2018 HESI EXIT V5

1. The nurse is has just admitted a client with severe depression. From which focus should the nurse identify a priority nursing diagnosis?
A) Nutrition
B) Elimination

C) Activity
D) Safety
The correct answer is D: Safety

2. While explaining an illness to a 10 year-old, what should the nurse keep in mind about the cognitive development at this age?
A) They are able to make simple association of ideas
B) They are able to think logically in organizing facts
C) Interpretation of events originate from their own perspective
D) Conclusions are based on previous experiences
The correct answer is B: Think logically in organizing facts

3. The nurse enters the room as a 3 year-old is having a generalized seizure. Which intervention should the nurse do first?
A) Clear the area of any hazards
B) Place the child on the side
C) Restrain the child
D) Give the prescribed anticonvulsant
The correct answer is B: Place the child on the side

4. The nurse is reviewing a depressed client's history from an earlier admission. Documentation of anhedonia is noted. The nurse understands that this finding refers to
A) Reports of difficulty falling and staying asleep
B) Expression of persistent suicidal thoughts
C) Lack of enjoyment in usual pleasures
D) Reduced senses of taste and smell
The correct answer is C: Lack of enjoyment in usual pleasures

5. A client has just returned to the medical-surgical unit following a segmental lung resection. After assessing the client, the first nursing action would be to
A) Administer pain medication
B) Suction excessive tracheobronchial secretions
C) Assist client to turn, deep breathe and cough

D) Monitor oxygen saturation
The correct answer is B: Suction excessive tracheobronchial secretions

6. While assessing a client in an outpatient facility with a panic disorder, the nurse completes a thorough health history and physical exam. Which finding is most significant for this client?
A) Compulsive behavior
B) Sense of impending doom
C) Fear of flying
D) Predictable episodes
The correct answer is B: Sense of impending doom

7. A 16 month-old child has just been admitted to the hospital. As the nurse assigned to this child enters the hospital room for the first time, the toddler runs to the mother, clings to her and begins to cry. What would be the initial action by the nurse?
A) Arrange to change client care assignments
B) Explain that this behavior is expected
C) Discuss the appropriate use of "time-out"
D) Explain that the child needs extra attention
The correct answer is B: Explain that this behavior is expected

8. A 15 year-old client with a lengthy confining illness is at risk for altered growth and development of which task?
A) Loss of control
B) Insecurity
C) Dependence
D) Lack of trust
The correct answer is C: Dependence

9. Which playroom activities should the nurse organize for a small group of 7 year-old hospitalized children?
A) Sports and games with rules
B) Finger paints and water play
C) "Dress-up" clothes and props
D) Chess and television programs
The correct answer is A: Sports and games with rules

10. The nurse is discussing dietary intake with an adolescent who has acne. The most

appropriate statement for the nurse is
A) "Eat a balanced diet for your age."
B) "Increase your intake of protein and Vitamin A."
C) "Decrease fatty foods from your diet."
D) "Do not use caffeine in any form, including chocolate."
The correct answer is A: "Eat a balanced diet for your age."

11. The nurse is assigned to a newly delivered woman with HIV/AIDS. The student asks the nurse about how it is determined that a person has AIDS other than a positive HIV test. The nurse responds
A) "The complaints of at least 3 common findings."
B) "The absence of any opportunistic infection."
C) "CD4 lymphocyte count is less than 200."
D) "Developmental delays in children."
The correct answer is C: "CD4 lymphocyte count is less than 200."

