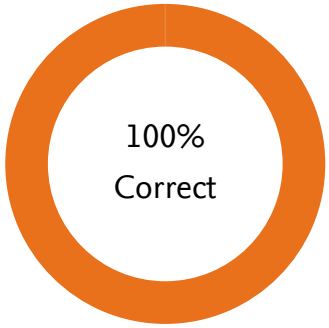
Return to Overview

Practice Test Assessment Performance



Blam!

Let's review your results from 2/3/2022 at 10:22 pm PST

Correct

The practical nurse (PN) performs a random blood glucose test for a client with a history of hypoglycemia and complains of dizziness. After test completion, which action should the PN perform first?

- Remove gloves and wash hands.
- Document results and actions in the medical record.

- [x] Dispose of lancet and test strip in proper receptacle.
- [ ] Discuss the test results with the client.

Rationale

Disposal of the lancet and test strip (C) prevents the transmission of bloodborne pathogens and is the priority. (A, B, and D) should follow, implementing sharps precautions.

Regarding client confidentiality, what information represents the correct understanding by the practical nurse of the guidelines set forth by HIPAA (Health Insurance Portability and Accountability Act)?

- [ ] Only clients can pick up their prescriptions at a pharmacy.
- [x] Past medical records for clients should be stored in a secured place.
- [ ] Computers that access client information cannot be in the public part of a nursing station.
- [ ] Whiteboards with a list of client names are prohibited in areas that the public can see.

Rationale

The Health Insurance Portability and Accountability act of 1996 (HIPPA) establishes that records with protected health information (PHI) must be stored in a secured place. The other options are not part of the HIPPA act.

Which action should the practical nurse (PN) implement to provide a sense of control to a toddler who is hospitalized?

- [ ] Put a cover over the child's crib.

- Ask parents to stay with the child.
- Assign the same nurses to care for the child.
- ✓ Follow the child's usual routines for feeding and bedtime.

Rationale

Routines are important to toddlers and give the child a sense of control, so following the child's usual routines during hospitalization should be implemented as much as possible.

Which interventions should the practical nurse (PN) implement in the postoperative period for a client who had surgery for cancer of the oral cavity? (Select all that apply.)

Select all that apply

- ✓ Provide meticulous oral hygiene.
- Advise the client to avoid straining at stool.
- ✓ Obtain daily weights to determine need for NGT feedings.
- ✓ Observe for temporary or permanent loss of taste.
- Monitor for gastric indigestion.

Rationale

Postoperative problems related to excision of a cancerous lesion in the oval cavity include the risk for infection, delayed wound healing in the oral mucosa, and gustatory deficits, if the client's tongue is resected or biopsied. Meticulous oral hygiene reduces oral flora and minimizes the risk for infection. Monitoring daily weight provides information about the client's need for supplemental NGT feedings to improve nutritional intake for healing and recovery. Observing for temporary or permanent loss of taste may indicate trauma of the tongue and glossopharyngeal nerve.

Which intervention is most important for the practical nurse to implement when suctioning the nasopharyngeal airways for a child after cardiac surgery?

- Perform oropharyngeal suctioning PRN.
- Suction for no longer than 5 seconds at a time.
- Assess for symptoms of respiratory distress during suctioning.
- ✓ Administer supplemental oxygen before and after suctioning.

Rationale

Hypoxia increases the cardiac workload after cardiac surgery, so supplemental oxygen should be administered with a manual resuscitation bag before and after suctioning (D) to prevent hypoxia. Although (A, B, and C) should be implemented, providing oxygenation is most important. To maintain a patent airway, oropharyngeal suctioning for a child after cardiac surgery should be performed PRN without deep insertion of the suction catheter which can cause vagal stimulation and laryngospasm. Suctioning should be intermittent and maintained for no more than five seconds to prevent depleting the oxygen supply. Signs of respiratory distress warrant cessation of suctioning if the client is experiencing intolerance.

A female client with terminal cancer is tearful and is becoming increasingly withdrawn from her family and the nursing staff. She refuses medications, treatments, food, and frequently says, "Why is God doing this to me?" Which intervention should the practical nurse implement?

- Monitor for an increased suicide risk.
- Implement measures to reduce her pain level.
- ✓ Contact her religious advisor to help her face death.

- ◯ Initiate discussions about her wishes for end-of-life care.

Rationale

The client's religious advisor should be contacted to assist the client cope with her spiritual distress regarding death (C). Although discussions about end-of-life care (D) should be initiated, the client's religious advisor, family, or healthcare provider should assist her in coordinating her wishes. The client's physical distress is influenced by (A and B) but do not address her expressed spiritual needs.

Which pathophysiological findings are characteristic in children with cystic fibrosis (CF)? (Select all that apply.)

Select all that apply

- ☐ Diabetes mellitus.
- ☐ Excessive salivation.
- ☐ Abnormal bone ossification.
- ✓ ☑ Pancreatic enzyme deficiency.
- ✓ ☑ Hypochloremia and hyponatremia.
- ✓ ☑ Viscous respiratory secretions.

Rationale

Correct selections are (D, E, and F). CF is characterized by exocrine gland dysfunction that produces thick, tenacious respiratory secretions (F), pancreatic enzyme deficiencies (D), and abnormally elevated chloride and sodium concentrations in the sweat (E). Diabetes is common with cystic fibrosis but is not a pathophysiological finding of CF (A). Impaired salivation, not (B), occurs from patchy fibrosis of salivary glands. Although impaired absorption of vitamin D and calcium utilization can lead to impaired bone formation (C), it is not considered a hallmark of CF.

