HESI EXIT COMPREHENSIVE REVIEW B

1.Which information is most concerning to the nurse when caring for an older client with bilateral cataracts?

A. States having difficulty with color perception
B. Presents with opacity of the lens upon assessment
C. Complains of seeing a cobweb-type structure in the visual field
D. Reports the need to use a magnifying glass to see small print

Rationale:
Visualization of a cobweb- or hairnet-type structure is a sign of a retinal detachment, which constitutes a medical emergency. Clients with cataracts are at increased risk for retinal detachment. Distorted color perception, opacity of the lens, and gradual vision loss are expected signs and symptom of cataracts but do not need immediate attention.

2.When caring for a client hospitalized with Guillain-Barré syndrome, which information is most important for the nurse to report to the primary health care provider?

A. Ascending numbness from the feet to the knees
B. Decrease in cognitive status of the client
C. Blurred vision and sensation changes
D. Persistent unilateral headache

Rationale:
A decline in cognitive status in a client is indicative of symptoms of hypoxia and a possible need to assist the client with mechanical ventilation. A primary health care provider will need to be contacted immediately. Options A, C, and D are findings associated with Guillain-Barré syndrome that should also be reported but are not as critical as the client's hypoxic status.

3. A client is admitted with a diagnosis of leukemia. This condition is manifested by which of the following?

A. Fever, elevated white blood count, elevated platelets
B. Fatigue, weight loss and anorexia, elevated red blood cells
C. Hyperplasia of the gums, elevated white blood count, weakness
D. Hypocellular bone marrow aspirate, fever, decreased hemoglobin level

Rationale:
Hyperplastic gums, weakness, and elevated white blood count are classic signs of leukemia. Options A, B, and D state incorrect information for symptoms of leukemia.

4. The nurse enters the examination room of a client who has been told by her health care provider that she has advanced ovarian cancer. Which response by the nurse is likely to be most supportive for the client?

A. "I know many women who have survived ovarian cancer."
B. "Let's talk about the treatments of ovarian cancer."
C. "In my opinion I would suggest getting a second opinion."
D. "Tell me about what you are feeling right now."

Rationale:
The most therapeutic action for the nurse is to be an active listener and to encourage the client to explore her feelings. Giving false reassurance or personal suggestions are not therapeutic communication for the client.

5. A nurse working in the emergency department admits a client with full-thickness burns to 50% of the body. Assessment findings indicate high-pitched wheezing, heart rate of 120 beats/min, and disorientation. Which action should the nurse take first?

A. Insert a large-bore IV for fluid resuscitation.
B. Prepare to assist with maintaining the airway.
C. Cleanse the wounds using sterile technique.
D. Administer an analgesic for pain.

Rationale:
High-pitched wheezing indicates laryngeal stridor, a sign of laryngeal edema associated with lung injury. Airway management is the first priority of care. Options A, C, and D are all appropriate interventions in managing the client with a burn but are not as critical as establishing an airway.

6. The nurse walks into the room and observes the client experiencing a tonic-clonic seizure. Which intervention should the nurse implement first?

A. Restrain the client to protect from injury.
B. Flex the neck to ensure stabilization.
C. Use a tongue blade to open the airway.
D. Turn client on the side to aid ventilation.

Rationale:
Maintaining the airway during a seizure is the priority for safety. Options A, B, and C are contraindicated during a seizure and may cause further injury to the client.

7. Which intervention should be included in the plan of care for a client admitted to the hospital with ulcerative colitis?

A. Administer stool softeners.
B. Place the client on fluid restriction.
C. Provide a low-residue diet.
D. Add a milk product to each meal.

Rationale:
A low-residue diet will help decrease symptoms of diarrhea, which are clinical manifestations of ulcerative colitis. Options A, B, and D are contraindicated and could worsen the condition.

8. A nurse implements an education program to reduce hospital readmissions for clients with heart failure. Which statement by the client indicates that teaching has been effective?

A. "I will not take my digoxin if my heart rate is higher than 100 beats/min."
B. "I should weigh myself once a week and report any increases."
C. "It is important to increase my fluid intake whenever possible."
D. "I should report an increase of swelling in my feet or ankles."

Rationale:
An increase in edema indicates worsening right-sided heart failure and should be reported to the primary health care provider. Digitalis should be held when the heart rate is lower than 60 beats/min. The client with heart failure should weigh himself or herself daily and report a gain of 2 to 3 lb. An increase in fluid can worsen heart failure.