12. The nurse is caring for a child who has just returned from surgery following a tonsillectomy and adenoidectomy. Which action by the nurse is appropriate?
A) Offer ice cream every 2 hours
B) Place the child in a supine position
C) Allow the child to drink through a straw
D) Observe swallowing patterns
The correct answer is D: Observe swallowing patterns

13. A 23 year-old single client is in the 33rd week of her first pregnancy. She tells the nurse that she has everything ready for the baby and has made plans for the first weeks together at home. Which normal emotional reaction does the nurse recognize?
A) Acceptance of the pregnancy
B) Focus on fetal development
C) Anticipation of the birth
D) Ambivalence about pregnancy
The correct answer is C: Anticipation of the birth

14. The nurse is planning care for a client with pneumococcal pneumonia. Which of the following would be most effective in removing respiratory secretions?
A) Administration of cough suppressants
B) Increasing oral fluid intake to 3000 cc per day
C) Maintaining bed rest with bathroom privileges
D) Performing chest physiotherapy twice a day

The correct answer is B: Increasing oral fluid intake to 3000 cc per day

15. The nurse in a well-child clinic examines many children on a daily basis. Which of the following toddlers requires further follow up?
A) A 13 month-old unable to walk
B) A 20 month-old only using 2 and 3 word sentences
C) A 24 month-old who cries during examination
D) A 30 month-old only drinking from a sip cup
The correct answer is D: A 30 month-old only drinking from a sip cup

16. Which of the following would be the best strategy for the nurse to use when teaching insulin injection techniques to a newly diagnosed client with diabetes?
A) Give written pre and post tests
B) Ask questions during practice
C) Allow another diabetic to assist
D) Observe a return demonstration
The correct answer is D: Observe a return demonstration

17. A client has developed thrombophlebitis of the left leg. Which nursing intervention should be given the highest priority?
A) Elevate leg on 2 pillows
B) Apply support stockings
C) Apply warm compresses
D) Maintain complete bed rest
The correct answer is A: Elevate leg on 2 pillows

18. A nurse from the surgical department is reassigned to the pediatric unit. The charge nurse should recognize that the child at highest risk for cardiac arrest and is the least likely to be assigned to
this nurse is which child?
A) Congenital cardiac defects
B) An acute febrile illness
C) Prolonged hypoxemia
D) Severe multiple trauma
The correct answer is C: Prolonged hypoxemia

19. A home health nurse is at the home of a client with diabetes and arthritis. The client has difficulty drawing up insulin. It would be most appropriate for the nurse to refer the

client to
A) A social worker from the local hospital
B) An occupational therapist from the community center
C) A physical therapist from the rehabilitation agency
D) Another client with diabetes mellitus and takes insulin
The correct answer is B: An occupational therapist from the community center

20. A priority goal of involuntary hospitalization of the severely mentally ill client is
A) Re-orientation to reality
B) Elimination of symptoms
C) Protection from harm to self or others
The correct answer is C: Protection from self harm and harm to others

21. The nurse is caring for a client with a long leg cast. During discharge teaching about appropriate exercises for the affected extremity, the nurse should recommend
A) Isometric
B) Range of motion
C) Aerobic
D) Isotonic
The correct answer is A: Isometric

22. The nurse is teaching parents about the treatment plan for a 2 weeks-old infant with Tetralogy of Fallot. While awaiting future surgery, the nurse instructs the parents to immediately report
A) Loss of consciousness
B) Feeding problems
C) Poor weight gain
D) Fatigue with crying
The correct answer is A: Loss of consciousness

23. A client is scheduled for an Intravenous Pyelogram (IVP). In order to prepare the client for this test, the nurse would
A) Instruct the client to maintain a regular diet the day prior to the examination
B) Restrict the client's fluid intake 4 hours prior to the examination
C) Administer a laxative to the client the evening before the examination
D) Inform the client that only 1 x-ray of his abdomen is necessary
The correct answer is C: Administer a laxative to the client the evening before the examination

24. The nurse is caring for a woman 2 hours after a vaginal delivery. Documentation indicates that the membranes were ruptured for 36 hours prior to delivery. What is the priority nursing diagnoses at this time?
A) Altered tissue perfusion
B) Risk for fluid volume deficit
C) High risk for hemorrhage
D) Risk for infection
The correct answer is D: Risk for infection

