passive ROM correctly, therefore the nurse should acknowledge this fact (A). The joint that is being exercised should be uncovered (B) while the rest of the body should remain covered for warmth and privacy. (C and D) do not provide adequate support to the joint while still allowing for joint movement.

Correct Answer: A

What is the most important reason for starting intravenous infusions in the upper extremities rather than the lower extremities of adults?

A. It is more difficult to find a superficial vein in the feet and ankles.

B. A decreased flow rate could result in the formation of a thrombosis.

C. A cannulated extremity is more difficult to move when the leg or foot is used.

D. Veins are located deep in the feet and ankles, resulting in a more painful procedure. - Venous return is usually better in the upper extremities. Cannulation of the veins in the lower extremities increases the risk of thrombus formation (B) which, if dislodged, could be life-threatening. Superficial veins are often very easy (A) to find in the feet and legs. Handling a leg or foot with an IV (C) is probably not any more difficult than

handling an arm or hand. Even if the nurse did believe moving a cannulated leg was more difficult, this is not the most important reason for using the upper extremities. Pain (D) is not a consideration.

Correct Answer: B

The nurse observes an unlicensed assistive personnel (UAP) taking a client's blood pressure with a cuff that is too small, but the blood pressure reading obtained is within the client's usual range. What action is most important for the nurse to implement?

A. Tell the UAP to use a larger cuff at the next scheduled assessment.

B. Reassess the client's blood pressure using a larger cuff.

C. Have the unit educator review this procedure with the UAPs.

D. Teach the UAP the correct technique for assessing blood pressure. - The most important action is to ensure that an accurate BP reading is obtained. The nurse should reassess the BP with the correct size cuff (B). Reassessment should not be postponed (A). Though (C and D) are likely indicated, these actions do not have the priority of (B).

Correct Answer: B

A client is to receive cimetidine (Tagamet) 300 mg q6h IVPB. The preparation arrives from the pharmacy diluted in 50 ml of 0.9% NaCl. The nurse plans to administer the IVPB dose over 20 minutes. For how many ml/hr should the infusion pump be set to deliver the secondary infusion? - The infusion rate is calculated as a ratio proportion problem, i.e., 50 ml/ 20 min : x ml/ 60 min. Multiply extremes and means 50 × 60 /20x 1= 300/20=150

Correct Answer: 150

Twenty minutes after beginning a heat application, the client states that the heating pad no longer feels warm enough. What is the best response by the nurse?

A. That means you have derived the maximum benefit, and the heat can be removed.

B. Your blood vessels are becoming dilated and removing the heat from the site.

C. We will increase the temperature 5 degrees when the pad no longer feels warm.

D. The body's receptors adapt over time as they are exposed to heat. - (D) describes thermal adaptation, which occurs 20 to 30 minutes after heat application. (A and B) provide false information. (C) is not based on a knowledge of physiology and is an unsafe action that may harm the client.

Correct Answer: D

The nurse is instructing a client with high cholesterol about diet and life style modification. What comment from the client indicates that the teaching has been effective?

A. If I exercise at least two times weekly for one hour, I will lower my cholesterol.

B. I need to avoid eating proteins, including red meat.

C. I will limit my intake of beef to 4 ounces per week.

D. My blood level of low density lipoproteins needs to increase. - 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 need to 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.

Correct Answer: C

The UAPs working on a chronic neuro unit ask the nurse to help them determine the safest way to transfer an elderly client with left-sided weakness from the bed to the chair. What method describes the correct transfer procedure for this client?

A. Place the chair at a right angle to the bed on the client's left side before moving.

B. Assist the client to a standing position, then place the right hand on the armrest.

C. Have the client place the left foot next to the chair and pivot to the left before sitting.

D. Move the chair parallel to the right side of the bed, and stand the client on the right foot. - (D) uses the client's stronger side, the right side, for weight-bearing during the transfer, and is the safest approach to take. (A, B, and C) are unsafe methods of transfer and include the use of poor body mechanics by the caregiver.

