1. A nurse is caring for a client who is at 33 weeks gestation following an amniocentesis. The nurse should monitor the client for which of the following complications?

a. contractions
b. Hypertention
c. Epigastric pain
d. vomiting

**Answer: a. Contraction**

Rational: Amniocentesis
-Can't be done before 16 weeks, not enough amniotic fluid.
-maternal risks: hemorrhage, feto maternal hemorrhage, infection, **contractions**/labor, abruptio placentae, damage to intestines or bladder, amniotic fluid embolism
-fetal risks: death, hemorrhage, infection, direct injury from the needle, miscarriage, and preterm, leakage of amniotic fluid

2. A nurse is providing teaching to an older adult client about methods to promote nighttime sleep. Which of the following instructions should the nurse include?

a. Stay in bed at least 1 hr if unable to fall asleep.
b. Take a 1 hr nap during the day
c. Perform exercises prior to bedtime
d. Eat a light snack before bedtime

**Answer:D. Eat a light snack before bedtime**
**Rational:Consume a light snack of carbohydrates at bedtime**

3. A nurse on a telemetry unit is caring for a client who becomes unconscious and whose monitor displays ventricular tachycardia. Which of the following actions should the nurse first take determining the client does not have a palpable pulse?

a. Assess heart sounds
b. Defibrillate
c. Establish IV access
d. Administer Epinephrine

Answer:B. **Defibrillate**
**Rational: The nurse needs to assess the client to determine stability before proceeding with further interventions. If the client has a pulse and is relatively stable, elective cardioversion or antidysrhythmic medications may be prescribed. The drug of choice for stable ventricular tachycardia with a pulse is amiodarone. If the client is pulseless or nonresponsive, the client is unstable and defibrillation is used**

4. A nurse is admitting a client who is one week postpartum and reports excessive vaginal bleeding. The nurse does not speak the same language as the client the client's partner and 10-year-old child are accompanying her. Which of the following actions should the nurse take to gather the client's admission data?

a. Have the client's child translate
b. Allow the client's partner to translate
c. Request a female interpreter through the facility
d. Ask a nursing student who speaks the same language as the client to translate.

**Answer: C. Request a female interpreter through the facility**
**Rational: We been told not to use family members if not facility interpreters**

5. A nurse is caring for a client who is febrile(fever). To reduce the client's fever, the nurse applies cooling. Which of the following indicates the client is having an adverse reaction to the cooling?

a. Flushing
b. Tachycardia
c. Restlessness
d. Shivering

**Answer: D. shivering**
**Rational: Hypothermia is the adverse reaction of cooling system for a febrile patient s/s of hypothermia: shivering, slurred speech, weak pulse drowsiness, confusion, loss of memory**

6. A nurse is caring for a client who has deep-vein thrombosis of the left lower extremity. Which of the following actions should the nurse take?

**The Answer should be: ensure that the lower extremity is elevated.**
Rational: **DVT causes edema; therefore, the UAP should elevate the extremity to promote venous return. Dependent positioning is appropriate for a client with arterial insufficiency. Placing a pillow under the knee would position the foot in a low position, and pressure behind the knee may obstruct venous flow. Massaging the extremity could dislodge the thrombus**

7. A nurse is reviewing assessment data from several clients. For which of the following clients should the nurse recommend referral to a dietitian?

a. An older adult client who has BMI of 24
b. A client who has a nonhealing leg ulcer
c. An older adult client who had presbyopia
d. A client who has an albumin level of 3.7 g/dl

Answer:B. A client who has a nonhealing leg ulcer

**Rational: type of patients that can be referred to dietitian are the ones that present: Physical S&S Malnutrition**
**Hair is dull, brittle, dry, or falls out easily**
**Swollen glands of neck and cheeks**
**Dry, rough, or spotty skin**
**Poor or delayed wound healing or sores**
**Thin appearance with lack of subcutaneous fat**
**Muscle wasting**
**Edema of lower extremities**
**Weakened hand grasp**
**Depressed mood**
**Abnormal heart rate/rhythm and BP**
**Enlarged liver or spleen**
**Loss of balance and coordination**
Presbyopia: farsighted

8. A nurse is providing discharge teaching to a client who has chronic kidney disease and is receiving hemodialysis. Which of the following instructions should the nurse include in the teaching?

a. Eat 1g/kg of protein per day
b. Take magnesium hydroxide for indigestion
c. Drink at least 3 L of fluid daily.
d. Consume foods high in K+

