NEW GENERATION ATI RN HESI EXIT EXAM REMEDIATION | REAL EXAMS 2023

The nurse is caring for a client who has a fiberglass long leg cast on the right leg. Which nursingactions should be implemented in the cast care of this client? SATA

a) Smelling the cast and feeling for the presence of hot spots on the cast.
b) Checking neurovascular status of the right exposed foot and toes every four hours.
c) Using a soft cotton-tipped 6-inch swab to help scratch beneath the cast.
d) Placing the nurse's finger in the client's cast while performing cast care.
e) Covering the perineal area of the cast with plastic before client uses the fracture bedpan.

a) Smelling the cast and feeling for the presence of hot spots on the cast.
b) Checking neurovascular status of the right exposed foot and toes every four hours.d) Placing the nurse's finger in the client's cast while performing cast care.
e) Covering the perineal area of the cast with plastic before client uses the fracture bedpan.

Rationale
Cast care should include ensuring the cast is not too tight, by placing a finger between the client'sskin and cast; by protecting the cast from being soiled by placing a protective plastic covering in the perineal area before the client uses a bedpan; by smelling for a foul odor coming from the cast; by palpating for hot spots on the cast every shift; and by performing neurovascular checks distal to the cast every four hours. Nothing should be placed in the cast to facilitate scratching beneath the cast.

The nurse is caring for an older client being treated for a cardiac condition who has developed"dry eyes". Which medication may be contributing to this condition?
a) Procainamide (Procanbid).
b) Iron supplements.
c) Atenolol (Tenormin).
d) Lipitor (Atorvastatin). c) Atenolol (Tenormin).

Rationale
Dry eyes is an annoying side effect of some medications that can cause a client to feel like theyhave something in their eye or a continuous scratchy sensation. This condition can cause eye strain and discomfort to a client. Clients prescribed Atenolol for hypertension are at risk of developing dry eyes as a side effect of the medication.

The UAP is assisting a client getting into the shower. The charge nurse answers a call from the cast clinic to immediately send the UAP's other assigned client to the clinic. Which action shouldthe nurse take?

a) Ask the UAP to find another team member to take the client to the clinic.
b) Notify the delegating nurse of the current request from the cast clinic.
c) Instruct the UAP to take the client to clinic after helping the other client taking a shower.
d) While the client is showering the UAP should take the other client to cast clinic.

b) Notify the delegating nurse of the current request from the cast clinic.Rationale
The charge nurse should notify the delegating nurse of the situation. The third principle of delegation is "The person to whom the assignment was delegated cannot delegate that assignment to someone else... the delegating nurse needs to be notified and reassign the task..."

During a literature review for a research study, the nurse discovers a separate study has alreadyproved the proposed hypothesis to be true. Which action should the nurse take regarding the proposed research study?

a) Discontinue the research.
b) Revise the hypothesis of the current study so it is unique.
c) Perform the current study as a replication study.
d) Contact the authors of the original study for permission to continue.

c) Perform the current study as a replication study.Rationale
Because of inherent scientific error that may exist within all research studies, hypotheses requiremore than one test to support their accuracy. A critical weakness with nursing research is a lack of replication. Retesting a hypothesis that has been shown to be true strengthens the findings of the earlier study and supports the use of those findings to influence clinical practice.
In assessing the scrotum of a male client, which finding would need to be reported to thehealthcare provider?

a) Asymmetric appearance.
b) Taut appearance of skin surface.
c) Deeper pigmentation of the underside.
d) Presence of sebaceous cysts. b) Taut appearance of skin surface.

Rationale
The skin surface of the scrotum should appear coarse, rather than taut, which may indicateswelling or edema and should be reported to the healthcare provider.
Which nursing intervention should the nurse implement when caring for a child with nephroticsyndrome?

a) Take vital signs every 2 hours.
b) Restrict the number of visitors.
c) Reposition the client every 2 hours.
d) Monitor fluid intake and urine output. d) Monitor fluid intake and urine output.

Rationale

Due to the pathophysiology of nephrotic syndrome, decreased colloidal osmotic pressure in the capillaries is decreased, resulting in overall body edema. Treatment usually includes infusion of25% albumin and use of diuretics to help pull fluids out of the interstitial tissues back into the vascular system. Fluid intake and urine output should be carefully monitored to prevent hypervolemia and edema and monitor the efficacy of the medical interventions.