9. After assessing a 26-year-old client with type 1 diabetes mellitus, which data may indicate that the client is experiencing chronic complications of diabetes?

A. Blood pressure, 159/98 mm Hg
B. Hemoglobin A1C (HbA_{1C}), 6%
C. Creatinine level, 1.0 mg/dL
D. Chronic sciatica

Rationale:
A blood pressure of 159/98 mm Hg is hypertensive and increases the client's risk for acute coronary syndrome and/or stroke. Options B and C are within defined parameters, and Option D is not a recognized chronic complication of diabetes.

10. When caring for a client with a tracheostomy, which intervention should the nurse delegate to the unlicensed assistive personnel (UAP)?

A. Teach the family about signs and symptoms of hypoxia.
B. Take the vital signs and obtain an O_2 saturation level.
C. Evaluate the need for tracheal suctioning.
D. Revise the plan of care to include tracheostomy care.

Rationale:
The nurse may delegate obtaining vital signs and O_2 saturation; however, the nurse is responsible for following up on any reported data. Options A, C, and D are all part of the nursing process and should not be delegated under the nurse's scope of practice.

11. The charge nurse is making assignments for the upcoming shift. Which client is most appropriate to assign to the practical nurse (PN)?

A. A client with nausea who needs a nasogastric tube inserted
B. A client in hypertensive crisis who needs titration of IV nitroglycerin
C. A newly admitted client who needs to have a plan of care established
D. A client who is ready for discharge who needs discharge teaching

Rationale:
The client mentioned in option A has a need for a skill that is within the scope of practice for the PN. Titration of an IV drip, establishing care plans, and discharge teaching are within the scope of practice of a registered nurse (RN) and are not delegated.

12. A nurse performs an initial admission assessment of a 56-year-old client. Which factor(s) would indicate that the client is at risk for metabolic syndrome? *(Select all that apply.)*

A. Abdominal obesity
B. Sedentary lifestyle
C. History of hypoglycemia
D. Hispanic or Asian ethnicity
E. Increased triglycerides

Rationale:
Metabolic syndrome is a name for a group of risk factors that increase the risk for coronary artery disease, type 2 diabetes, and stroke (A, B, D, and E). Hypoglycemia is not a risk factor for metabolic syndrome (C).

13. Which clinical manifestation in the client with hyperthyroidism is most important to report to the health care provider?

A. Nervousness
B. Increased appetite
C. Apical heart rate of 130 beats/min
D. Insomnia

Rationale:
The apical heart rate of 130 beats/min is a critical finding that could lead to heart failure or other cardiac disorders. Options A, B, and D are all expected findings that should also be reported but are not as critical.

14. The nurse administers atropine sulfate ophthalmic drops preoperatively to the right eye of a client scheduled for cataract surgery. Which response by the client indicates that the drug was effective?

A. The pupils become equal and reactive to light.
B. The right pupil constricts within 30 minutes.
C. Bilateral visual accommodation is restored.
D. The right pupil dilates after drop instillation.

Rationale:
Atropine is a mydriatic drug which causes pupil dilation and paralysis in

preparation for surgery or examination. Options A, B, and C do not describe the therapeutic effects of atropine sulfate ophthalmic drops prior to cataract surgery.

15. A client with human immunodeficiency virus (HIV) develops a painful blistering skin rash on the right lateral abdominal area. Which drug should the nurse expect to administer to treat this condition?

A. Levofloxacin
B. Acyclovir sodium
C. Fluconazole
D. Esomeprazole

Rationale:
The clinical manifestations listed are consistent with herpes zoster (shingles). Acyclovir sodium is an antiviral used to treat herpes zoster or shingles. Levofloxacin is an antibiotic and may be used to treat pneumonia or other infections in the HIV client. Fluconazole is an antifungal and is used to treat candidiasis in the HIV client. Esomeprazole is a protein pump inhibitor used for gastroesophageal reflux disease.

16. When assessing a 38-year-old client with tuberculosis who is taking rifampin, which finding would be most important to report to the primary health care provider immediately?

A. Orange-colored urine
B. Potassium level, 4.9 mEq/L
C. Elevated liver enzyme levels
D. Blood urea nitrogen (BUN) level, 12 mg/dL.

Rationale:
Rifampin can cause hepatotoxicity, so elevated liver enzyme levels need to be closely monitored and reported to the health care provider. Orange discoloration of the urine is an expected side effect of this medication. The potassium level is normal. A BUN level of 12 mg/dL is within defined parameters.