**Answer: A. Eat 1g/kg of protein per day**
**Rational: Protein intake and hemodialysis**
**protein is not routinely restricted.**
Magnesium hydroxide. **Please don't chose this anwer!**

**-Magnesium is excreted by the kidneys, and patients with CKD should not use OTC products containing magnesium. The other mediations are appropriate for a patient with CKD.**

9. A nurse is caring for a client who is receiving intermittent enteral tube feedings. Which of the following places the client at risk for aspiration?

a. Sitting in high-fowlers position during the feeding
b. History of gastroesophageal reflux disease (GERD)
c. Receiving a high osmolality formula
d. A residual of 65ml 1 hr postprandial

**Answer: B. History of gastroesophageal reflux disease (GERD)**
Rational: **Pt with higher Risk of aspiration a in clients with GERD**

10. A nurse is providing prenatal teaching to a client who is 12 weeks of gestation. The nurse should tell the client she will undergo which of the following screening test at 16 weeks of gestation?

a. Chorionic villus sampling
b. Cervical cultures for chlamydia
c. Non-stress test
d. Maternal serum alpha-fetoprotein

**Answer: D.Maternal serum alpha-fetoprotein(performed ideally at 16 to 18 weeks)**

**Rational:** **Screening is usually done by taking a sample of your blood between 15 and 20 weeks of pregnancy (16 to 18 weeks is ideal). The multiple markers include: AFP screening. Also called maternal serum AFP, this blood test measures the level of AFP in your blood during pregnancy.**

**High levels of alpha-fetoprotein: May indicate neural tube defects, anencephaly or abdominal wall defect. Would follow up with ultrasound.**

11. A nurse is caring for a client who is on bed rest. The nurse should recognize that which of the following findings is a complication of immobility?

a. Decreased serum calcium levels
b. Increased blood pressure
c. Swollen area on calf
d. Urinary frequency

**Answer: C. Swollen area on calf**

Rational: primary and serious effects of immobility on the musculoskeletal system atrophy (decreased muscle size); contractures; ankylosis (fixation of a joint**); osteoporosis (loss of bone density)**; footdrop (plantar flexion)

12. A nurse in an acute care mental health facility is participating in a medication-education group. The leader of the group uses laissez-faire leadership style. Which of the following actions should the nurse expect from the leader during the session?

a. The leader encourages group members to remain silent until questions are called for.
b. The leader lectures about medication adverse rxn to the group members.
c. The leader allows the group to discuss whatever they would like regarding their medications.
d. The leader has group members vote on what they would like to learn about during the session.

**Answer: C. The leader allows the group to discuss whatever they would like regarding their medications.**

**Rational: Laissez-Faire**
**leader gives up control with free-run or permissive style**

13. A nurse is providing teaching about digoxin administration to the parents of a toddler who has heart failure. Which of the following statements should the nurse include in the teaching?

a. "You can add the medication to a half-cup of your child's favorite juice"
b. "Repeat the dose if your child vomits within1 hour after taking the medication." (u don't suppose to re administer, even if the dose is missed)
c. "Limit your child's potassium intake while she is taking this medication."
d. "Have your child drink a small glass of water after swallowing the medication."

**answer:D. "Have your child drink a small glass of water after swallowing the medication."** ."(to prevent tooth decay if child has teeth)
**Rational: make the child to drink water and** Brush the child's teeth after giving the medication

14. A nurse is providing teaching to a client who has a depressive disorder and a new prescription for phenelzine. Which of the following foods should the nurse instruct the client to avoid?

a. Grapefruit
b. Spinach
c. Cottage Cheese
d. Smoked Salmon

**Answer:D. Smoked Salmon**
Rational: Foods to avoid/restrict
Avocados, bananas, raisins, papaya, canned figs
fava beans
cheese (cottage okay), sour cream, **yogurt**
**beer, wine (esp. red)**
beef or chicken liver, pate, meat extracts, pickled or kippered herring pepperoni, salami, sausage, bologna/hot dogs
soy sauce
all yeast
**chocolate**
**Smoked fish should be avoided. Dried or cured fish, as well as fish that has been fermented, smoked, or aged has a high amount of tyramine.**

15. MATH

16. A nurse is planning care for a client who has bipolar disorder and is experiencing mania. Which of the following interventions should the nurse include in the plan?

a. Encourage the client to spend time in the day room

b. Withdraw the client's TV privileges if he does not attend group therapy.
c. Encourage the client to take frequent rest periods
d. Place the client in seclusion when he exhibits signs of anxiety.