Correct Answer: D

An unlicensed assistive personnel (UAP) places a client in a left lateral position prior to administering a soap suds enema. Which instruction should the nurse provide the UAP?

A. Position the client on the right side of the bed in reverse Trendelenburg.

B. Fill the enema container with 1000 ml of warm water and 5 ml of castile soap.

C. Reposition in a Sim's position with the client's weight on the anterior ilium.

D. Raise the side rails on both sides of the bed and elevate the bed to waist level. - The left sided Sims' position allows the enema solution to follow the anatomical course of the intestines and allows the best overall results, so the UAP should reposition the client in the Sims' position, which distributes the client's weight to the anterior ilium (C). (A) is inaccurate. (B and D) should be implemented once the client is positioned.

Correct Answer: C

A client who is a Jehovah's Witness is admitted to the nursing unit. Which concern should the nurse have for planning care in terms of the client's beliefs?

A. Autopsy of the body is prohibited.

B. Blood transfusions are forbidden.

C. Alcohol use in any form is not allowed.

D. A vegetarian diet must be followed. - Blood transfusions are forbidden (B) in the Jehovah's Witness religion. Judaism prohibits (A). Buddhism forbids the use of (C) and drugs. Many of these sects are vegetarian (D), but the direct impact on nursing care is (B).

Correct Answer: B

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

A. Observe the appearance of the skin under the ice pack.

B. Instruct the client regarding the need for the covering.

C. Reapply the covering after filling with fresh ice.

D. Ask the client how long the ice was applied to the skin. - The first action taken by the nurse should be to assess the skin for any possible thermal injury (A). If no injury to the skin has occurred, the nurse can take the other actions (B, C, and D) as needed.

Correct Answer: A

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 weighing 182 pounds. Using a drip factor of 60 gtt/ml, how many drops per minute should the client receive?

A. 31 gtt/min.

B. 62 gtt/min.

C. 93 gtt/min.

D. 124 gtt/min. - (D) is the correct calculation: Convert lbs to kg: 182/2.2 = 82.73 kg. Determine the dosage for this client: 5 mcg × 82.73 = 413.65 mcg/min. Determine how

many mcg are contained in 1 ml: 250/50,000 mcg = 200 mcg per ml. The client is to receive 413.65 mcg/min, and there are 200 mcg/ml; so the client is to receive 2.07ml per minute. With a drip factor of 60 gtt/ml, then 60 × 2.07 = 124.28 gtt/min (D) OR, using dimensional analysis: gtt/min = 60 gtt/ml X 250 ml/50 mg X 1 mg/1,000 mcg X 5 mcg/kg/min X 1 kg/2.2 lbs X 182 lbs.

Correct Answer: 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 fine now. What action is best for the nurse to take?

A. Record the coughing incident. No further action is required at this time.

B. Stop the feeding, explain to the family why it is being stopped, and notify the healthcare provider.

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

D. Inject 30 ml of air into the tube while auscultating the epigastrium for gurgling. - Coughing, vomiting, and suctioning can precipitate displacement of the tip of the small bore feeding tube upward into the esophagus, placing the client at increased risk for aspiration. Checking the sample of fluid withdrawn from the tube (after clearing the tube with 30 ml of air) for acidic (stomach) or alkaline (intestine) values is a more sensitive method for these tubes, and the nurse should assess tube placement in this way prior to taking any other action (C). (A and B) are not indicated. The auscultating method (D) has been found to be unreliable for small-bore feeding tubes.

Correct Answer: C

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, timed-release capsules are not available, which dosing schedule should the nurse advise the client to follow?

A. 9 a.m., 1 p.m., and 5 p.m.

B. 8 a.m., 4 p.m., and midnight.

C. Before breakfast, before lunch and before dinner.

D. With breakfast, with lunch, and with dinner. - Theophylline should be administered on a regular around-the-clock schedule (B) to provide the best bronchodilating effect and reduce the potential for adverse effects. (A, C, and D) do not provide around-the- clock dosing. Food may alter absorption of the medication (D).

