HESI Critical Care Exam Questions with Answers and Rationales||Rated A+||latest 2023/24.(all you need)

- A patientwith asthma receives a prescription for high blood pressure during a clinic visit. Which prescription should the nurse anticipate the patientto receive that is least likely toexacerbate asthma?
    - Carteolol (Ocupress).
    - Propranolol hydrochloride (Inderal).
    - Pindolol (Visken). **Incorrect**
    - Metoprolol tartrate (Lopressor). **Correct**

The best antihypertensive agent for clients with asthma is metoprolol (Lopressor) (C), a beta2 blocking agent which is also cardioselective and less likely to cause bronchoconstriction. Pindolol (A) is a beta2 blocker that can cause bronchoconstriction and increase asthmatic symptoms. Although carteolol (B) is a beta blocking agent and an effective antihypertensive agent used in managing angina, it can increase a client's risk for bronchoconstriction due to its nonselective beta blocker action. Propranolol (D) also blocks the beta2 receptors in the lungs, causing bronchoconstriction, and is not indicated in clients with asthma and other obstructive pulmonary disorders.

- A male patientwho has been taking propranolol (Inderal) for 18 months tells the nurse that the healthcare provider discontinued the medication because his blood pressure has been normal forthe past three months. Which instruction should the nurse provide?

- Obtain another antihypertensive prescription to avoid withdrawal symptoms.
- Stop the medication and keep an accurate record of blood pressure.
- Report any uncomfortable symptoms after stopping the medication.
- Ask the healthcare provider about tapering the drug dose over the next week. **Correct**

Although the healthcare provider discontinued the propranolol, measures to prevent rebound cardiac excitation, such as progressively reducing the dose over one to two weeks (C), should be recommended to prevent rebound tachycardia, hypertension, and ventricular dysrhythmias. Abrupt cessation (A and B) of the beta-blocking agent may precipitate tachycardia and rebound hypertension, so gradual weaning should be recommended. (D) is not indicated.

• A patientwho is taking clonidine (Catapres, Duraclon) reports drowsiness. Which additionalassessment should the nurse make?

- Has the patientexperienced constipation recently?
- Did the patientmiss any doses of the medication?
- How long has the patientbeen taking the medication? **Correct**
- Does the patientuse any tobacco products?

Drowsiness can occur in the early weeks of treatment with clonidine and with continued use becomes less intense, so the length of time the patienthas been on the medication (A) provides information to direct additional instruction. (B, C, and D) are not relevant.

4.ID: 6974873590

The nurse is preparing to administer atropine, an anticholinergic, to a patientwho is scheduled for a cholecystectomy. The patientasks the nurse to explain the reason for the prescribed medication.What response is best for the nurse to provide?

- Provide a more rapid induction of anesthesia.
- Induce relaxation before induction of anesthesia.
- Decrease the risk of bradycardia during surgery. **Correct**
- Minimize the amount of analgesia needed postoperatively.

Atropine may be prescribed preoperatively to increase the automaticity of the sinoatrial node and

prevent a dangerous reduction in heart rate (B) during surgical anesthesia. (A, C and D) do not address the therapeutic action of atropine use perioperatively.

5.ID: 6974876286

An 80-year-old patientis given morphine sulphate for postoperative pain. Which concomitant medication should the nurse question that poses a potential development of urinary retention inthis geriatric client?

- Antacids.
- Tricyclic antidepressants. **Correct**
- Nonsteroidal antiinflammatory agents.
- Insulin.

Drugs with anticholinergic properties, such as tricyclic antidepressants (C), can exacerbate urinary retention associated with opioids in the older client. Although tricyclic antidepressants and antihistamines with opioids can exacerbate urinary retention, the concurrent use of (A and B)

with opioids do not. Nonsteroidal antiinflammatory agents (D) can increase the risk for bleeding,

but do not increase urinary retention with opioids (D).

6.ID: 6974873559

A patientwith osteoarthritis is given a new prescription for a nonsteroidal antiinflammatory drug (NSAID). The patientasks the nurse, "How is this medication different from the acetaminophen I have been taking?" Which information about the therapeutic action of NSAIDs should the nurseprovide?

- Are less expensive.
- Provide antiinflammatory response. **Correct**
- Increase hepatotoxic side effects.
- Cause gastrointestinal bleeding.

