NEW GENERATION HESI NCLEX COMPREHENSIVE EXIT EXAM | ATI NURSING EXIT EXAM 2023- 2024 |REAL EXAMS

1.ID: 20767710339

Enalapril maleate is prescribed for a hospitalized client. Which assessment does the nurse perform asa priority before administering the medication?

Checking the client's blood pressure

Correc Checking the client's peripheral pulses Checking the most recent potassium level

Checking the client's intake-and-output record for the last 24 hours

Rationale: Enalapril maleate is an angiotensin-converting enzyme (ACE) inhibitor used to treat hypertension.One common side effect is postural hypotension. Therefore the nurse would check the client's blood pressure immediately before administering each dose. Checking the client's peripheral pulses, the results of the most recent potassium level, and the intake and output for the previous 24 hours are not specifically associated with this mediation.

2.ID: 20767710336

A client is scheduled to undergo an upper gastrointestinal (GI) series, and the nurse provides instructions to theclient about the test. Which statement by the client indicates a need for further instruction?

"The test will take about 30 minutes."

"I need to fast for 8 hours before the test."

"I need to drink citrate of magnesia the night before the test and give myself a Fleet enema on the

morning of the test." Correc

"I need to take a laxative after the test is completed, because the liquid that I'll have to drink for the test can be constipating."

Rationale: No special preparation is necessary before a GI series, except that NPO (nothing by mouth) status must be maintained for 8 hours before the test. An upper GI series involves visualization of the esophagus, duodenum, and upper jejunum by means of the use of a contrast medium. It involves swallowing a contrast medium (usually barium), which is administered in a flavored milkshake. Films are taken at intervals during the test, which takes about 30 minutes. After an upper GI series, the client is prescribed a laxative to hasten elimination of the barium. Barium that remains in the colon may become hard and difficult to expel, leading to fecal impaction.

3.ID: 20767710333

A nurse on the evening shift checks a primary health care provider's prescriptions and notes that the dose of aprescribed medication is higher than the normal dose. The nurse calls the primary health care provider's answering service and is told that the primary health care provider is off for the night and will be available inthe morning. What should the nurse do next?

Call the nursing supervisor

Ask the answering service to contact the on-call primary health care provider Correc

Withhold the medication until the primary health care provider can be reached in the morning Administer the medication but consult the primary health care provider when he becomes available

Rationale: The nurse has a duty to protect the client from harm. A nurse who believes that a primary health care provider's prescription may be in error is responsible for clarifying the prescription before carrying it out. Therefore the nurse would not administer the medication;

instead, the nurse would withhold the medication until the dose can be clarified. The nurse would not wait until the next morning to obtain clarification. It is premature to call the nursing supervisor.

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4.ID: 20767707972

An emergency department (ED) nurse is monitoring a client with suspected acute myocardial infarction (MI) who is awaiting transfer to the coronary intensive care unit. The nurse notes the sudden onset of premature ventricular contractions (PVCs) on the monitor, checks the client's carotid pulse, and determines that the PVCs are not perfusing. What is the nurse's most appropriate action?

Document the findings

Ask the ED primary health care provider to check the client Correc

Continue to monitor the client's cardiac status

Inform the client that PVCs are expected after an MI

Rationale: The most appropriate action by the nurse would be to ask the ED health care provider to check the client. PVCs are a result of increased irritability of ventricular cells. Peripheral pulses may be absent or diminished with the PVCs themselves because the decreased stroke volume of the premature beats may in turn decrease peripheral perfusion. Because other rhythms also cause widened QRS complexes, it is essential that the nurse determine whether the premature beats are resulting in perfusion of the extremities. This is done by palpating the carotid, brachial, or femoral artery while observing the monitor for widened complexes or by auscultating for apical heart sounds. In the situation of acute MI, PVCs may be considered warning dysrhythmias, possibly heralding the onset of ventricular tachycardia or ventricular fibrillation. Therefore, the nurse would not tell the client that the PVCs are expected. Although the nurse will continue to monitor the

client and document the findings, these are not the most appropriate actions of those provided.

Test-Taking Strategy: Focus on the subject, client with PVCs on the monitor. Use the process of elimination.Note the strategic words "*most appropriate.*" This indicates the best action by the nurse in this situation.

Recalling the significance of PVCs after acute MI and also noting the strategic words "*not perfusing*" willdirect you to the correct option.