A six-year-old client, who received a kidney transplant presents with signs including fever, decreased urine output, and tenderness over the transplanted organ. Laboratory results reveal anelevated serum creatinine level. This presentation is likely due to which cause?

a) Immunosuppression medications.
b) Obstructive uropathy.
c) Transplant rejection.
d) Nephrotic syndrome. c) Transplant rejection.

Rationale
Transplant rejection is caused by the recipient's immune system response to foreign tissue. Signsthat may alert the nurse to rejection of a kidney transplant include fever, tenderness over the graft area, decreased urine output, and elevated serum creatinine.

A child recently treated for strep throat presents with gross hematuria, facial swelling, and elevated blood pressure. Laboratory tests reveal proteinuria and azotemia. Which conditionshould the nurse suspect?

a) Acute pyelonephritis.
b) Acute glomerular nephritis.
c) Nephrotic syndrome.
d) IgA nephropathy. b) Acute glomerular nephritis.

Rationale
Acute glomerulonephritis (GN) usually manifests after strept throat or other streptococcal infection. Typical signs of acute GN include gross hematuria, facial edema, hypertension, andproteinuria.

A child who is recovering from surgery for removal of a Wilms tumor develops abdominal painand distension, absence of bowel sounds, and vomiting. Which complication should the nurse suspect?

a) Intestinal obstruction.
b) Abdominal peritonitis.
c) Pyloric stenosis.
d) Infectious gastritis. a) Intestinal obstruction.

Rationale
Surgical intervention for Wilms tumor involves removal of the tumor, which requires either apartial or radical nephrectomy. Small bowel obstruction is one of the most common postoperative complications following removal of a Wilms tumor.

A child diagnosed with Wilms tumor is being treated with dactinomycin. What class of drug isthis medication?

a) Mitotic inhibitor.
b) Antitumor antibiotic.
c) Corticosteroid.
d) Alkylating agent. b) Antitumor antibiotic.

Rationale
Dactinomycin, also known as actinomycin D, is an anti-tumor antibiotic used in the treatment ofa variety of cancers, including Wilms tumor.

The nurse is reviewing medication education with a client who was prescribed triamcinolone(Dermasorb) for the treatment of eczema. Which statement by the client indicates the client misunderstands safe administration?

a) Apply to affected areas, avoiding contact with the eyes.
b) Continue to apply medication for a few days after area has cleared.
c) Cover weeping or denuded areas with an occlusive dressing after medication application.
d) Affected areas treated with the medication can burn easily with sunlight exposure.
c) Cover weeping or denuded areas with an occlusive dressing after medication application. The nurse explains to a new staff member that the goals of the therapeutic milieu for eating disorder are designed to help a client establish more adaptive behavioral patterns and developnormal eating habits.

Which environmental characteristics of the milieu should the nurse include?
a) Precise meal times, adherence to the selected menu, observation during and after meals, andregularly scheduled weighing.
b) Client freedom to decide when and what to eat, observation before and after meals, and noweighing for the first week.
c) Menus that can be altered to suit the client's taste, observation before and after meals, andregular weighing.
d) Client freedom to design the meals, infrequent observation to allow the client some space, anddaily weighing. a) Precise meal times, adherence to the selected menu, observation during and after meals, and regularly scheduled weighing.

The nurse is assessing the femoral insertion site of a client who recently had a cardiac catheterization. The client reports discomfort at the site. According to the standing orders, whichaction should the nurse implement? (Click on the chart tab for additional information. Please scroll to the bottom right corner to view all information contained in the client's medical record.)Vital signs:
1. Every 15 mins x4; then every 30 mins x 4; then every 1 hour x 2 and then 4 times daily whileawake.
2. Notify Cardiologist for symptomatic hypotension; systolic BP less than 90; heart rate less than50 beats/minute.
Activity:
1.Bedrest for 6 hours; HOB less than 30 degrees for 6 hours
2.(R) leg straight for 6 hours with a 5 pounds weighted sandbag at femoral insertion site.Medications:

1. Aspirin (ASA) 325mg (1) tablet PO daily
2. Acetaminophen 300mg/ codeine phosphate 30mg (Tynelol #3) 1 to 2 tablet PO every 4 to 6hours as needed