Nonsteroidal antiinflammatory drugs (NSAIDs) have antiinflammatory properties (B), which relieves pain associated with osteoarthritis and differs from acetaminophen, a non-narcotic analgesic and antipyretic. (A) does not teach the patientabout the medication's actions. Although NSAIDs are irritating to the gastrointestinal (GI) system and can cause GI bleeding (C), instructions to take with food in the stomach to manage this as an expected side effect should be included, but this does not answer the client's question. Acetaminophen is potentially hepatotoxic

- , not NSAIDs.

7.ID: 6974876262

A patientwith cancer has a history of alcohol abuse and is taking acetaminophen (Tylenol) forpain. Which organ function is most important for the nurse to monitor?

- Cardiorespiratory.
- Liver. **Correct**
- Sensory.
- Kidney.

Acetaminophen and alcohol are both metabolized in the liver. This places the patientat risk for hepatotoxicity, so monitoring liver (A) function is the most important assessment because the combination of acetaminophen and alcohol, even in moderate amounts, can cause potentially fatal liver damage. Other non-narcotic analgesics, such as n onsteroidal anti-inflammatory drugs (NSAIDs), are more likely to promote adverse renal effects (B). Acetaminophen does not place the patientat risk for toxic reactions related to (C or D).

8.ID: 6974875110

The nurse obtains a heart rate of 92 and a blood pressure of 110/76 prior to administering a scheduled dose of verapamil (Calan) for a patientwith atrial flutter. Which action should the nurseimplement?

- Give intravenous (IV) calcium gluconate.
- Withhold the drug and notify the healthcare provider.
- Administer the dose as prescribed. **Correct**
- Recheck the vital signs in 30 minutes and then administer the dose.

Verapamil slows sinoatrial (SA) nodal automaticity, delays atrioventricular (AV) nodal conduction, which slows the ventricular rate, and is used to treat atrial flutter, so (A) should be

implemented, based on the client's heart rate and blood pressure. (B and C) are not indicated. (D)

delays the administration of the scheduled dose.

9.ID: 6974873583

A patientis admitted to the hospital with a diagnosis of Type 2 diabetes mellitus and influenza.Which categories of illness should the nurse develop goals for the client's plan of care?

- One chronic and one acute illness. **Correct**
- Two acute illnesses.
- One acute and one infectious illness. **Incorrect**
- Two chronic illnesses.

The plan of care should include goals that are specific for chronic and acute illnesses. Adult-onset diabetes is a life-long chronic disease, whereas influenza is an acute illness with a short term duration (C). (A, B, and D) do not include the correct duration categories for this situation.

10.ID: 6974877914

Following an emergency Cesarean delivery, the nurse encourages the new mother to breastfeedher newborn. The patientasks why she should breastfeed now. Which information should the nurse provide?

- Stimulate contraction of the uterus. **Correct**
- Initiate the lactation process.
- Facilitate maternal-infant bonding.

- Prevent neonatal hypoglycemia.

When the infant suckles at the breast, oxytocin is released by the posterior pituitary to stimulates

the "letdown" reflex, which causes the release of colostrum, and contracts the uterus (C) to prevent uterine hemorrhage. (A and B) do not support the client's need in the immediate period after the emergency delivery. Although maternal-newborn bonding (D) is facilitated by early breastfeeding, the priority is uterine contraction stimulation.

11.ID: 6974875104

Which intervention should the nurse include in the plan of care for a female patientwith severepostpartum depression who is admitted to the inpatient psychiatric unit?

- Restrict visitors who irritate the client.
- Full rooming-in for the infant and mother.
- Supervised and guided visits with infant. **Correct**
- Daily visits with her significant other.

Structured visits (C) provide an opportunity for the mother and infant to bond and should be facilitated and encouraged according to the client's pace of progress. (A) is unrealistic and may not be safe for the baby or the client. (B) is an unrealistic expectation. Although daily visits may provide support, the significant other may not be able to be there every day (D) based on other family responsibilities.

12.ID: 6974873535

A 16-year-old male patientis admitted to the hospital after falling off a bike and sustaining a fractured bone. The healthcare provider explains the surgery needed to immobilize the fracture.Which action should be implemented to obtain a valid informed consent?

- Obtain the permission of the custodial parent for the surgery. **Correct**
- Notify the non-custodial parent to also sign a consent form.
- Instruct the patientsign the consent before giving medications.
- Obtain the signature of the client's stepfather for the surgery. **Incorrect**

The patientis a minor and cannot legally sign his own consent unless he is an emancipated minor,

so the consent should be obtained from the guardian for this client, which is the custodial parent

- (A) is not a legal option. A stepparent is not a legal guardian for a minor unless the child has

been adopted by the stepparent (C). The non-custodial parent does not need to co-sign this form (D).