Review: PVCs after acute MI

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Critical Care

Giddens Concepts: Clinical Judgment, Perfusion

HESI Concepts: Clinical Decision Making/Clinical Judgment, Perfusion

Awarded 263.0 points out of 263.0 possible points.

5.ID: 20767710330

NPO status is imposed 8 hours before the procedure on a client scheduled to undergo electroconvulsive therapy (ECT) at 1 p.m. On the morning of the procedure, the nurse checks the client's record and notes that the client routinely takes an oral antihypertensive medication each morning. What action should the nurse take?

Administer the antihypertensive with a small sip of water

Correc Withhold the antihypertensive and administer it at

bedtime Administer the medication by way of the

intravenous (IV) route

Hold the antihypertensive and resume its administration on the day after the ECT

Rationale: The nurse should administer the antihypertensive with a small sip of water. General anesthesia is required for ECT, so NPO status is imposed for 6 to 8 hours before treatment to help prevent aspiration.

Exceptions include clients who routinely receive cardiac medications, antihypertensive agents, or histamine (H2) blockers, which should be administered several hours before treatment with a small sip of water.

Withholding the antihypertensive and administering it at bedtime and withholding the antihypertensive andresuming administration on the day after the ECT are incorrect actions, because antihypertensives must be administered on time; otherwise, the risk for rebound hypertension exists. The nurse would not administer a medication by way of a route that has not been prescribed.

Test-Taking Strategy: Focus on the subject, client scheduled for an ECT who is NPO. Use the process of elimination. Use your knowledge of the principles of medication administration to help eliminate the option that involves administering the medication by way of a route other than the prescribed one. Recalling that antihypertensives must be administered on a regular schedule will assist you in eliminating the options that involve withholding the medication.

Review: ECT

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Mental Health

Giddens Concepts: Clinical Judgment, Safety

HESI Concepts: Clinical Decision Making/Clinical Judgment, Safety

Awarded 263.0 points out of 263.0 possible

points.6.ID: 20767710327

A client who recently underwent coronary artery bypass graft surgery comes to the primary health care provider's office for a follow-up visit. On assessment, the client tells the nurse that he is feeling depressed. Which response by the nurse is therapeutic?

"Tell me more about what you’re feeling." Correc

"That’s a normal response after this type of surgery."

"It will take time, but I promise you, you will get over this depression." "Every client who has this surgery feels the same way for about a month."

Rationale: The therapeutic response by the nurse is, "Tell me more about what you’re feeling." When a client expresses feelings of depression, it is extremely important for the nurse to further explore these feelings with the client. In stating, "This is a normal response after this type of surgery" the nurse provides false reassurance and avoids addressing the client’s feelings. "It will take time, but I promise you, you will get over the depression" is also a false reassurance, and it does not encourage the expression of feelings. "Every client who has this surgery feels the same way for about a month" is a generalization that avoids the client’s feelings.

Test-Taking Strategy: Focus on the subject, depression. Note the strategic word “*therapeutic.*” This indicates the statement that would have a positive effect on the client. Use your knowledge of therapeutic communication techniques. Eliminate the options that are nontherapeutic and do not encourage the client to express feelings. Remember to always focus on the client’s feelings.

Review: therapeutic communication *Level of Cognitive Ability:* Applying

Client Needs: Psychosocial

Integrity

Integrated Process: Communication and Documentation

Content Area: Adult Health/Cardiovascular

Giddens Concepts: Communication, Mood and

Affect*HESI Concepts:* Communication, Mood

and Affect, Awarded 263.0 points out of 263.0

possible points.

7.ID: 20767710324

A client in labor experiences spontaneous rupture of the membranes. The nurse immediately counts the fetal heart rate (FHR) for 1 full minute and then checks the amniotic fluid. The nurse notes that the fluid is yellow and has a strong odor. Which action should be the nurse's priority?

Contact the primary health care provider Correc

Document the findings

Check the fluid for

protein

Continue to monitor the client and the FHR

Rationale: The priority action is for the nurse to contact the primary health care provider. The FHR is assessed for at least 1 minute when the membranes rupture. The nurse also checks the quantity, color, and odor of the amniotic fluid. The fluid should be clear (often with bits of vernix) and have a mild odor. Fluid with a foul or strong odor, cloudy appearance, or yellow coloration suggests chorioamnionitis and warrants notifying the primary health care provider. A large amount of vernix in the fluid suggests that the fetus is preterm. Greenish, meconium-stained fluid may be seen in cases of postterm gestation or placental insufficiency. Checking the fluid for protein is not

associated with the data in the question. The nurse would continue to monitor the clientand the FHR and would document the findings.