Additional prescriptions:

1. Check cath insertion site ; distal pulses to cath insertion site; (R) leg extremity for color,temperature and movement with vital signs.
2. If bleeding occurs at femoral puncture site; apply manual pressure and notify physician ifbleeding doesn't stop after 5 minutes.

a) Notify the healthcare provider.
b) Administer acetaminophen/ codeine phosphate.
c) Place an ice pack to area of discomfort.
d) Apply manual pressure to insertion site. b) Administer acetaminophen/ codeine phosphate.A nurse is assigned the care of a client who is presently experiencing hypovolemic shock. The client's MAP has decreased by 20 mmHg from its baseline, tissue ischemia and anoxia of non- vital organs is occurring, pulses are weak, urine output is absent and the client's skin is cool andmoist. The client appears to be confused and extremely anxious. Which stage of hypovolemic shock do these clinical signs and symptoms indicate?

a) Initial stage.
b) Refractory Stage.
c) Progressive stage.
d) Non-progressive stage. c) Progressive stage.

The nurse is assessing a client's cranial nerves. How can the nurse test cranial nerve VI?

a) Perform the pupillary response to light.
b) Perform the Webber and Rinne tests.
c) Perform the shoulder shrug against resistance.
d) Perform the six cardinal fields of gaze test. d) Perform the six cardinal fields of gazetest.

The nurse is assessing a client for hypoxia. What signs and symptoms should the nurse expect?
Select all that apply

a) Restlessness, anxiousness and pallor in color.
b) Heart rate drops and client becomes hypotensive.
c) Client reports feeling dizzy and lightheaded.
d) Increase in pulse and blood pressure.
e) Difficulty concentrating and client appears fatigue. a) Restlessness, anxiousness andpallor in color.
c) Client reports feeling dizzy and lightheaded.
d) Increase in pulse and blood pressure.
e) Difficulty concentrating and client appears fatigue.

Which action should the nurse take when caring for a child with epiglottitis?

a) Examine the throat with tongue depressor.
b) Set up emergency airway equipment at bedside.
c) Place the child in supine position.
d) Perform a throat culture. b) Set up emergency airway equipment at bedside.

Which intervention should the nurse implement to assist a child and the family to reduce the riskof an asthma exacerbation?

a) Help them recognize triggers.
b) Encourage peak pulmonary flow measurement.
c) Demonstrate use of MDI spacer.
d) Provide emergency treatment plan. a) Help them recognize triggers.

When caring for an infant with gastrointestinal reflux disorder (GERD), the nurse should be alertfor which complication?

a) Apnea.
b) Weight gain.
c) Abdominal distension.
d) Swelling of the extremities. a) Apnea.

The nurse is assessing an agitated three-year-old child who is leaning forward with their chin thrust out, mouth open, and tongue protruded with copious amount of drooling present. The client's vital signs are tympanic temperature of 103.1°F (39.5°C), pulse of 110 beats per minuteand respiratory rate of 28 per minute. Which condition should the nurse suspect?

a) Croup.
b) Bronchiolitis.
c) Acute epiglottitis.
d) Gastroesophageal reflux. c) Acute epiglottitis.

A 10-year-old client with asthma arrives at an urgent care clinic with apparent bronchial constriction. Which class of drugs should the nurse expect to be administered for this condition?

a) Methylxanthines.
b) Anticholinergics.
c) Long-acting beta2 agonists.
d) Oral corticosteroids. d) Oral corticosteroids.

A nursing team is reviewing its quality improvement plan. Which source of data will answer thequestion, "Are there fewer nosocomial infections this year"?

a) Nurses' quarterly clinical performance evaluations.
b) Client's outcomes from delivery of care processes.
c) Post discharge client satisfaction surveys.
d) Recommendations from the hospital's review committee. b) Client's outcomes from delivery ofcare processes.

The nurse reads an article about new trends in nursing career settings, such as shopping mallsand fields that employ migrant workers. The article also notes a shift in emphasis toward advocacy and research. Which factor has prompted these innovative trends in nursing?

a) Increased scope of practice secondary to client needs.
b) Increased nursing and health care provider shortages.
c) Increased awareness of nursing capabilities.
d) Increased cost effectiveness. a) Increased scope of practice secondary to client needs.