Which factor should the practical nurse (PN) consider prior to providing morning hygiene care to a male client who is of Middle-Eastern descent ?

- Skin color.
- Economic status.
- ✓ Personal preferences.
- Sociocultural background.

Rationale

Hygiene is considered an invasion of personal space, and clients vary in their perceptions of how and who may assist in their care. Personal preferences (C) should be assessed in advance of hygiene care. Skin color (A), economic status (B), and sociocultural background (D) do not address the client's perceptions or preferences.

The caregiver of an 88-year-old client tells the practical nurse (PN) that the client takes frequent naps during the day and awakens frequently during the night. Which information should the PN provide?

- The client should be given a hypnotic to ensure an adequate sleep pattern through the night.
- To prevent fatigue, an older client should obtain at least 10 hours of sleep in 24 hours.
- An older client should nap less during the day to ensure a longer sleep pattern at night.
- ✓ It is normal for an aging client to awaken more often during the night and nap during the day.

Rationale

Sleep habits are individualized, but an older client normally sleeps less at night with more naps taken during the day, so the caregiver should be reassured that this is an expected, normal sleep pattern (D) for the client. (A) places the client at risk for dependency and is not indicated. (B and C) are inaccurate.

The practical nurse (PN) is caring for an older client with an infection. Which finding should the PN anticipate as a delayed response in this client?

- ✓ Fever.
- Fatigue.
- Malaise.
- Confusion.

Rationale

An early systemic immune response is fever, but older clients are at risk for an impaired immune response related to chronic illness or polypharmacy, such as antiinflammatory steroids. This older client may manifest fever after presenting with fatigue, malaise, and confusion.

Which client receiving infusion therapy is the best assignment for the practical nurse (PN)?

- Client who hemorrhaged and needs a unit of whole blood started on admission to the postoperative unit.
- Client who is receiving diltiazem (Cardizem) IV titrated for a heart rate between 60 to 80.

- Client who requires fingerstick glucose checks while receiving a regular insulin IV solution.
- ✓ Older adult client who is confused and has a peripheral saline lock that should to be flushed every eight hours.

Rationale

Client acuity is affected by unstable health alterations that require multisystem organ assessment and determines client care assignments that should be aligned with the PN or RN scope of practice. An older adult client with a saline lock that is routinely flushed for patency every 8h is a non-complex care assignment within the scope of practice for the PN.

An older client is being discharged from the hospital to return to the assisted living community after undergoing a right hip replacement. The client is using a four-point walker. When planning the client's discharge, which member of the healthcare team is most important for the practical nurse to coordinate continued care for the client?

- **Case manager.**
- ✓ **Physical therapist.**
- **Occupational therapist.**
- **Social worker.**

Rationale

To establish the client's independence, the physical therapist (B) should continue the client's progression of mobility in the assisted living facilty. (A, C, and D) are all available ancillary health care members that can be utilized if needed for other client needs, but (B) is the priority for the client to regain independent mobility.

A new father asks the practical nurse (PN) the reason for placing an ophthalmic ointment in his newborn's eyes. What information should the PN provide?

- Possible exposure to an environmental staphylococcus infection can infect the newborn's eyes and cause visual deficits.
- The newborn is at risk for blindness from a corneal syphilitic infection acquired from a mother's infected vagina.
- Treatment prevents tear duct obstruction with harmful exudate from a vaginal birth that can lead to dry eyes in the newborn.
- ✓ State law mandates all newborns receive prophylactic treatment to prevent gonorrheal or chlamydial ophthalmic infection.

Rationale

Many states mandate prophylactic use of erythromycin ointment in all newborn's eyes within 2 hours of birth because of the risk of blindness from an ophthalmic infection acquired during a vaginal birth, if the mother is infected with a gonorrheal or chlamydial organism (D). (A, B, and C) are inaccurate.

A client who has been taking furosemide (Lasix) for the past two months is 2 days postoperative for a suprapubic prostatectomy. After breakfast, the client is in the bathroom straining to have a bowel movement when he calls the practical nurse (PN) complaining of sudden onset of shortness of breath and acute chest pain. Which condition should the practical nurse (PN) assess the client?

- Stable angina pectoris.
- Pulmonary edema.

- [x] Pulmonary embolism.
- [ ] Gastroesophageal reflux.

Rationale

The client's postoperative status and possible dehydration related to recent use of Lasix places the client at risk for pulmonary embolism, which is a postoperative complication characterized by acute chest pain and shortness of breath precipitated by straining on stool. (A, B, and D) are not characterized by chest pain and shortness of breath associated with a Valsalva maneuver.

Which finding should the practical nurse (PN) report to the healthcare provider that indicates a client with cirrhosis is progressing to hepatic encephalopathy (hepatic coma)?

- [ ] 2+ pitting edema up to the lower thighs.
- [ ] Serum clotting results three times above normal.
- [ ] Spider nevi (telangiectasias).
- [x] Serum ammonia levels twice the normal value.

Rationale

Hepatic coma results in cerebral dysfunction when serum ammonia is not eliminated and builds up in the bloodstream (D). (A, B, and C) are all expected findings for clients with cirrhosis, but elevated serum ammonia level is indicative of hepatic failure.

Which finding in a newborn is most important for the practical nurse (PN) to report?

- [x] Clinical jaundice evident on the forehead within 24 hours of birth.
- [ ] Icterus color of blanched skin on the thorax at day 3 after birth.