Test-Taking Strategy: Focus on the data in the question and note the strategic word "*priority*." This indicates the most important action the nurse should take. Noting the words "yellow" and has a "strong odor" will directyou to the correct option.

Review: ruptured membranes

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Maternity/Intrapartum

Giddens Concepts: Clinical Judgment, Reproduction

HESI Concepts: Clinical Decision Making/Clinical Judgment, Sexuality/Reproduction

Awarded 263.0 points out of 263.0 possible

points.8.ID: 20767710321

A nurse has assisted a primary health care provider in inserting a central venous access device into a client witha diagnosis of severe malnutrition who will be receiving parenteral nutrition (PN). After insertion of the catheter what does the nurse immediately do?

Call the radiography department to obtain a chest x-ray Correc

Check the client's blood glucose level to serve as a baseline

measurementHang the prescribed bag of PN and start the infusion at

the prescribed rate

Infuse normal saline solution through the catheter at a rate of 100 mL/hr to maintain patency

Rationale: The nurse should immediately make arrangements to have a chest x-ray done. One

major complication associated with central venous catheter placement is pneumothorax, which may result from accidental puncture of the lung. After the catheter has been placed but before it is used for infusions, its placement must be checked with an x-ray. Hanging the prescribed bag of PN and starting the infusion at the prescribed rate and infusing normal saline solution through the catheter at a rate of 100 mL/hr to maintain patency are all incorrect because they could result in the infusion of solution into a lung if a pneumothorax is present. Although the nurse may obtain a blood glucose measurement to serve as a baseline, this action is not the priority.

Test-Taking Strategy: Focus on the subject, client who just had a central venous access device inserted. Note the strategic word "*immediately*." This indicates the most important next action the nurse must take. Use

the ABCs — airway, breathing, and circulation. Recall that pneumothorax is a complication of the insertion of this type of catheter

Review: central venous catheter placement

Level of Cognitive Ability: Applyin

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Intravenous therapy

Giddens Concepts: Care Coordination, Nutrition

HESI Concepts: Collaboration/Managing Care, Nutrition

Awarded 263.0 points out of 263.0 possible points.

9.ID: 20767709711

A rape victim being treated in the emergency department says to the nurse, "I'm really worried that I've gotHIV now." What is the most appropriateresponse by the nurse?

"HIV is rarely an issue in rape victims."

"Every rape victim is concerned about

HIV."

"You're more likely to get pregnant than to contract HIV."

"Let's talk about the information that you need to determine your risk of contracting HIV." Correc

Rationale: The most appropriate response by the nurse is the one that encourages the client to talk about her condition. HIV is a concern of rape victims. Such concern should always be addressed, and the victim shouldbe given the information needed to evaluate his or her risk. Pregnancy may occur as a result of rape, and pregnancy prophylaxis can be offered in the emergency department or during follow-up, once the results of a pregnancy test have been obtained. However, stating, "You're more likely to get pregnant than to contract HIV" avoids the client's concern. Similarly, "HIV is rarely an issue in rape victims" and "Every rape victim isconcerned about HIV" are generalized responses that avoid the client's concern.

Test-Taking Strategy: Focus on the subject, rape victim. Note the strategic words "*most appropriate.*" This indicates the best response the nurse can give the client. Use your knowledge of therapeutic communication techniques. Eliminate the options that are comparable or alike in that the nurse avoids addressing the client's concern.

Review: rape victim

Level of Cognitive Ability: Applying

Client Needs: Psychosocial Integrity

Integrated Process: Communication and Documentation

Content Area: Mental Health

Giddens Concepts: Communication,

Immunity *HESI Concepts:* Communication,

Immunity Awarded 263.0 points out of 263.0

possible points. 10. ID: 20767707969

A client is taking prescribed ibuprofen 200 mg orally four times daily, to relieve joint pain resulting from rheumatoid arthritis. The client tells the nurse that the medication is causing nausea and indigestion. What should the nurse tell the client?

"I will contact your primary health care provider."

"Stop taking the medication."

"Take the medication with food." Correc

"Take the medication twice a day instead of four times a day."