While assessing a client's health history, the nurse notes that the client has been prescribedlevonorgestrel and ethinyl estradiol (Lutera). Which health outcome would indicate this medication is effective?

a) Pregnancy.
b) Regularity of menstrual cycles.
c) Enlargement of mammary tissues.
d) Increase maturation of ovarian follicle.b) Regularity of menstrual cycles.
The nurse is caring for a client who is showing signs of a tension pneumothorax. Whichintervention should the nurse be prepared to implement?

a) Application of occlusive dressing
b) Emergency thoracotomy.
c) Insertion of chest tube.
d) Needle thoracostomy. d) Needle thoracostomy.
While caring for a pregnant client, the nurse explores ways the client can prioritize her role in herfamily and in her home. Which outcome shows that this intervention has been effective?

a) Decreased episodes of fatigue.
b) Decreased episodes of nausea.
c) Increased maternal weight.
d) Increased maternal sleep. a) Decreased episodes of fatigue.
In what ways does the Health Insurance Portability and Accountability Act (HIPAA) protectindividuals? Select all that apply

a) It gives clients the right to consent to disclosure of their records.
b) It gives the clients the ability to choose private rooms only.
c) It keeps individuals from losing health insurance when changing jobs.
d) It ensures the message boards in rooms include the plan of care to ensure continuity.
e) It requires nurses to maintain reasonable privacy when communicating with or about clients.
a) It gives clients the right to consent to disclosure of their records.
e) It requires nurses to maintain reasonable privacy when communicating with or about clients. The nurse is conducting a health promotion presentation about stroke prevention for a group of residents in a retirement community. Which should the nurse identify as a modifiable risk factorfor stroke?

a) Gender.
b) Race.
c) Age.
d) Diet. d) Diet.
The nurse working on a geriatric unit notices that many of the clients with Alzheimer's disease and dementia develop increased confusion and agitated behaviors later in the day. Which term isused to describe this behavior?

a) Delirium.
b) Sundowning.

c) Regression.
d) Depression. b) Sundowning.
A 67-year-old client takes amitriptyline hydrochloride (Elavil) to manage neuropathic pain associated with diabetic neuropathy. The client has developed severe xerostomia since startingthis medication. Which strategy should the nurse recommend for relief of xerostomia?

a) Use a dehumidifier at night.
b) Chew sugar-free gum.
c) Increase dietary sodium.
d) Increase caffeine intake. b) Chew sugar-free gum.
The nurse is preparing a client education class at the adult senior center about strokes. Whichmnemonic should be used to teach to assess for the warning signs of a stroke?

a) RACE.
b) FAST.
c) STOP.
d) ABCD. b) FAST.
The health care provider prescribes levodopa/carbidopa (Sinemet) for an older client with Parkinson disease. Which instruction should the nurse teach the client in regards to taking thismedication?

a) With the largest meal of the day.
b) With a high-protein meal.
c) 30 to 60 minutes before eating.
d) Only when symptoms occur. c) 30 to 60 minutes before eating. Which factor contributes to the development of secondary hypertension?

a) Sepsis.
b) Sodium consumption.
c) Low body mass index.
d) Kidney disease. d) Kidney disease.

Rationale
Hypertension is classified as primary or secondary, depending on the underlying cause. Secondary hypertension is associated with disease states such as renal disease, adrenal tumors,and thyroid disease.
The nurse is performing an admission assessment on an older client who has been admitted for severe partial-thickness and full-thickness burns of their legs and buttocks. Which condition isthe client at greatest risk developing initially?

a) Blood dyscrasia.
b) Hypovolemic shock.
c) Severe respiratory congestion.
d) Opportunistic infection. b) Hypovolemic shock.

Rationale

Hypovolemic shock produced by burns occurs most often in people with large partial-thicknessor full-thickness burns. It is caused primarily by a shift of plasma from the vascular space into the interstitial space.
The nurse is having difficulty locating the pedal pulses of an older client diagnosed with peripheral artery disease. Which action should the nurse perform to help locate the client's pulse?

a) Apply additional pressure using three fingers.
b) Use a Doppler device to locate the pulse.
c) Elevate the legs above the level of the heart.
d) Ask another nurse to find the pulse. b) Use a Doppler device to locate the pulse.
The nurse is counseling the parents of a child with adrenocortical insufficiency. The nurse shouldeducate the parents about the signs and symptoms of which condition that can occur as a result ofprolonged hydrocortisone therapy?

a) Gastric ulcers.
b) Weight loss.
c) Drowsiness.
d) Decreased blood pressure. a) Gastric ulcers.