**C. Encourage the client to take frequent rest periods.**
**Rational: The nurse should encourage the client to take frequent rest periods throughout the day. Clients experiencing mania are at risk of exhaustion that can be life threatening. Give water: High caloric finger food meals!!**

17. A parish nurse is leading a support group for clients whose family members have committed suicide. Which of the following strategies should the nurse plan to use during the group session?
a. Initiate a discussion with clients about ways to cope with the changes in the family dynamics
b. Encourage clients to establish a timeline for their own grieving process.
c. Discourage clients from sharing negative aspects of their own grieving process
d. Assist clients in identifying ways suicide could have been prevented.

Answer:B. encourage clients to establish a timeline for their own grieving process.
Encourage seems to be a key word!!

18. A nurse manager observes two staff nurses reviewing the computer records of a client who is not under their care. Which of the following actions should the nurse manager take 1st?
a. Instruct the nurses to close the client's computer record.
b. Request the nurses present an in-service on client confidentiality.
c. Advise the nurses to read the facility's confidentiality policy.
d. Place documentation of the nurses' actions in the personnel file.

Answer:A. Instruct the nurses to close the client's computer record.

19. A nurse is reviewing the medical record of a client who has schizophrenia and is taking clozapine. Which of the following findings should the nurse identify as a contradiction to the administration of clozapine?
a. Heart rate 58/min
b. Fasting blood glucose 100mg/dL
c. Hgb 14 g/dL
d. WBC count 2900/mm3

**Answer: D. WBC count 2900/mm3**
**Rational: Clozapine can cause agranulocytosis, which can be fatal due to overwhelming infection. The nurse should identify a WBC count below 3000/mm3 as a possible manifestation of agranulocytosis and should withhold the medication and notify the provider.**
Clozapine:Antipsychotics second generation(atypical)

Use:Schizophrenia S/E:Hypotension, constipation,tachycardia,sedation, agranulocytosis,seizures.

20. A nurse is caring for multiple clients on a medical surgical unit. For which of the following nursing activities is it required that the nurse use sterile gloves?

a. Inserting an NG tube
b. Administering total parental nutrition through a central venous access device
c. Initiating IV access
d. Performing tracheostomy care

**Answer:D. Performing tracheostomy care**(according to med/surg book u wear sterile gloves)

**Rational:**

1. tracheosotomy patient should never lie flat
2. increase oxygenation, before, during and after procedure
3. poor NS in the basin
4. **do sterile gloves**
5. make sure suction does not exceed 120 mm hg
6. flush suction catheter
7. insert into the tracheostomy tubing until you meet resistance or until patient coughs

21. A nurse is caring for a client who is at 11 weeks of gestation. Which of the following immunizations should the nurse recommend?

**a. Influenza**
**b. Measles, mumps and rubella**
**c. Human papilloma virus**
**d. Varicella**

**Answer: A. Influenza**

**Pregnant and postpartum women are at higher risk for severe illness and complications from influenza than women who are not pregnant because of changes in the immune system, heart, and lungs during pregnancy…. Influenza vaccination can be administered at any time during pregnancy, before and during the influenza season.** Women who are or will be pregnant during influenza season should receive IIV(11wks Influenza)

22. A nurse is inserting an indwelling urinary catheter for a male client. Which of the following actions should the nurse take?

a. Perform the cleansing procedure with the fresh swab two times.
b. Lift the penis so it is perpendicular to the client's body.
c. Cleanse the tip of the penis in the side to side motion.
d. Pick up the catheter 13 cm (5 in) from its tip.

Answer: B. Lift the penis so it is perpendicular to the client's body.

**Rational:** **Using the sterile dominant hand, pick up the catheter with a gloved hand. Holding the catheter loosely, insert it into the urethral opening of a female patient. For a male patient, life his penis to a perpendicular position and lightly apply traction in an upward position using the non-dominant hand. Gently insert the catheter one to two inches past where the patient's urine is located**

23. A nurse is providing teaching to a client who is at 14 weeks of gestation about findings to report to the provider. Which of the following findings should the nurse include in the teaching?

a. Bleeding gums
b. Faintness upon rising
c. Swelling of the face
d. Urinary frequency

**Answer: C. Swelling of the face**
**Rational: 14 weeks gestation, what should patient report to the MD ,Swelling of the face (sign of preeclampsia)**

24. A nurse has received change of shift report for a group of clients. Which of the following actions should the nurse take to manage time effectively?

a. Document client care at the end of the shift.
b. Make a client to do list for the day.
c. Skip breaks until client tasks are complete.
d. Focus on several client tasks at a time