Rationale: Ibuprofen is a nonsteroidal antiinflammatory medication. Side effects include nausea (with or without vomiting) and dyspepsia (heartburn, indigestion, or epigastric pain). If gastrointestinal distress occurs,the client should be instructed to take the medication with milk or food. The nurse would not instruct the client to stop the medication or instruct the client to adjust the dosage of a prescribed medication; these actions are not within the legal scope of the role of the nurse. Contacting the primary health care provider is premature, because the client's complaints are side effects that occasionally occur and can be relieved by taking the medication with milk or food.

Test-Taking Strategy: Focus on the subject, ibuprofen. Use guidelines related to medication administration to assist you to eliminate the options that indicate to stop the medication or adjust the prescribed dose. To select from the remaining options, think about the side effects of the medication.

Review: ibuprofen

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Pharmacology

Giddens Concepts: Client Education, Safety

HESI Concepts: Safety, Teaching and Learning/Patient

EducationAwarded 263.0 points out of 263.0 possible points.

11.ID: 20767709708

The night nurse is caring for a client who just had a craniotomy. The nurse is monitoring the client's Jackson- Pratt drain that is being maintained on suction. The nurse notes that a total of 200 mL of red drainage has drained from the Jackson-Pratt (J-P) tube in the last 8 hours. What action should the nurse take?

Document the amount in the client's record. Incorrec

Discontinue the Jackson-Pratt drain from suction.

Continue to monitor the amount and color of the drainage.

Notify the primary health care provider immediately of the amount of drainage. Correc

Rationale: The nurse must immediately notify the primary health care provider of this excessive amount of drainage. The primary health care provider must also be immediately notified of any saturated head dressings. The normal amount of drainage from a Jackson-Pratt drain is 30 to 50 mL per shift. Discontinuing the suctionfrom the J-P drain is not an option and is not done. Also, just documenting the amount in the client's record isnot correct even though the nurse would document that the primary health care provider was notified of the total drain amount. Just continuing to monitor the amount of drainage is also not an option.

Test-Taking Strategy: Focus on the subject, craniotomy. First eliminate the nurse shutting off the suction because this is not done with a J-P drain and also the nurse would not do this without the primary health care provider's order. Eliminate the options that are comparable or alike because the nurse is not aware of the urgency of the large amount of drainage but just documents and continues to monitor the J-P drainage.

Review: craniotomy

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Adult Health/Neurological

Giddens Concepts: Clinical Judgment, Tissue Integrity

HESI Concepts: Clinical Decision Making/Clinical Judgment, Tissue

IntegrityAwarded 0.0 points out of 263.0 possible points.

12.ID: 20767709705

Lorazepam 1 mg by way of intravenous (IV) injection (IV push) is prescribed for a client for the managementof anxiety. The nurse prepares the medication as prescribed. Over what period of time should the nurse administer this medication?

3 minutes Correc

10 seconds

15 seconds

30 minutes

Rationale: Lorazepam is a benzodiazepine. When administered by IV injection, each 2 mg or fraction thereof is administered over a period of 1 to 5 minutes. Ten seconds and 30 seconds are brief periods. Thirty minutes is a lengthy period.

Test-Taking Strategy: Focus on the subject, lorazepam. Eliminate the options that indicate delivery times of 10 and 15 seconds, because these periods are very brief. Next eliminate the option of 30 minutes because of its lengthiness.

Review: lorazepam IV push

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Pharmacology

Giddens Concepts: Clinical Judgment, Safety

HESI Concepts: Clinical Decision Making/Clinical Judgment,

SafetyAwarded 263.0 points out of 263.0 possible points.

13.ID: 20767709702

A nurse, conducting an assessment of a client being seen in the clinic for signs/symptoms of a sinus infection, asks the client about medications that he is taking. The client tells the nurse that he is taking nefazodone hydrochloride. On the basis of this information, the nurse determines that the client most likely has a history ofwhat problem?

Depression Correc

Diabetes mellitus

Hyperthyroidism

Coronary artery disease

Rationale: The client is most likely suffering from depression. Nefazodone hydrochloride is an antidepressant used as maintenance therapy to prevent relapse of an acute depression. Diabetes mellitus, hypethyroidism, and coronary artery disease are not treated with this medication.