Rationale
Corticosteroids, such as hydrocortisone, may cause impaired gastric mucus production and gastric bicarbonate secretion. Prolonged use of hydrocortisone may result in abdominal pain andincreased vulnerability to ulceration.
The nurse is evaluating a client who is receiving parenteral nutrition. An assessment reveals decreased oxygenation saturation levels, shortness of breath, coughing, and decreased blood pressure. The nurse is correct to take which action?

a) Remove the central catheter and insert a chest tube.
b) Obtain an order for intravenous antibiotics.
c) Clamp the catheter and position the patient in a left-sided Trendelenburg position.
d) Perform blood glucose monitoring and retest the levels in 15-30 minutes. c) Clamp thecatheter and position the patient in a left-sided Trendelenburg position

Rationale
The client's symptoms indicate a potential air embolism, which may result from part of the catheter system being open or removed without being clamped. The nurse should clamp thecatheter, position the client on the left side in Trendelenburg position, call the health care provider, and administer oxygen as needed.
The nurse noticed that the prescribed 12 units of NPH/aspart (75/25) insulin appeared cloudywhen drawn up into the insulin syringe. What action should the nurse take?

a) Discard the drawn up dose of insulin and insulin vial.
b) Proceed to administer the prescribed drawn up insulin.
c) Withdraw 9 units from an NPH vial and 3 units from a vial of aspart insulin..

d) Place the vial on the counter and allow the insulin to settle and clear up.
b) Proceed toadminister the prescribed drawn up insulin.

Rationale
NPH and premixed insulin should be cloudy when mixed properly. The nurse should expect thedose of 75/25 premixed insulin to be cloudy.
The nurse is educating a high-risk client about prevention of coronary artery disease (CAD).Which statement should the nurse include?

a) "Omega fats should be minimize in your daily use."
b) "Consume at least 1800 mg of sodium per day ."
c) "Reduced the amount of soy products in your diet."
d) "Limit the intake of sweetened beverages." d) "Limit the intake of sweetenedbeverages."

The nurse calculates a client's body mass index (BMI). The client's height is 6 feet and 6 inches(198cm) and the BMI is 30. How should the nurse categorize this BMI?

a) Obesity.
b) Overweight.
c) Underweight.
d) Normal weight. a) Obesity.

Rationale
A BMI of 30-39 is considered obesity according to the U.S. National Institutes of Health. The nurse is caring for a pregnant client who has expressed concerns about her cravings for"nonfood" items. Which reported craving increases the client's risk for gestational diabetes?

a) Corn starch.
b) Ice chips.
c) Baking soda.
d) Tooth paste. a) Corn starch.

Rationale
Pica refers to the consumption of nonfood substances, or food items that lack nutritional value.Consuming excessive amounts of corn starch may contribute to gestational diabetes.
The nurse is performing discharge instruction for a client with moderate congestive heart failure(CHF). Which statement by the client demonstrates the teaching was successful?

a) "I can add salt to one meal each day."
b) "I should season my chicken with rosemary and garlic."
c) "I can have up to two glasses of wine daily."
d) "Pickles are a good snack to replace electrolytes." b) "I should season my chicken withrosemary and garlic."

A male client tells the home health nurse that he takes two tablespoons of a liquid antacid everyday. How many mL of medication should the nurse document? (Enter numeric value only.)

30mL

Rationale: Each tablespoon = 15 mL.15 mL x 2 tablespoons = 30 mL.

A client is being discharged with a prescription for hyoscyamine for irritable bowel syndrome(IBS). Which side effect of this medication should the nurse prepare the client for?

a) Diarrhea.
b) Blurred vision.
c) Dry mouth.
d) Increased tear production. c) Dry mouth.