Correct Answer: B

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

A. 13 ml/hour.

B. 63 ml/hour.

C. 80 ml/hour.

D. 125 ml/hour. - (B) is the correct calculation: To calculate this problem correctly, remember that the dose of KCl is not used in the calculation. 250 ml/4 hours = 63 ml/hour.

Correct Answer: B

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

A. Be sure to have a complete physical examination before beginning your planned exercise program.

B. Be careful that the exercise program doesn't simply add to your stress level, making you want to eat more.

C. Increased exercise helps to reduce stress, so you may not need to spend money on a stress management class.

D. Make sure to monitor your weight loss regularly to provide a sense of accomplishment and motivation. - The most important teaching is (A), so that the client will not begin a dangerous level of exercise when he is not sufficiently fit. This might result in chest pain, a heart attack, or stroke. (B, C, and D) are important instructions, but are of less priority than (A).

Correct Answer: A

The nurse is teaching a client proper use of an inhaler. When should the client administer the inhaler-delivered medication to demonstrate correct use of the inhaler?

A. Immediately after exhalation.

B. During the inhalation.

C. At the end of three inhalations.

D. Immediately after inhalation. - The client should be instructed to deliver the medication during the last part of inhalation (B). After the medication is delivered, the client should remove the mouthpiece, keeping his/her lips closed and breath held for several seconds to allow for distribution of the medication. The client should not deliver the dose as stated in (A or D), and should deliver no more than two inhalations at a time (C).

Correct Answer: B

The healthcare provider prescribes the diuretic metolazone (Zaroxolyn) 7.5 mg PO. Zaroxolyn is available in 5 mg tablets. How much should the nurse plan to administer?

A. ½ tablet.

B. 1 tablet.

C. 1½ tablets.

D. 2 tablets. - (C) is the correct calculation: D/H × Q = 7.5/5 × 1 tablet = 1½ tablets.

Correct Answer: C

The healthcare provider prescribes furosemide (Lasix) 15 mg IV stat. On hand is Lasix 20 mg/2 ml. How many milliliters should the nurse administer?

A. 1 ml.

B. 1.5 ml.

C. 1.75 ml.

D. 2 ml. - (B) is the correct calculation: Dosage on hand/amount on hand = Dosage desired/x amount. 20 mg : 2 ml = 15 mg : x . 20x = 30. x = 30/20; = 1½ or 1.5 ml.

Correct Answer: B

Heparin 20,000 units in 500 ml D5W at 50 ml/hour has been infusing for 5½ hours. How much heparin has the client received?

A. 11,000 units.

B. 13,000 units.

C. 15,000 units.

D. 17,000 units. - (A) is the correct calculation: 20,000 units/500 ml = 40 units (the amount of units in one ml of fluid). 40 units/ml x 50 ml/hr = 2,000 units/hour (1,000 units in 1/2 hour). 5.5 x 2,000 = 11,000 (A). OR, multiply 5 x 2,000 and add the 1/2 hour amount of 1,000 to reach the same conclusion = 11,000 units.

Correct Answer: A

The healthcare provider prescribes morphine sulfate 4mg IM STAT. Morphine comes in 8 mg per ml. How many ml should the nurse administer?

A. 0.5 ml.

B. 1 ml.

C. 1.5 ml.

D. 2 ml. - Using ratio and proportion:

8mg: 1ml :: 4mg:Xml

8X=4

X=0.5

Correct Answer: A

The nurse prepares a 1,000 ml IV of 5% dextrose and water to be infused over 8 hours. The infusion set delivers 10 drops per milliliter. The nurse should regulate the IV to administer approximately how many drops per minute?

A. 80

B. 8

C. 21

D. 25 - The accepted formula for figuring drops per minute is: amount to be infused in one hour × drop factor/time for infusion (min)= drops per minute. Using this formula: 1,000/8 hours = 125 ml/ hour 125 × 10 (drip factor) = 1,250 drops in one hour. 1,250/ 60 (number of minutes in one hour) = 20.8 or 21 gtt/min (C).

Correct Answer: C

Which action is most important for the nurse to implement when donning sterile gloves?