25. The parents of a newborn male with hypospadias want their child circumcised. The best response by the nurse is to inform them that
A) Circumcision is delayed so the foreskin can be used for the surgical repair
B) This procedure is contraindicated because of the permanent defect
C) There is no medical indication for performing a circumcision on any child
D) The procedure should be performed as soon as the infant is stable
The correct answer is A: Circumcision is delayed so the foreskin can be used for the surgical repair

26. The nurse is caring for a client in the late stages of Amyotrophic Lateral Sclerosis (A.L.S.). Which finding would the nurse expect?
A) Confusion
B) Loss of half of visual field
C) Shallow respirations
D) Tonic-clonic seizures
The correct answer is C: Shallow respirations

27. A client complained of nausea, a metallic taste in her mouth, and fine hand tremors 2 hours after her first dose of lithium carbonate (Lithane). What is the nurse's best explanation of these findings?
A) These side effects are common and should subside in a few days
B) The client is probably having an allergic reaction and should discontinue the drug
C) Taking the lithium on an empty stomach should decrease these symptoms
D) Decreasing dietary intake of sodium and fluids should minimize the side effects
The correct answer is A: These side effects are common and should subside in a few days

28. A 57 year-old male client has a hemoglobin of 10 mg/dl and a hematocrit of 32%. What would be the most appropriate follow-up by the home care nurse?

A) Ask the client if he has noticed any bleeding or dark stools
B) Tell the client to call 911 and go to the emergency department immediately
C) Schedule a repeat Hemoglobin and Hematocrit in 1 month
D) Tell the client to schedule an appointment with a hematologist
The correct answer is A: Ask the client if he has noticed any bleeding or dark stools

29. A client is scheduled for a percutaneous transluminal coronary angioplasty (PTCA). The nurse knows that a PTCA is the
A) Surgical repair of a diseased coronary artery
B) Placement of an automatic internal cardiac defibrillator
C) Procedure that compresses plaque against the wall of the diseased coronary artery to improve blood flow
D) Non-invasive radiographic examination of the heart
The correct answer is C: Procedure that compresses plaque against the wall of the diseased coronary artery to improve blood flow

30. For a 6 year-old child hospitalized with moderate edema and mild hypertension associated with acute glomerulonephritis (AGN), which one of the following nursing interventions would be appropriate?
A) Institute seizure precautions
B) Weigh the child twice per shift
C) Encourage the child to eat protein-rich foods
D) Relieve boredom through physical activity
The correct answer is A: Institute seizure precautions

31. Following mitral valve replacement surgery a client develops PVC's. The health care provider orders a bolus of Lidocaine followed by a continuous Lidocaine infusion at a rate of 2 mgm/minute. The IV solution contains 2 grams of Lidocaine in 500 cc's of D5W. The infusion pump delivers 60 micro drops/cc. What rate would deliver 4 mgm of Lidocaine/ minute?
A) 60 microdrops/minute
B) 20 microdrops/minute
C) 30 microdrops/minute
D) 40 microdrops/minute
The correct answer is A: 60 microdrops/minute
2 gm=2000 mgm
2000 mgm/500 cc = 4 mgm/x cc 2000x
= 2000

x= 2000/2000 = 1 cc of IV solution/minute CC
x 60 microdrops = 60 microdrops/minute

32. An adolescent client comes to the clinic 3 weeks after the birth of her first baby. She tells the nurse she is concerned because she has not returned to her pre-pregnant weight. Which action should the
nurse perform first?
A) Review the client's weight pattern over the year
B) Ask the mother to record her diet for the last 24 hours
C) Encourage her to talk about her view of herself
D) Give her several pamphlets on postpartum nutrition
The correct answer is C: Encourage her to talk about her view of herself

33. To prevent a valsalva maneuver in a client recovering from an acute myocardial infarction, the nurse would
A) Assist the client to use the bedside commode
B) Administer stool softeners every day as ordered
C) Administer anti dysrhythmics prn as ordered
D) Maintain the client on strict bed rest
The correct answer is B: Administer stool softeners every day as ordered