Rationale
Anticholinergic side effects are common with hyoscyamine. The nurse should prepare the clientfor symptoms such as dry mouth.
A client is admitted with coffee ground emesis. This symptom is indicative of which diagnosis?

a) Lower GI bleed.
b) Upper GI bleed.
c) Appendicitis.
d) Diverticulitis. b) Upper GI bleed

Rationale
Stomach enzymes breaks down any blood from an upper GI bleed, which leads the vomitus toappear as dark coffee ground emesis. Coffee ground emesis is a clinical sign of an upper GI bleed.
In palpating the liver of a female client, the nurse feels the edge of the liver as a firm, regularridge as the client inhales. What action should the nurse take in response to this finding?

a) Document the finding.
b) Remove pressure immediately.
c) Ask the client to hold her breath.
d) Check for ascites. a) Document the finding.

Rationale
Feeling the edge of the liver as a firm, regular ridge as the client inhales is a normal finding during an abdominal assessment. This normal finding should be documented in the healthcarerecord.
The nurse is monitoring a client who has just returned from a liver biopsy. Which sign shouldalert the nurse that a serious complication has occurred as a result of this procedure?

a) Confusion.
b) Decreased blood pressure.
c) Nausea and vomiting.
d) Hematoma at the incision site. b) Decreased blood pressure.

Rationale
A liver biopsy is performed by inserting a needle into an area of the liver to remove a small sample of tissue. Because the liver is highly vascular, a small amount of

bleeding is expected;

however, a drop in blood pressure may indicate that a significant amount of bleeding hasoccurred.

The nurse is preparing to educate a client with newly diagnosed diabetes. Which strategies aremost effective in providing client education?
Select all that apply

a) Determine which extrinsic and intrinsic factors motivates the client.
b) Assess the client's ability to retain and recall newly acquired information.
c) Ensure the client teaching material is written at least 12th grade level.
d) Limit the complexity at each teaching session based on client's attention span.

a) Determinewhich extrinsic and intrinsic factors motivates the client.
b) Assess the client's ability to retain and recall newly acquired information.
d) Limit the complexity at each teaching session based on client's attention span.

The sibling of a young client with borderline personality disorder asks the nurse why the clienthas frequent mood changes. Which is the best response by the nurse to explain the neurobiological basis of this behavior?

a) Brief shifts in mood are caused by an imbalance of nervous system chemicals that helpregulate emotions.
b) Shifts in mood are the result of an intolerance to certain chemicals found in food substances.
c) Mood changes are due to the client's emotional immaturity and lack of insight into thisbehavior.
d) Mood changes are common in clients during this phase of life due to hormonal changes.

a) Brief shifts in mood are caused by an imbalance of nervous system chemicals that helpregulate emotions.

Rationale
Affective instability is characterized by brief shifts in mood. This condition is attributed toexcessive limbic reactivity in the neurological circuits responsible for the regulation of theneurotransmitter, GABA.

During a family therapy session, the parents of a client diagnosed with anorexia nervosa ask if there is any neurobiological basis for this behavioral disorder. Which explanation by the therapistis accurate?

a) "Research has discovered abnormal serotonin pathways."
b) "Researchers feel that ingesting certain chemical additives triggers the disease."
c) "Eating disorders develop when increased levels of adrenaline cause suppression of hunger."
d) "Eating disorders are initially caused by infections of the gastrointestinal system."

a)"Research has discovered abnormal serotonin pathways."

Rationale
The etiology of eating disorders is varied and complex. From a neurobiological basis, brain scanshave demonstrated alterations in the serotonin pathway. The alteration in serotonin can result in reduced impulse control, mood problems, and altered motivation for eating and enjoying food.

A client diagnosed with kidney stones is experiencing a urine output decrease of less than 0.5ml/kg per hour; increase BUN and creatinine levels; decrease glomerular filtration rate; flank

pain and wheezes and crackles in their lungs, along with 2+ pitting edema in their extremities.Which complication is the client most likely developing?

a) Cystitis.
b) Urolithiasis.
c) Pyelonephritis.
d) Acute kidney injury. d) Acute kidney injury.