A. Maintain thumb at a ninety degree angle.

B. Hold hands with fingers down while gloving.

C. Keep gloved hands above the elbows.

D. Put the glove on the dominant hand first. - Gloved hands held below waist level are considered unsterile (C). (A and B) are not essential to maintaining asepsis. While it may be helpful to put the glove on the dominant hand first, it is not necessary to ensure asepsis (D).

Correct Answer: C

A client's infusion of normal saline infiltrated earlier today, and approximately 500 ml of saline infused into the subcutaneous tissue. The client is now complaining of

excruciating arm pain and demanding "stronger pain medications." What initial action is most important for the nurse to take?

A. Ask about any past history of drug abuse or addiction.

B. Measure the pulse volume and capillary refill distal to the infiltration.

C. Compress the infiltrated tissue to measure the degree of edema.

D. Evaluate the extent of ecchymosis over the forearm area. - Pain and diminished pulse volume (B) are signs of compartment syndrome, which can progress to complete loss of the peripheral pulse in the extremity. Compartment syndrome occurs when external pressure (usually from a cast), or internal pressure (usually from subcutaneous infused fluid), exceeds capillary perfusion pressure resulting in decreased blood flow to the extremity. (A) should not be pursued until physical causes of the pain are ruled out. (C) is of less priority than determining the effects of the edema on circulation and nerve function. Further assessment of the client's ecchymosis can be delayed until the signs of edema and compression that suggest compartment syndrome have been examined (D).

Correct Answer: B

An elderly male client who is unresponsive following a cerebral vascular accident (CVA) is receiving bolus enteral feedings though a gastrostomy tube. What is the best client position for administration of the bolus tube feedings?

A. Prone.

B. Fowler's.

C. Sims'.

D. Supine. - The client should be positioned in a semi-sitting (Fowler's) (B) position during feeding to decrease the occurrence of aspiration. A gastrostomy tube, known as a PEG tube, due to placement by a percutaneous endoscopic gastrostomy procedure, is inserted directly into the stomach through an incision in the abdomen for long-term administration of nutrition and hydration in the debilitated client. In (A and/or C), the client is placed on the abdomen, an unsafe position for feeding. Placing the client in (D) increases the risk of aspiration.

Correct Answer: B

A 73-year-old female client had a hemiarthroplasty of the left hip yesterday due to a fracture resulting from a fall. In reviewing hip precautions with the client, which instruction should the nurse include in this client's teaching plan?

A. In 8 weeks you will be able to bend at the waist to reach items on the floor.

B. Place a pillow between your knees while lying in bed to prevent hip dislocation.

C. It is safe to use a walker to get out of bed, but you need assistance when walking.

D. Take pain medication 30 minutes after your physical therapy sessions. - The client's affected hip joint following a hemiarthroplasty (partial hip replacement) is at risk of dislocation for 6 months to a year following the procedure. Hip precautions to prevent dislocation include placing a pillow between the knees to maintain abduction of the hips (B). Clients should be instructed to avoid bending at the waist (A), to seek assistance for both standing and walking until they are stable on a walker or cane (C), and to take pain

medication 20 to 30 minutes prior to physical therapy sessions, rather than waiting until the pain level is high after their therapy.

Correct Answer: B

A client with pneumonia has a decrease in oxygen saturation from 94% to 88% while ambulating. Based on these findings, which intervention should the nurse implement first?

A. Assist the ambulating client back to the bed.

B. Encourage the client to ambulate to resolve pneumonia.

C. Obtain a prescription for portable oxygen while ambulating.

D. Move the oximetry probe from the finger to the earlobe. - An oxygen saturation below 90% indicates inadequate oxygenation. First, the client should be assisted to return to bed (A) to minimize oxygen demands. Ambulation increases aeration of the lungs to prevent pooling of respiratory secretions, but the client's activity at this time is depleting oxygen saturation of the blood, so (B) is contraindicated. Increased activity increases respiratory effort, and oxygen may be necessary to continue ambulation (C), but first the client should return to bed to rest. Oxygen saturation levels at different sites should be evaluated after the client returns to bed (D).

