HESI Fundamentals Practice Test B

What is the rationale for using the nursing process in planning care for clients?

A. As a scientific process to identify nursing diagnoses of a clients' healthcare problems.

B. To establish nursing theory that incorporates the biopsychosocial nature of humans.

C. As a tool to organize thinking and clinical decision making about clients' healthcare needs.

D. To promote the management of client care in collaboration with other healthcare professionals.

(ANS-: C)

What activity should the nurse use in the evaluation phase of the nursing process?

A. Ask a client to evaluate the nursing care provided.

B. Document the nursing care plan in the progress notes.

C. Determine whether a client's health problems have been alleviated.

D. Examine the effectiveness of nursing interventions toward meeting client outcomes. (ANS-: D

Which statement is an example of a correctly written nursing diagnosis statement?

A. Altered tissue perfusion related to congestive heart failure.

B. Altered urinary elimination related to urinary tract infection.

C. Risk for impaired tissue integrity related to client's refusal to turn.

D. Ineffective coping related to response to positive biopsy test results.

(ANS-: D

What action by the nurse demonstrates culturally sensitive care?

A. Asks permission before touching a client.

B. Avoids questions about male-female relationships.

C. Explains the differences between Western medical care and cultural folk remedies.

D. Applies knowledge of a cultural group unless a client embraces Western customs. (ANS-: A

A nurse is becoming increasingly frustrated by the family members' efforts to participate in the care of a hospitalized client. What action should the nurse implement to cope with these feelings of frustration?

A. Suggest that other cultural practices be substituted by the family members.

B. Examine one's own culturally based values, beliefs, attitudes, and practices.

C. Explain to the family that multiple visitors are exhausting to the client.

D. Allow the situation to continue until a family member's action may harm the client. (ANS-: B

Which technique is most important for the nurse to implement when performing a physical assessment?

A. A head-to-toe approach.

B. The medical systems model.

C. A consistent, systematic approach.

D. An approach related to a nursing model. (ANS-: C

A 73-year-old Hispanic client is seen at the community health clinic with a history of protein malnutrition. What information should the nurse obtain first?

A. Amount of liquid protein supplements consumed daily.

B. Foods and liquids consumed during the past 24 hours.

C. Usual weekly intake of milk products and red meats.

D. Grains and legume combinations used by the client. (ANS-: B

The nurse formulates the nursing diagnosis of, "Ineffective health maintenance related to lack of motivation" for a client with Type 2 diabetes. Which finding supports this nursing diagnosis?

A. Does not check capillary blood glucose as directed.

B. Occasionally forgets to take daily prescribed medication.

C. Cannot identify signs or symptoms of high and low blood glucose.

D. Eats anything and does not think diet makes a difference in health.

(ANS: D

Which statement correctly identifies a written learning objective for a client with peripheral vascular disease?

A. The nurse will provide client instruction for daily foot care.

B. The client will demonstrate proper trimming toenail technique.

C. Upon discharge, the client will list three ways to protect the feet from injury.

D. After instruction, the nurse will ensure the client understands foot care rationale.

(ANS-: C

A middle-aged woman who enjoys being a teacher and mentor feels that she should pass down her legacy of knowledge and skills to the younger generation. According to Erikson, she is involved in what developmental stage?

A. Generativity.

B. Ego integrity.

C. Identification.

D. Valuing wisdom

(ANS-: A

Which statement best describes durable power of attorney for health care?

A. The client signs a document that designates another person to make legally binding healthcare decisions if client is unable to do so.

B. The healthcare decisions made by another person designated by the client are not legally binding.

C. Instructions about actions to be taken in the event of a client's terminal or irreversible condition are not legally binding.

D. Directions regarding care in the event of a terminal or irreversible condition must be documented to ensure that they are legally binding.

(ANS- A

A male client with an infected wound tells the nurse that he follows a macrobiotic diet. Which type of foods should the nurse recommend that the client select from the hospital menu?

A. Low fat and low sodium foods.

B. Combination of plant proteins to provide essential amino acids.

C. Limited complex carbohydrates and fiber.

D. Increased amount of vitamin C and beta carotene rich foods.

(ANS-: B

A client with Raynaud's disease asks the nurse about using biofeedback for self-management of symptoms. What response is best for the nurse to provide?
A. The responses to biofeedback have not been well established and may be a waste of time and money.
B. Biofeedback requires extensive training to retrain voluntary muscles, not involuntary responses.
C. Although biofeedback is easily learned, it is mostly often used to manage exacerbation of symptoms.
D. Biofeedback allows the client to control involuntary responses to promote peripheral vasodilation.
(ANS-: D

A female client informs the nurse that she uses herbal therapies to supplement her diet and manage common ailments. What information should the nurse offer the client about general use of herbal supplements?
A. Most herbs are toxic or carcinogenic and should be used only when proven effective.
B. There is no evidence that herbs are safe or effective as compared to conventional supplements in maintaining health.
C. Herbs should be obtained from manufacturers with a history of quality control of their supplements.
D. Herbal therapies may mask the symptoms of serious disease, so frequent medical evaluation is required during use.
(ANS: C

A female client who has breast cancer with metastasis to the liver and spine is admitted with constant, severe pain despite around-the-clock use of oxycodone (Percodan) and amitriptyline (Elavil) for pain control at home. During the admission assessment, which information is most important for the nurse to obtain?