Rationale
The client has already been diagnosed with urolithiasis which are the diagnosed kidney stones. The client is presenting signs and symptoms of acute kidney injury as a result of the kidney stones causing obstruction(s). Decrease in urine output less than 0.5m/kg per hour; abnormal orsharp increase of BUN and creatinine levels; decrease in their GFR and signs and symptoms offluid overload as evidence of pulmonary edema and peripheral edema and flank pain.
The nurse is preparing a client for an esophagogastroduodenoscopy (EGD) following an episodeof acute gastrointestinal bleeding. The client asks why the EGD is being performed. Which reason should the nurse give?

a) To rule out malignancy.
b) To remove intestinal obstructions.
c) To cauterize the site.
d) To locate the source of bleeding. d) To locate the source of bleeding.
The nurse is caring for a pregnant client who has been diagnosed with preeclampsia. The nurse has taught the client how to check her blood pressure at home. Which expected outcome shouldthe nurse plan for this client?

a) The client will report abnormal blood pressures to the health care provider.
b) The client will lie down after a high blood pressure reading.
c) The client will reduce sodium intake after a high blood pressure reading.
The client will discuss high blood pressure readings at schedule appointments a) The clientwill report abnormal blood pressures to the health care provider.
A client who is status post thyroidectomy 12 hours ago appears to be becoming increasingly anxious and is complaining about being uncomfortable and extremely thirsty. The nurse notes the client is lying in bed supine with the head of the bed elevated 30°; their neck dressing appearsto be dry and intact; and NS @60ml/hr is infusing without any signs and/or symptoms of infiltration. Which intervention should the nurse implement first?

a) Offer the client their prescribed pain medication.
b) Obtain a prescription to obtain a serum calcium level.
c) Reassure the client and state to them it appears you are anxious.
d) Gently roll the client to the side and inspect the back of their neck area. d) Gently roll theclient to the side and inspect the back of their neck area.

Rationale
The nurse needs to gently roll the client to the side and inspect back of their neck area to ensurethey are not bleeding. A client is at risk of hemorrhaging within the

first 24 hours status post a

thyroidectomy. One of the first signs of hemorrhaging is "thirst". Signs of restlessness oragitation and anxiety can also be a sign of hemorrhaging after an invasive procedure.
An emergency department nurse is triaging an unaccompanied, unconscious client. Upon inspection the nurse notices some paradoxical movement of the anterior lower chest area. Theclient's blood pressure is 88/54mmHg. The heart rate is 112 beats per minute and the client's oxygen saturation via pulse oximetry is 91% on room air. Based on these findings which condition should the nurse suspect?

a) Lung tumor.
b) Broken ribs.
c) Pneumothorax.
d) Pulmonary infiltrates. b) Broken ribs.

Rationale
The client's presenting symptom of paradoxical movement of the thorax cavity is indicative of broken ribs or one rib that is fractured in more than one place. This condition is referred to as a "flail chest". The paradoxical chest movement is often accompanied by client complaints of pain,especially when coughing or trying to breath deeply. Other symptoms include dyspnea, cyanosis,tachycardia and hypotension depending upon how severe the injury.
The nurse is assessing a client who was out in the woods and developed a rash twenty-four hourslater. The rashes are present on both lower legs and outer aspects of their hands and forearms.
The appearance of these rashes are red with linear streaks of papules and vesicles which aredraining clear light yellow fluid. What type of hypersensitivity/allergy reaction is this?

a) Type IV: Delayed involving the release of sensitized T-cells with an antigen.
b) Type I: Immediate in which the reaction of the IgE antibody on mast cells with an antigen.
c) Type II: Cytotoxic in which the reaction of the IgG with the host's cell membranes andantigen.
d) Type III: Immune Complex-mediated involving the formation of immune complex of antigenand antibody. a) Type IV: Delayed involving the release of sensitized T-cells with an antigen.

Rationale
Type IV: Delayed hypersensitivity is the result of the reaction of sensitized T-cells with antigen and release of lymphokines, which activates macrophages and induces inflammation. Clinical examples of these types of reactions are seen with exposure to poison ivy or oak; graft rejection;positive TB skin tests and the disease sarcoidosis
A client from a nursing home is admitted with diagnoses of diabetes mellitus, chronic pancreatitis and alcoholism. The healthcare provider has prescribed the client pancrelipase(Creon, Pancrease). How should the nurse document the effectiveness of this prescribed medication?

a) The absence or presence of delirium tremors.

b) The character and quality of abdominal pain.
c) Glucometer readings before and after each meal.
d) The number, frequency and consistency of stools per day. d) The number, frequencyand consistency of stools per day.