

HESI PN Module Exam 10

A nurse is assigned to care four clients on the medical-surgical unit. Which client should the nurse see first on the shift assessment?

- A) A client admitted with pneumonia with a fever of 100°F and some diaphoresis
 - B) A client with congestive heart failure with clear lung sounds on the previous shift
 - C) A client with new-onset of shortness of breath (SOB) and a history of pulmonary edema
 - D) A client undergoing long-term corticosteroid therapy with mild bruising on the anterior surfaces of the arms - CORRECT ANSWER
- C) A client with new-onset of shortness of breath and history of pulmonary edema

Rationale:

The client who should be seen first is the one with SOB and a history of pulmonary edema. In light of such a history, SOB could indicate that fluid-volume overload has once again developed. The client with a fever and who is diaphoretic is at risk for insufficient fluid volume as a result of loss of fluid through the skin, but this client is not the priority.

A client with gastroenteritis who has been vomiting and has diarrhea is admitted to the hospital with a diagnosis of dehydration. For which clinical manifestations that correlate with this fluid imbalance would the nurse assess the client? Select all that apply.

- A) Decreased Pulse
- B) Decreased urine output
- C) Increased BP

D) Increased RR

E) Decreased respiratory depth - CORRECT ANSWER B, D

Rationale:

A client with dehydration has an increased depth and rate of respirations. The diminished fluid volume is perceived by the body as a decreased oxygen level (hypoxia), and increased respiration is an attempt to maintain oxygen delivery. Other assessment findings in insufficient fluid volume are decreased urine volume, increased pulse, weight loss, poor skin turgor, dry mucous membranes, concentrated urine with increased specific gravity, increased hematocrit, and altered level of consciousness. Increased blood pressure, decreased pulse, and increased urine output occur with fluid-volume overload.

A nurse is reviewing the medical records of the clients for the assigned 7 a.m.-7 p.m. shift. Which client will the nurse monitor most closely for excessive fluid volume?

A) A 48yo client receiving diuretics to treat hypertension

B) A 35yo client who is vomiting undigested food after eating

C) An 85yo client receiving IV therapy at a rate of 100 mL/hr

D) A 65yo client with an NG tube attached to low suction following partial gastrectomy - CORRECT ANSWER C) An 85yo client receiving IV therapy at a rate of 100mL/hr

Rationale:

The older adult client receiving IV therapy at 100 mL/hr is at the greatest risk for excessive fluid volume because of the diminished cardiovascular and renal function that occur with aging. Other causes of excessive fluid volume include renal failure, heart failure, liver disorders, excessive use of hypotonic IV fluids to replace isotonic losses, excessive irrigation of body fluids, and excessive ingestion

of table salt. A client who is receiving diuretics, vomiting, or has a nasogastric tube attached to suction is at risk for deficient fluid volume.

A nurse is caring for a client who is being treated for congestive heart failure and has been assigned a nursing diagnosis of excessive fluid volume. Which finding causes the nurse to determine that the client's condition has improved?

- A) Dyspnea
- B) 1+ edema in legs
- C) Moist crackles in the lower lobes of the lungs
- D) Weight loss of 4 lb in 24 hours - CORRECT ANSWER
- D) Weight loss of 4 lb in 24 hours

Rationale:

One sign that excessive fluid volume is resolving is loss of body weight. It is important to recall that 1 L of fluid weighs 1 kg, which equals 2.2 lb (1 liter = 2.2 lb = 1 kg). The other options listed indicate that the client is retaining fluid.

Assessment findings associated with excessive fluid volume include cough, dyspnea, rales or crackles, tachypnea, tachycardia, increased blood pressure and bounding pulse, increased central venous pressure, weight gain, edema, neck and hand vein distention, altered level of consciousness, and decreased hematocrit. These symptoms must be reversed if the fluid-volume excess is to be resolved.

A nurse notes that a client has ST-segment depression on the electrocardiogram (ECG) monitor. With which potassium reading does the nurse associate this finding?

- A) 3.1 mEq/L
- B) 4.2 mEq/L
- C) 4.5 mEq/L

D) 5.4 mEq/L - CORRECT ANSWER A) 3.1 mEq/L

Rationale:

A serum potassium level below 3.5 mEq/L is indicative of hypokalemia, the most common electrolyte imbalance, which is potentially life-threatening. ECG changes in hypokalemia include peaked P waves, flat T waves, a depressed ST segment, and prominent U waves. Readings of 4.5 mEq/L and 4.2 mEq/L are normal potassium levels; 5.4 mEq/L indicates hyperkalemia.

A health care provider writes a prescription for the administration of intravenous (IV) potassium chloride to a client with hypokalemia. The nurse should reinforce which client instructions?

A) A catheter will be inserted to drain your bladder

B) A large intravenous line will be inserted into your chest vein

C) This infusion requires use of a large caliber IV tubing

D) This medication is diluted in a large bag of IV fluid and infused slowly into your vein - CORRECT ANSWER D) The medication is diluted in a large bag of IV fluid and infused slowly into your vein

Rationale:

Potassium chloride administered IV must always be diluted in IV fluid. Undiluted potassium chloride given IV can cause cardiac arrest. Potassium chloride is never administered as a bolus (IV push) injection; an IV push would result in sudden severe hyperkalemia, which could precipitate cardiac arrest. Although urine output is monitored carefully during administration, it is not necessary to insert a Foley catheter unless this is specifically prescribed. Potassium chloride should be administered with the use of a controlled IV infusion device to avoid bolus infusion and increased risk of cardiac arrest. A central IV line is not necessary; potassium chloride may be administered through a peripheral IV line.

A nurse notes that a client's serum potassium level is 5.8 mEq/L. The nurse interprets this as an expected finding in the client with?

- A) Diarrhea
- B) Wound drainage
- C) Addison disease
- D) Heart failure being treated with loop diuretics - CORRECT ANSWER C) Addison disease

Rationale:

A serum potassium level greater than 5.1 mEq/L indicates hyperkalemia, and the nurse would report the finding to the health care provider. Adrenal insufficiency (Addison disease) is a cause of hyperkalemia. Other common causes of hyperkalemia include tissue damage, such as that in burn injuries, renal failure, and the use of potassium-sparing diuretics. The client with diarrhea or wound drainage or the client being treated with diuretics is at risk for hypokalemia.

A nurse is caring for a client experiencing hyponatremia who was admitted to the medical-surgical unit with fluid-volume overload. For which clinical manifestations of this electrolyte imbalance does the nurse monitor this client? Select all that apply.

- A) Slow pulse
- B) Decreased urine output
- C) Skeletal muscle weakness
- D) Hyperactive bowel sounds
- E) Hyperactive deep tendon reflexes - CORRECT ANSWER C, D