17. A client with non-Hodgkin lymphoma has been prescribed cyclophosphamide IV for therapy. Which assessment finding would need to be reported immediately to the oncologist?

A. Sores on the mouth or tongue
B. Chills, fever, and sore throat
C. Loss of appetite or weight with diarrhea
D. Changes in color of fingernails or toenails

Rationale:
Cyclophosphamide is an immunosuppressive drug used to treat lymphoma and puts the client at risk for infection. Signs and symptoms of an infection should be reported to the oncologist immediately. Options A and C are expected signs and symptoms of non-Hodgkin lymphoma. Option D is a normal side effect of cyclophosphamide.

18. A nurse is assessing a client with heart failure who has been prescribed digoxin for therapy. Which finding indicates an issue with the medication management?

A. Regular heart rate of 88 beats/min
B. Serum potassium level, 2.9 mEq/L
C. Weight decreases by 1 lb daily
D. Serum sodium level, 138 mEq/L

Rationale:
A serum potassium level of 2.9 mEq/L is low, and side effects of digoxin toxicity are exacerbated when the potassium level is low. Options A, C, and D are all expected findings when caring for a client with congestive heart failure.

19. Which statement by the U.S. Food and Drug Administration (FDA) is an example of a black box or black label warning for the drug clopidogrel?

A. This drug could cause heart attack or stroke when taken by clients with certain genetic conditions.
B. Clopidogrel helps prevent platelets from sticking together and forming clots in the blood.
C. This drug can be taken in combination with aspirin to reduce the risk of acute coronary syndrome.
D. Clopidogrel can reduce the risk of a future heart

attack when taken by clients with peripheral artery disease.

Rationale:
A black box warning is a notice required by the FDA on a prescription drug that warns of potentially dangerous side effects. Options B, C, and D are all desired effects of the drug.

20. The nurse is caring for a client with an ischemic stroke who has a prescription for tissue plasminogen activator (t-PA) IV. Which actions should the nurse expect to implement? *(Select all that apply.)*

A. Administer aspirin with tissue plasminogen activator (t-PA).
B. Complete the National Institute of Health Stroke Scale (NIHSS).
C. Assess the client for signs of bleeding during and after the infusion.
D. Start t-PA within 6 hours after the onset of stroke symptoms.
E. Initiate multidisciplinary consult for potential rehabilitation.

Rationale:
Neurologic assessment, including the NIHSS, is indicated for the client receiving t-PA. This includes close monitoring for bleeding during and after the infusion; if bleeding or other signs of neurologic impairment occur, the infusion should be stopped (B, C, and E). Aspirin is contrain-dicated with t-PA because it increases the risk for bleeding (A). The administration of t-PA within 6 hours of symptoms is concurrent with a diagnosis of a myocardial infarction and within 4.5 hours of symptoms is concurrent for a stroke (D).

21. Which action by the nurse is consistent with culturally competent care?

A. Treating each client the same regardless of race or religion
B. Ensuring that all Native American clients have access to a shaman
C. Understanding one's own world view in addition to the client's

D. Including the family in the plan of care for older clients

Rationale:
The nurse should understand his or her own values and views to prevent those values from being imparted to others, in addition to understanding the client's cultural views. Treating every client the same or assuming that all clients share the same values does not exhibit cultural competence or sensitivity.

22. The charge nurse reviews the charting of a graduate nurse. Which indicates a need for further education on documentation?

A. Uses descriptive words such as "gurgling" to describe breath sounds.
B. Records temperature 30 minutes before and after giving acetaminophen.
C. Charts some actions in advance of performing them.
D. Includes the client's response to an intervention.

Rationale:
Charting actions prior to implementing them is an example of fraudulent charting, and the graduate nurse should receive further education. Options A, B, and D are appropriate charting examples.

23. Which data obtained during a respiratory assessment for a 78-year-old client is most important to report to the primary health care provider?

A. Auscultation of vesicular breath sounds
B. Pulse oximetry reading of 89%
C. Arterial PaO_2 of 86%
D. Resonance on percussion of the lungs

Rationale:
An oxygen saturation lower than 90% indicates hypoxia. Options A, C, and D are all normal findings.

24. The nurse hears a series of long-duration, discontinuous, low-pitched sounds on auscultation of a client's lower lung fields. Which documentation of this finding is correct?