Test-Taking Strategy: Focus on the subject, nefazodone hydrochloride. Note the strategic words "*most likely.*" This indicates the problem the client probably has. Knowledge regarding the use of this medication is required to answer this question correctly. Recalling that nefazodone hydrochloride is an antidepressant will direct you to the correct option.

Review: Nefazodone hydrochloride *Level of Cognitive Ability:* Analyzing*Client Needs:* Physiological Integrity

Integrated Process: Nursing Process/Assessment

Content Area: Pharmacology

Giddens Concepts: Clinical Judgment, Evidence

HESI Concepts: Clinical Decision Making/Clinical Judgment, Evidence Based Practice/

EvidenceAwarded 263.0 points out of 263.0 possible points.

14.ID: 20767709499

Phenelzine sulfate is prescribed for a client with depression. The nurse provides information to the

client about the adverse effects of the medication and tells the client to contact the primary health

care

provider immediately if he/she experiences what sign/symptom?

Dry mouth

Restlessne

ss

Feelings of depression

Neck stiffness or soreness Correc

Rationale: The client is taught to immediately contact the primary health care provider if the client experiences any occipital headache radiating frontally and neck stiffness or soreness, which could be the first sign of a hypertensive crisis. Phenelzine sulfate, a monoamine oxidase inhibitor (MAOI), is an antidepressant and is used to treat depression. Hypertensive crisis, an adverse effect of this medication, is characterized by hypertension, frontally radiating occipital headache, neck stiffness and soreness, nausea, vomiting, sweating, fever and chills, clammy skin, dilated pupils, and palpitations. Tachycardia, bradycardia, and constricting chestpain may also be present. Dry mouth and restlessness are common side effects of the medication.

Test-Taking Strategy: Use the process of elimination and focus on the subject, phenelzine sulfate.

Note

the strategic word "*immediately.*" This indicates a quick action by the client. Recalling that the medication is an MAOI and the common and adverse effects of the medication will help direct you to the correct option.

Review: Phenelzine sulfate

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Teaching and

Learning*Content Area:* Mental Health

Giddens Concepts: Client Education, Safety

HESI Concepts: Safety, Teaching and Learning/Patient

EducationAwarded 263.0 points out of 263.0 possible points.

15.ID: 20767709496

Risperidone is prescribed for a client hospitalized in the mental health unit for the treatment of a psychotic disorder. Which finding in the client's medical record would prompt the nurse to contact the prescribing primary health care provider before administering the medication?

The client has a history of cataracts.

The client has a history of hypothyroidism.

The client takes a prescribed antihypertensive. Correc

The client is allergic to acetylsalicylic acid (aspirin).

Rationale: Risperidone is an antipsychotic medication. Contraindications to the use of risperidone include cardiac disorders, cerebrovascular disease, dehydration, hypovolemia, and therapy with antihypertensive agents. Risperidone is used with caution in clients with a history of seizures. History of cataracts, hypothyroidism, or allergy to aspirin does not affect the administration of this medication.

Test-Taking Strategy: Focus on the subject, client taking risperidone. Knowledge of the contraindications to the use of risperidone is required to answer this question correctly. It is important to remember that one such contraindication is therapy with an antihypertensive medication.

Review: Resperidone

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Pharmacology

Giddens Concepts: Collaboration, Safety

HESI Concepts: Collaboration/Managing Care,

Safety Awarded 263.0 points out of 263.0 possible

points.

16. ID: 20767709493

A client who has been undergoing long-term therapy with an antipsychotic medication is admitted

to the inpatient mental health unit. Which finding does the nurse, knowing that long-term use of an

antipsychotic medication can cause tardive dyskinesia, monitor in the client?

Fever

Diarrhea

Hypertensio

n

Tongue protrusion Correc

Rationale: The clinical manifestations include abnormal movements (dyskinesia) and involuntary movements of the mouth, tongue ("flycatcher tongue"), and face. Tardive dyskinesia is a severe reaction associated with long-term use of antipsychotic medications. In its most severe form, tardive dyskinesia involves the fingers, arms, trunk, and respiratory muscles. When this occurs, the medication is discontinued. Fever, diarrhea, and hypertension are not characteristics of tardive dyskinesia.

Test-Taking Strategy: Focus on the subject, antipsychotic medication. Knowledge of the clinical manifestations associated with tardive dyskinesia is needed to answer this question correctly. Recalling that the clinical manifestations of tardive dyskinesia include abnormal movements and involuntary movements will direct you to the correct option. If you had difficulty with this question.