A. Sensory pattern, area, intensity, and nature of the pain.

B. Trigger points identified by palpation and manual pressure of painful areas.

C. Schedule and total dosages of drugs currently used for breakthrough pain.

D. Sympathetic responses consistent with onset of acute pain.

(ANS-: A

A client who has moderate, persistent, chronic neuropathic pain due to diabetic neuropathy takes gabapentin (Neurontin) and ibuprofen (Motrin, Advil) daily. If Step 2 of the World Health Organization (WHO) pain relief ladder is prescribed, which drug protocol should be implemented?

A. Continue gabapentin.

B. Discontinue ibuprofen.

C. Add aspirin to the protocol.

D. Add oral methadone to the protocol.

(ANS- Correct Answer: A

To obtain the most complete assessment data for a client with chronic pain, which information should the nurse obtain?

A. Can you describe where your pain is the most severe?

B. What is your pain intensity on a scale of 1 to 10?

C. Is your pain best described as aching, throbbing, or sharp?

D. Which activities during a routine day are impacted by your pain?

(ANS- Correct Answer: D

A male client with acquired immunodeficiency syndrome (AIDS) develops cryptococcal meningitis and tells the nurse he does not want to be resuscitated if his breathing stops. What action should the nurse implement?
A. Document the client's request in the medical record.
B. Ask the client if this decision has been discussed with his healthcare provider.
C. Inform the client that a written, notarized advance directive, is required to withhold resuscitation efforts.
D. Advise the client to designate a person to make healthcare decisions when the client is unable to do so.
(ANS- Advance directives are written statements of a person's wishes regarding medical care, and verbal directives may be given to a healthcare provider with specific instructions in the presence of two witnesses. To obtain this prescription, the client should discuss his choice with the healthcare provider (B). (A) is insufficient to implement the client's request without legal consequences. Although (C and D) provide legal protection of the client's wishes, the present request needs additional action.
Correct Answer: B

The nurse is discussing dietary preferences with a client who adheres to a vegan diet. Which dietary supplement should the nurse encourage the client to include the dietary plan?
A. Fiber.
B. Folate.
C. Ascorbic acid.
D. Vitamin B12.

(ANS- : D

The nurse is preparing a male client who has an indwelling catheter and an IV infusion to ambulate from the bed to a chair for the first time following abdominal surgery. What action(s) should the nurse implement prior to assisting the client to the chair? (Select all that apply.)

A. Pre-medicate the client with an analgesic.

B. Inform the client of the plan for moving to the chair.

C. Obtain and place a portable commode by the bed.

D. Ask the client to push the IV pole to the chair.

E. Clamp the indwelling catheter.

F. Assess the client's blood pressure.

(ANS- The nurse should plan to implement (A, B, D, and F). Pre-medicating the client with an analgesic (A) reduces the client's pain during mobilization and maximizes compliance. To ensure the client's cooperation and promote independence, the nurse should inform the client about the plan for moving to the chair (B) and encourage the client to participate by pushing the IV pole when walking to the chair (D). The nurse should assess the client's blood pressure (F) prior to mobilization, which can cause orthostatic hypotension. (C and E) are not indicated.

Correct Answer: A, B, D, F

A client is demonstrating a positive Chvostek's sign. What action should the nurse take?

A. Observe the client's pupil size and response to light.

B. Ask the client about numbness or tingling in the hands.

C. Assess the client's serum potassium level.

D. Restrict dietary intake of calcium-rich foods.

(ANS- A positive Chvostek's sign is an indication of hypocalcemia, so the client should be assessed for the subjective symptoms of hypocalcemia, such as numbness or tingling of the hands (B) or feet. (A and C) are unrelated assessment data. (D) is contraindicated because the client is hypocalcemic and needs additional dietary calcium.

Correct Answer: B

When preparing to administer an intravenous medication through a central venous catheter, the nurse aspirates a blood return in one of the lumens of the triple lumen catheter. Which action should the nurse implement?

A. Flush the lumen with the saline solution and administer the medication through the lumen.

B. Determine if a PRN prescription for a thrombolytic agent is listed on the medication record.

C. Clamp the lumen and obtain a syringe of a dilute heparin solution to flush through the tubing.

D. Withdraw the aspirated blood into the syringe and use a new syringe to administer the medication.

(ANS- Aspiration of a blood return in the lumen of a central venous catheter indicates that the catheter is in place and the medication can be administered. The

nurse should flush the tubing with the saline solution, administer the medication (A), then flush the lumen with saline again. (B and C) are not necessary. The aspirated blood can be flushed back through the closed system into the client's bloodstream, but does not need to be withdrawn (D).
Correct Answer: A

Which client assessment data is most important for the nurse to consider before ambulating a postoperative client?
A. Respiratory rate.
B. Wound location.
C. Pedal pulses.
D. Pain rating.
(ANS- Mobilization and ambulation increase oxygen use, so it is most important to assess the client's respiratory rate (A)before ambulation to determine tolerance for activity. (B, C, and D) are also important, but are of lower priority than (A).
Correct Answer: A

The nurse is administering an intermittent infusion of an antibiotic to a client whose intravenous (IV) access is an antecubital saline lock. After the nurse opens the roller clamp on the IV tubing, the alarm on the infusion pump indicates an obstruction. What action should the nurse take first?
A. Check for a blood return.
B. Reposition the client's arm.
C. Remove the IV site dressing.
D. Flush the lock with saline.
(ANS- If the client's elbow is bent, the IV may be unable to infuse, resulting in an obstruction alarm, so the nurse should first attempt to reposition the client's arm to