Correct Answer: A

A client with chronic renal failure selects a scrambled egg for his breakfast. What action should the nurse take?

A. Commend the client for selecting a high biologic value protein.

B. Remind the client that protein in the diet should be avoided.

C. Suggest that the client also select orange juice, to promote absorption.

D. Encourage the client to attend classes on dietary management of CRF. - 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. Although a low-protein diet is followed (B), some protein is essential. Orange juice is rich in potassium, and should not be encouraged (C). The client has made a good diet choice, so (D) is not necessary.

Correct Answer: A

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

A. What is your daily calorie consumption?

B. What vitamin and mineral supplements do you take?

C. Do you feel that you are overweight?

D. Will a clear liquid diet be okay after surgery? - 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 anesthesia will determine the need for a clear liquid diet (D), rather than the client's preference.

Correct Answer: B

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

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

B. Exchange the client's grape juice for cranberry juice.

C. Bring the client additional fruit at mid-morning.

D. Encourage additional oral intake of juices and water. - Dark amber urine is characteristic of fluid volume deficit, and the client should be encouraged to increase fluid intake (D). Caffeine, however, is a diuretic (A), and may worsen the fluid volume deficit. Any type of juice will be beneficial (B), since the client is not dysuric, a sign of an urinary tract infection. The client needs to restore fluid volume more than solid foods (C).

Correct Answer: D

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

A. Apply a condom catheter.

B. Apply a skin protectant.

C. Encourage increased fluid intake.

D. Assess for bladder 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 the skin of a client with urinary incontinence. (C) may worsen the bladder distention.

Correct Answer: D

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

A. Obtain the pre-transfusion hemoglobin level.

B. Prime the tubing and prepare a blood pump set-up.

C. Monitor vital signs q15 minutes for the first hour.

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.

Correct Answer: D

Which snack food is best for the nurse to provide a client with myasthenia gravis who is at risk for altered nutritional status?

A. Chocolate pudding.

B. Graham crackers.

C. Sugar free gelatin.

D. Apple slices. - The client with myasthenia gravis 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 and require 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.

Correct Answer: A

The nurse is evaluating client learning about a low-sodium diet. Selection of which meal would indicate to the nurse that this client understands the dietary restrictions?

A. Tossed salad, low-sodium dressing, bacon and tomato sandwich.

B. New England clam chowder, no-salt crackers, fresh fruit salad.

C. Skim milk, turkey salad, roll, and vanilla ice cream.

D. Macaroni and cheese, diet Coke, a slice of cherry pie. - Skim milk, turkey, bread, and ice cream (C), while containing some sodium, are considered low-sodium foods. Bacon (A), canned soups (B), especially those with seafood, hard cheeses, macaroni, and most diet drinks (D) are very high in sodium.

Correct Answer: C

Which nutritional assessment data should the nurse collect to best reflect total muscle mass in an adolescent?

A. Height in inches or centimeters.

B. Weight in kilograms or pounds.

C. Triceps skin fold thickness.

D. Upper arm circumference. - Upper arm circumference (D) is an indirect measure of muscle mass. (A and B) do not distinguish between fat (adipose) and muscularity. (C) is a measure of body fat.

Correct Answer: D

An elderly resident of a long-term care facility is no longer able to perform self-care and is becoming progressively weaker. The resident previously requested that no resuscitative efforts be performed, and the family requests hospice care. What action should the nurse implement first?

A. Reaffirm the client's desire for no resuscitative efforts.

B. Transfer the client to a hospice inpatient facility.

C. Prepare the family for the client's impending death.

D. Notify the healthcare provider of the family's request. - The nurse should first communicate with the healthcare provider (D). Hospice care is provided for clients with a limited life expectancy, which must be identified by the healthcare provider. (A) is not

necessary at this time. Once the healthcare provider supports the transfer to hospice care, the nurse can collaborate with the hospice staff and healthcare provider to determine when (B and C) should be implemented.

Correct Answer: D

After completing an assessment and determining that a client has a problem, which action should the nurse perform next?