34. A 3 year-old had a hip spica cast applied 2 hours ago. In order to facilitate drying, the nurse should
A) Expose the cast to air and turn the child frequently
B) Use a heat lamp to reduce the drying time
C) Handle the cast with the abductor bar
D) Turn the child as little as possible
The correct answer is A: Expose the cast to air and turn the child frequently

35. The nurse is caring for a 13 year-old following spinal fusion for scoliosis. Which of the following interventions is appropriate in the immediate postoperative period?
A) Raise the head of the bed at least 30 degrees
B) Encourage ambulation within 24 hours
C) Maintain in a flat position, logrolling as needed
D) Encourage leg contraction and relaxation after 48 hours
The correct answer is C: Maintain in a flat position, logrolling as needed

36. A client was admitted to the psychiatric unit after complaining to her friends and

family that neighbors have bugged her home in order to hear all of her business. She remains aloof from other clients, paces the floor and believes that the hospital is a house of torture. Nursing interventions for the client should appropriately focus on efforts to

A) Convince the client that the hospital staff is trying to help
B) Help the client to enter into group recreational activities
C) Provide interactions to help the client learn to trust staff
D) Arrange the environment to limit the client's contact with other clients

The correct answer is C: Provide interactions to help the client learn to trust staff

37. The nurse is assessing an infant with developmental dysplasia of the hip. Which finding would the nurse anticipate?

A) Unequal leg length
B) Limited adduction
C) Diminished femoral pulses
D) Symmetrical gluteal folds

The correct answer is A: Unequal leg length

38. A nurse is caring for a 2 year-old child after corrective surgery for Tetralogy of Fallot. The mother reports that the child has suddenly begun seizing. The nurse recognizes this problem is probably due to

A) A cerebral vascular accident
B) Postoperative meningitis
C) Medication reaction
D) Metabolic alkalosis

The correct answer is A: A cerebral vascular accident

39. Following a diagnosis of acute glomerulonephritis (AGN) in their 6 year-old child, the parents remark: "We just don't know how he caught the disease!" The nurse's response is based on an understanding that

A) AGN is a streptococcal infection that involves the kidney tubules
B) The disease is easily transmissible in schools and camps
C) The illness is usually associated with chronic respiratory infections
D) It is not "caught" but is a response to a previous B-hemolytic strep infection

The correct answer is D: It is not "caught" but is a response to a previous B-hemolytic strep infection

40. A couple asks the nurse about risks of several birth control methods. What is he most appropriate response by the nurse?

A) Norplant is safe and may be removed easily
B) Oral contraceptives should not be used by smokers

C) Depo-Provera is convenient with few side effects
D) The IUD gives protection from pregnancy and infection
The correct answer is B: Oral contraceptives should not be used by smokers

41. A client experiences postpartum hemorrhage eight hours after the birth of twins. Following administration of IV fluids and 500 ml of whole blood, her hemoglobin and hematocrit are within normal limits. She asks the nurse whether she should continue to breast feed the infants. Which of the following is based on sound rationale?
A) "Nursing will help contract the uterus and reduce your risk of bleeding."
B) "Breastfeeding twins will take too much energy after the hemorrhage."
C) "The blood transfusion may increase the risks to you and the babies."
D) "Lactation should be delayed until the "real milk" is secreted."
The correct answer is A: "Nursing will help contract the uterus and reduce your risk of bleeding."