Review: tardive dyskinesia.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Assessment

Content Area: Pharmacology

Giddens Concepts: Clinical Judgment, Psychosis

HESI Concepts: Clinical Decision Making/Clinical Judgment, Cogintion-Psychosis

Awarded 263.0 points out of 263.0 possible points.

17.ID: 20767709490

A nurse is reviewing the record of a client scheduled for electroconvulsive therapy (ECT). Which diagnosis, if noted on the client's record, would indicate a need to contact the primary health care provider who is scheduled to perform the ECT?

Recent stroke

Correc

Hypothyroidism

History of

glaucoma

Peripheral vascular disease

Rationale: Several conditions pose risks in the client scheduled for ECT. Among them are recent myocardial infarction or stroke and cerebrovascular malformations or intracranial lesions. Hypothyroidism, glaucoma, and peripheral vascular disease are not contraindications to this treatment.

Test-Taking Strategy: Focus on the subject, ECT. Knowledge regarding the risks associated with ECT is required to answer this question correctly. Note the word "recent" in the correct option, which should help recognize the correct option.

Review: ECT

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Assessment

Content Area: Mental Health

Giddens Concepts: Collaboration, Safety

HESI Concepts: Collaboration/Managing Care, SafetyAwarded 263.0 points out of 263.0 possible points.

18.ID: 20767709487

The nurse is caring for a client who just returned to the surgical unit after having a suprapubic prostatectomy. What type of medication does the nurse expect to be ordered?

Phenothiazines

Antispasmodics

Antidyskinetics

Benzodiazepines

Rationale: Antispasmodics are prescribed for bladder spasms related to a suprapubic prostatectomy. Thissurgery involves removal of the prostate gland by an abdominal incision with a bladder incision.

Phenothiazines are a class of antipsychotic medications. Antidyskinetics have an anticholinergic action and are used to treat Parkinson's disease and some of the acute movement disorders that may be caused by antipsychotic agents. Benzodiazepines are central nervous system (CNS) depressants and can cause sedation and psychomotor slowing. They can also intensify depression caused by other drugs. Benzodiazepines have some potential for abuse and should be used with caution in clients known to abuse alcohol or other

psychoactive medications.

Test-Taking Strategy: Focus on the subject, medication after a suprapubic prostatectomy. To answer this question accurately, you must be familiar with this surgery and how it is performed. Focusing on the data in the question and noting the strategic word "*suprapubic*" will direct you to the correct type of medication.

Review: suprapubic prostatectomy

Level of Cognitive Ability:

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Implementation

Content Area: Adult Health/Renal

Giddens Concepts: Client Education, Elimination

HESI Concepts: Elimination, Teaching and Learning/Patient Education

Awarded 263.0 points out of 263.0 possible points.

19.ID: 20767709484

A nurse is preparing a poster for a health fair booth promoting primary prevention of skin cancer. Whichrecommendations does the nurse include on the poster? Select all that apply.

Seek medical advice if you find a skin lesion. Correc

Use sunscreen with a low sun protection factor (SPF). Incorrec

Avoid sun exposure before 10 a.m. and after 4 p.m. Incorrec

Wear a hat, opaque clothing, and sunglasses when out in the sun. Correc

Examine the body every 6 months for possibly cancerous or precancerous lesions.

Rationale: Measures to prevent skin cancer include avoiding sun exposure between 10 a.m. and 4 p.m.; using sunscreen with a high SPF; wearing a hat, opaque clothing, and sunglasses when out in the sun; and examining the body every month for possibly cancerous or precancerous lesions. The

client should also seek medical advice if any changes in a skin lesion are noted.

Test-Taking Strategy: Focus on the subject, the prevention of skin cancer. Read each option carefully. Eliminate the option that includes the words "low sun protection factor." Next eliminate the option that includes "every 6 months." To select from the remaining options, recall that the skin should be protected from the sun even more carefully between the hours of 10 a.m. and 4 p.m.