**Answer:B. make a client to do list for the day.**

25. A nurse is developing a plan of care for a newborn whose mother tested positive for heroin during pregnancy the newborn is experiencing neonatal abstinence syndrome which of the following actions should the nurse include in the plan?

a. Minimize noise and the newborns environment.
b. Administer naloxone to the newborn. ( u give phenobarbitol not naloxone for withdrawals)
c. Swaddled the newborn with his legs extended (legs flexed)
d. Maintain eye contact with the newborn during feeding. (no eye contact)

**Answer: A. Minimize noise and the newborns environment.**
Rational: **Neonatal substance withdrawal: Nursing Care**
**Nursing care for maternal substance use and neonatal effects or withdrawal include the following in addition to normal newborn care.**
**● Perform ongoing assessment of the newborn using the neonatal abstinence scoring system assessment, as RX'ed.**
**● Elicit and assess the newborn's reflexes.**
**● Monitor the newborn's ability to feed and digest intake.**

**Offer small frequent feedings.**
**● Swaddle the newborn with legs flexed.**
**● Offer non-nutritive sucking.**
**● Monitor the newborn's fluids and electrolytes with skin turgor, mucous membranes, fontanels, daily weights, and I&O.**
**● Reduce environmental stimuli (decrease lights, lower noise level).**

26. A nurse is assessing the fontanels of an eight-month-old infant. Which of the following findings should the nurse recognized as an expected finding?

a. The anterior fontanel is open
b. The posterior fontanel is open (posterior closes between 6 to 8 weeks so they would be closed at 8 months)
c. both fontanels are the same size
d. both fontanels show molding

**Answer: A.The anterior fontanel is open ( anterior closes between 12 months and 18 monthsso would be open)**
**Rational : Anterior fontanels close by 18 months old**
**Posterior fontanels 6-8 weeks**
(posterior closes between 6 to 8 weeks so they would be closed at 8 months)

**27. A nurse is caring for a client who has acute diverticulitis which of the following diet should the nurse recommend to the client?

a. High residue
b. Lactose free
c. gluten-free
d. low fiber

**Answer: D. Low fiber**
Rational: **As you start feeling better, your doctor will recommend that you slowly add low-fiber foods.**
**Examples of low-fiber foods include:**

- Canned or cooked fruits without skin or seeds
- Canned or cooked vegetables such as green beans, carrots and potatoes (without the skin)
- Eggs, fish and poultry
- Refined white bread
- Fruit and vegetable juice with no pulp
- Low-fiber cereals
- Milk, yogurt and cheese
- White rice, pasta and noodles

**28. The nurses caring for a client who is 48 hrs post op following a total hip arthroplasty which of the following actions should the nurse include in the plan of care?

a. Administer low-dose heparin

b. Placed the client on a full liquid diet
c. using an incentive spirometer every three hours
d. Maintain the client on bed rest

**Answer:A. Administer low-dose heparin**
**Rational: One of the possible complications of post op total hip arthroplasty is DVT to help prevent the nurse should administer Low-dose heparin injections.**

29. A nurse providing teaching to the parent of an infant who has a cleft lip palette. Which of the following feeding technique should the nurse include in the teaching?
a. Burp the infant frequently during feedings
b. Position the nipple at the front of the infants mouth
c. Hold the infant in a supine position
d. used feeding devices without nipples

**Answer:A. Burp the infant frequently during feedings**
Rational: Feed in upright position in frequent, small amounts; burp frequently

30. A nurse in an acute mental health care facility is prioritizing care for multiple clients. Which of the following client should the nurse first
a. A client who has depressive disorder and requires assistance with ADLs
b. A client who has obsessive-compulsive disorder and is upset about her change in daily routine
c. A client who taking clozapine to treat schizophrenia and reports a sore throat
d. A client who has narcissistic personality disorder and is mocking others during group therapy.

**Answer: C. A client who taking clozapine to treat schizophrenia and reports a sore throat**
**Rational: Signs of a sore throat or an infection could indicate agranulocytosis, which is a life-threatening side effect of clozapine (Clozaril). Yellowish halos around lights are not a side effect of clozapine (Clozaril). Joint pain or swelling is not a side effect of clozapine (Clozaril). Narrowing of the field of vision is not a side effect of clozapine (Clozaril).**

31. The nurses planning care for a group of clients and is working with the one license practice nurse (LPN) and one assistive personnel (AP). Which of the following actions should the nurse take first to manage her time effectively?
a. Develop an hourly timeframe for tasks
b. Scheduled daily activities
c. determine goals of the day
d. delegate tasks to the AP

**answer: C. determine goals of the day**