A. Determine the etiology of the problem.

B. Prioritize nursing care interventions.

C. Plan appropriate interventions.

D. Collaborate with the client to set goals. - Before planning care, the nurse should determine the etiology, or cause, of the problem (A), because this will help determine (B, C, and D).

Correct Answer: A

An elderly client who requires frequent monitoring fell and fractured a hip. Which nurse is at greatest risk for a malpractice judgment?

A. A nurse who worked the 7 to 3 shift at the hospital and wrote poor nursing notes.

B. The nurse assigned to care for the client who was at lunch at the time of the fall.

C. The nurse who transferred the client to the chair when the fall occurred.

D. The charge nurse who completed rounds 30 minutes before the fall occurred. - The four elements of malpractice are: breach of duty owed, failure to adhere to the recognized standard of care, direct causation of injury, and evidence of actual injury. The hip fracture is the actual injury and the standard of care was "frequent monitoring."
(C) implies that duty was owed and the injury occurred while the nurse was in charge of the client's care. There is no evidence of negligence in (A, B, and D).

Correct Answer: C

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? The client

A. asks relevant questions regarding the dressing change.

B. states he will be able to complete the wound care regimen.

C. demonstrates the wound care procedure correctly.

D. has all the necessary supplies for wound care. - 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 prior to discharge than the nurse's assessment of the client's ability to complete the wound care.

Correct Answer: C

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

A. Establish a new nursing diagnosis.

B. Note which actions were not implemented.

C. Add additional nursing orders to the plan.

D. Collaborate with the healthcare provider to make changes. - First, the nurse reviews 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.

Correct Answer: B

The healthcare provider prescribes 1,000 ml of Ringer's Lactate with 30 Units of Pitocin to run in over 4 hours for a client who has just delivered a 10 pound infant by cesarean section. The tubing has been changed to a 20 gtt/ml administration set. The nurse plans to set the flow rate at how many gtt/min?

A. 42 gtt/min.

B. 83 gtt/min.

C. 125 gtt/min.

D. 250 gtt/min. - gtt/min = 20gtts/ml X 1000 ml/4hrs X 1 hr/60 min

Correct Answer: B

Seconal 0.1 gram PRN at bedtime is prescribed to a client for rest. The scored tablets are labeled grain 1.5 per tablet. How many tablets should the nurse plan to administer?

A. 0.5 tablet.

B. 1 tablet.

C. 1.5 tablets.

D. 2 tablets. - 15 gr=1 Gm. Converting the prescribed dose of 0.1 grams to grains requires multiplying 0.1 × 15 = 1.5 grains. The tablets come in 1.5 grains, so the nurse should plan to administer 1 tablet (B).

Correct Answer: B

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

A. Aspirating gastric contents to assure a pH value of 4 or less.

B. Hearing air pass in the stomach after injecting air into the tubing.

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

D. Checking the remaining length of tubing to ensure that the correct length was inserted. - Both (A and B) are methods used to determine proper placement of the NG tubing. However, the best indicator that the tubing is properly placed is (C). (D) is not an indicator of proper placement.

Correct Answer: C

The nurse is caring for a client who is receiving 24-hour total parenteral nutrition (TPN) via a central line at 54 ml/hr. When initially assessing the client, the nurse notes that the TPN solution has run out and the next TPN solution is not available. What immediate action should the nurse take?

A. Infuse normal saline at a keep vein open rate.

B. Discontinue the IV and flush the port with heparin.

C. Infuse 10 percent dextrose and water at 54 ml/hr.

D. Obtain a stat blood glucose level and notify the healthcare provider. - TPN is discontinued gradually to allow the client to adjust to decreased levels of glucose. Administering 10% dextrose in water at the prescribed rate (C) will keep the client from experiencing hypoglycemia until the next TPN solution is available. The client could experience a hypoglycemic reaction if the current level of glucose (A) is not maintained or if the TPN is discontinued abruptly (B). There is no reason to obtain a stat blood glucose level (D) and the healthcare provider cannot do anything about this situation.

Correct Answer: C