Review: skin cancer

Level of Cognitive Ability: Applying

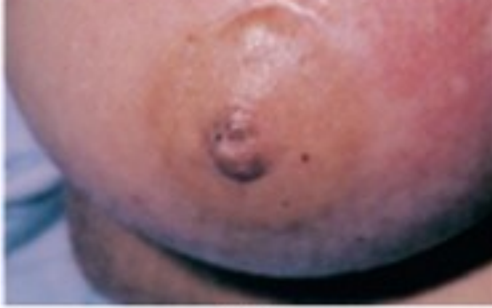
Client Needs: Health Promotion and Maintenance*Integrated Process:* Teaching and Learning *Content Area:* Adult Health/ Oncology

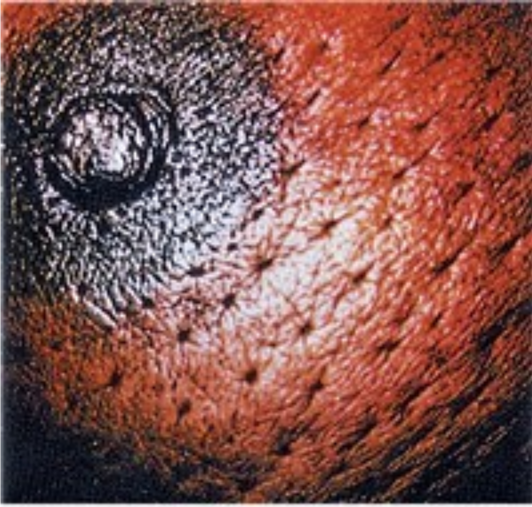
Giddens Concepts: Cellular Regulation, Health Promotion

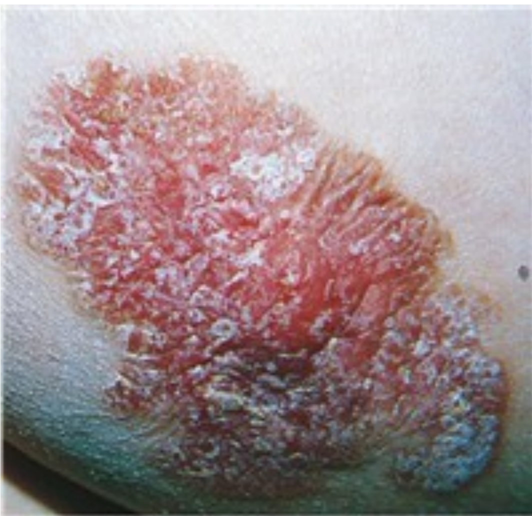
HESI Concepts: Cellular Regulation, Health, Wellness, and Illness-Health PromotionAwarded 0.0 points out of 263.0 possible points.

20.ID: 20767709481

A nurse reviewing the medical record of a client with a diagnosis of infiltrating ductal carcinoma of the breast notes documentation of the presence of *peau d'orange* skin. On the basis of this notation, which finding would the nurse expect to note on assessment of the client's breast?







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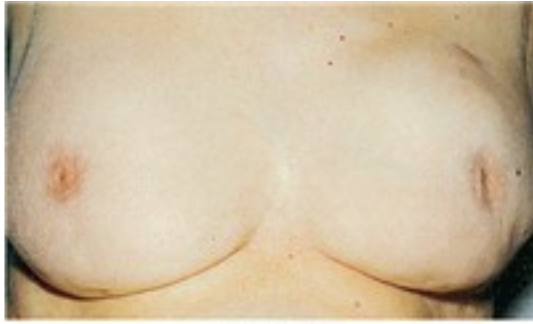

Rationale: Peau d'orange (French for "orange peel") is the term used to describe skin dimpling, resembling the skin of an orange, at the location of a breast mass. This change, along with increased vascularity, nippleretraction, or ulceration, may indicate advanced disease. Erythema, or reddening, of the breast indicates inflammation such as that resulting from cellulitis or a breast abscess. Paget's disease is a rare type of breast cancer that is manifested as a red, scaly nipple; discharge; crusting lasting more than a few weeks. In nippleretraction, the nipple is pointed or pulled in an abnormal direction. It is suggestive of malignancy.

Test-Taking Strategy: Focus on the subject, peau d'orange. Recalling the appearance of this characteristic will help you find the correct option. Note the word "orange" and the appearance of the breast in the correct option.

Review: breast cancer

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Assessment

Content Area: Adult Health/Oncology

Giddens Concepts: Cellular Regulation, Tissue

Integrity*HESI Concepts:* Cellular Regulation, Tissue

Integrity Awarded 263.0 points out of 263.0 possible

points.