42. The nurse is caring for a post-surgical client at risk for developing deep vein thrombosis. Which intervention is an effective preventive measure?
A) Place pillows under the knees
B) Use elastic stockings continuously
C) Encourage range of motion and ambulation
D) Massage the legs twice daily
The correct answer is C: Encourage range of motion and ambulation

43. The nurse is caring for a 20 lbs (9 kg) 6 month-old with a 3 day history of diarrhea, occasional vomiting and fever. Peripheral intravenous therapy has been initiated, with 5% dextrose in 0.33%
normal saline with 20 mEq of potassium per liter infusing at 35 ml/hr. Which finding should be reported to the health care provider immediately?
A) 3 episodes of vomiting in 1 hour
B) Periodic crying and irritability
C) Vigorous sucking on a pacifier
D) No measurable voiding in 4 hours
The correct answer is D: No measurable voiding in 4 hours

44. Which response by the nurse would best assist the chemically impaired client to deal with issues of guilt?
A) "Addiction usually causes people to feel guilty. Don’t worry, it is a typical response due to your drinking behavior."
B) "What have you done that you feel most guilty about and what steps can you begin to take to help you lessen this guilt?"

C) "Don’t focus on your guilty feelings. These feelings will only lead you to drinking and taking drugs."
D) "You’ve caused a great deal of pain to your family and close friends, so it will take time to undo all the things you’ve done."
The correct answer is B: "What have you done that you feel most guilty about and what steps can you begin to take to help you lessen this guilt?"

45. A client with schizophrenia is receiving Haloperidol (Haldol) 5 mg t.i.d.. The client’s family is alarmed and calls the clinic when "his eyes rolled upward." The nurse recognizes this as what type of side effect?
A) Oculogyric crisis
B) Tardive dyskinesia
C) Nystagmus
D) Dysphagia
The correct answer is A: Oculogyric crisis

46. Which of the following measures would be appropriate for the nurse to teach the parent of a nine month-old infant about diaper dermatitis?
A) Use only cloth diapers that are rinsed in bleach
B) Do not use occlusive ointments on the rash
C) Use commercial baby wipes with each diaper change
D) Discontinue a new food that was added to the infant's diet just prior to the rash
The correct answer is D: Discontinue a new food that was added to the infant"s diet just prior to the rash

47. A mother brings her 26 month-old to the well-child clinic. She expresses frustration and anger due to her child's constantly saying "no" and his refusal to follow her directions. The nurse explains this is
normal for his age, as negativism is attempting to meet which developmental need?
A) Trust
B) Initiative
C) Independence
D) Self-esteem
The correct answer is C: Independence

48. Which behavioral characteristic describes the domestic abuser?
A) Alcoholic
B) Over confident
C) High tolerance for frustrations

D) Low self-esteem
The correct answer is D: Low self-esteem

49. Which statement by the client with chronic obstructive lung disease indicates an understanding of the major reason for the use of occasional pursed-lip breathing
A) "This action of my lips helps to keep my airway open."
B) "I can expel more when I pucker up my lips to breathe out."
C) "My mouth doesn't get as dry when I breathe with pursed lips."
D) "By prolonging breathing out with pursed lips the little areas in my lungs don't collapse."
The correct answer is D: "By prolonging breathing out with pursed lips my little areas in my lungs don"t collapse."

50. During the admission assessment on a client with chronic bilateral glaucoma, which statement by the client would the nurse anticipate since it is associated with this problem?
A) "I have constant blurred vision."
B) "I can't see on my left side."
C) "I have to turn my head to see my room."
D) "I have specks floating in my eyes."
The correct answer is C: "I have to turn my head to see my room."

51. A 19 year-old client is paralyzed in a car accident. Which statement used by the client would indicate to the nurse that the client was using the mechanism of "suppression"?
A) "I don't remember anything about what happened to me."
B) "I'd rather not talk about it right now."
C) "It's all the other guy's fault! He was going too fast."
D) "My mother is heartbroken about this."
The correct answer is A: "I don"t remember anything about what happened to me."

52. While caring for the client during the first hour after delivery, the nurse determines that the uterus is boggy and there is vaginal bleeding. What should be the nurse's first action?
A) Check vital signs
B) Massage the fundus
C) Offer a bedpan
D) Check for perineal lacerations
The correct answer is B: Massage the fundus