21.ID: 20767707966

The mother of an adolescent diagnosed with type 1 diabetes mellitus tells the nurse that her child is a member of the school soccer team and expresses concern about her child's participation in sports. What does the nursetell the mother after providing information to the mother about diet, exercise, insulin, and blood glucose control?

To always administer less insulin on the days of soccer games

That it is best not to encourage the child to participate in sports activities

That the child should eat a carbohydrate snack about a half-hour before each soccer game Correc

To administer additional insulin before a soccer game if the blood glucose level is 240 mg/dL (13.3 mmol/L) or higher and ketones are present.

Rationale: The child with diabetes mellitus who is active in sports requires additional food intake in the form of a carbohydrate snack about a half-hour before the anticipated activity. Additional food will need to be consumed, often as frequently as every 45 minutes to 1 hour, during prolonged periods of activity. If the bloodglucose level is increased (240 mg/dL [13.3 mmol/L] or more) and ketones are present before planned exercise, the activity should be postponed until the blood glucose has been controlled. Moderate to high ketone values should be reported to the primary health care provider. There is no reason for the child to avoid participating in sports.

Test-Taking Strategy: Focus on the data in the question. First, eliminate the option that contains the closed- ended word "*always.*" Next, recall the importance of the child's participation in activities, which will help you eliminate the option involving avoidance of activities. To select from the remaining options, recall the association of insulin, diet, and exercise in the control of the blood glucose level, which will direct you to the correct option.

Review: child with diabetes mellitus *Level of Cognitive*

Ability: Applying *Client Needs:*

Physiological Integrity

Integrated Process: Teaching and Learning

Content Area: Child Health – Metabolic/Endocrine

Giddens Concepts: Glucose Regulation, Client Education

HESI Concepts: Metabolism/Glucose Regulation, Teaching and Learning/Patient

EducationAwarded 263.0 points out of 263.0 possible points.

22.ID: 20767709478

A client diagnosed with chronic kidney disease who requires dialysis three times a week for the rest of his life says to the nurse, "Why should I even bother to watch what I eat and drink? It doesn't really matter what I do if I'm never going to get better!" On the basis of the client's statement, the nurse determines that the client is experiencing which problem?

Anxiety

Powerlessness

Correc Ineffective

coping Disturbed

body image

Rationale: Powerlessness is present when a client believes that he or she has no control over the situation or that his or her actions will not affect an outcome in any significant way. Anxiety is a vague uneasy feeling of apprehension. Some factors in anxiety include a threat or perceived threat to physical or emotional integrity or self-concept, changes in role function, and a threat to or change in socioeconomic status. Ineffective coping ispresent when the client exhibits impaired adaptive abilities or behaviors in meeting the demands or roles expected. Disturbed body image is diagnosed when there is an alteration in the way the client perceives his or her own body image.

Test-Taking Strategy: Focus on the subject, dialysis. Use the process of elimination. Note that the statement "It doesn't really matter what I do..." implies that the client has a sense of no control of the situation. This will direct you to the correct option.

Review: powerlessness

Level of Cognitive Ability: Analyzing

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process/

Analysis*Content Area:* Adult Health/Renal

Giddens Concepts: Clinical Judgment, Mood and Affect

HESI Concepts: Clinical Decision Making/Clinical Judgment, Mood and

AffectAwarded 263.0 points out of 263.0 possible points.

23.ID: 20767709475

A nurse is providing morning care to a client in end-stage kidney disease. The client is reluctant to talk andshows little interest in participating in hygiene care. Which statement by the nurse would be therapeutic? "What are your feelings right now?" Correc

"Why don't you feel like washing up?"

"You aren’t talking today. Cat got your tongue?"

"You need to get yourself cleaned up. You have company coming today."

Rationale: Asking, "What are your feelings right now?" encourages the client to identify his or her emotions or feelings, which is a therapeutic communication technique. In stating, "Why don't you feel like washing up?" the nurse is requesting an explanation of feelings and behaviors for which the client may not know the reason. Requesting an explanation is a nontherapeutic communication technique. "You aren’t talking today. Cat got your tongue?" is a nontherapeutic cliché. The statement "You need to get yourself cleaned up. You have company coming today" is demanding, demeaning to the client, and nontherapeutic.

Test-Taking Strategy: Focus on the subject, end-stage kidney disease. Note the strategic word *“therapeutic.”* This indicates the statement that would have a positive effect on the client. Use your