13.ID: 6974876258

During a patientassessment, the patientsays, "I can't walk very well." Which action should thenurse implement first?

- Predict the likelihood of the outcome.
- Consider alternatives.
- Choose the most successful approach.
- Identify the problem. **Correct**

The sequential steps in problem-solving are to first identify the problem (B), then consider alternatives (C), consider outcomes of the alternatives (D), predict the likelihood of the outcomes

occurring, and choose the alternative with the best chance of success (A).

14.ID: 6974875112

The nurse identifies a client's needs and formulates the nursing problem of, "Imbalanced nutrition: less than body requirements, related to mental impairment and decreased intake, asevidenced by increasing confusion and weight loss of more than 30 pounds over the last 6 months." Which short-term goal is best for this client?

- Verbalize understanding of plan and of intention to eat meals.
- Eat 50% of six small meals each day by the end of one week. **Correct**
- Meals prepared during hospitalization will be fed by the nurse.
- Demonstrate progressive weight gain toward the ideal weight.

Short-term goals should be realistic and attainable and should have a timeline of 7 to 10 days before discharge. (A) meets those criteria. (B) is nurse-oriented. (C) may be beyond the capabilities of a confused client. (D) is a long-term goal.

15.ID: 6974873569

A male patientis angry and is leaving the hospital against medical advice (AMA). The patientdemands to take his chart with him and states the chart is "his" and he doesn' t want any morecontact with the hospital. How should the nurse respond?

- This hospital does not need to keep it if you are leaving and not returning here.
- Because you are leaving against medical advice, you may not have your chart.
- The information in your chart is confidential and cannot leave this facilitylegally.

- The chart is the property of the hospital but I will see that a copy is made for you.

Correct

The chart is the property of the facility, but the patienthas a legal right to the information in it, even if he is leaving AMA, so a copy of the record (D) should be provided. The patientdoes not lose his legal rights to his medical record if he leaves AMA (A). The medical record is confidential, but the hospital protects the client's privacy by not allowing unauthorized access to the record, so the hospital may provide the patientwith a copy (B). The hospital must maintain records of the care provided and should not release the original record (C).

16.ID: 6974877906

The nurse manager is assisting a nurse with improving organizational skills and time management. Which nursing activity is the priority in pre-planning a schedule for selectednursing activities in the daily assignment?

- Tracheostomy tube suctioning. **Incorrect**
- Medication administration. **Correct**
- Colostomy care instruction.
- patientpersonal hygiene.

In developing organizational skills, medication administration is based on a prescribed schedule that is time-sensitive in the delivery of nursing care and should be the priority in scheduling nursing activities in a daily assignment. Although suctioning a client's tracheostomy takes precedence in providing care, the client's PRN need is less amenable to a preselected schedule. (B and C) can be scheduled around time-sensitive delivery of care.

17.ID: 6974876220

What nursing delivery of care provides the nurse to plan and direct care of a group of clients overa 24-hour period?

- Case management.
- Team nursing. **Incorrect**
- Primary nursing. **Correct**
- Functional nursing.

Primary nursing (B) is a model of delivery of care where a nurse is accountable for planning care

for clients around the clock. Functional nursing (D) is a care delivery model that provides client care by assignment of functions or tasks. Team nursing (A) is a care delivery model where assignments to a group of clients are provided by a mixed-staff team. Case management (C) is the delivery of care that uses a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs and promote quality cost-effective outcomes.

18.ID: 6974876280

Two unlicensed assistive personnel (UAP) are arguing on the unit about who deserves to take a break first. What is the most important basic guideline that the nurse should follow in resolvingthe conflict?

- Require the UAPs to reach a compromise.
- Weigh the consequences of each possible solution. **Incorrect**
- Encourage the two to view the humor of the conflict.
- Deal with issues and not personalities. **Correct**

Dealing with the issues which are concrete, not personalities (A) which include emotional reactions, is one of seven important key behaviors in managing conflict. (B, C, and D) do not resolve the conflict when diverse opinions are expressed emotionally.

19.ID: 6974873531

The nurse is caring for a patientwho is unable to void. The plan of care establishes an objectivefor the patientto ingest at least 1000 mL of fluid between 7:00 am and 3:30 pm. Which patientresponse should the nurse document that indicates a successful outcome?

- Demonstrates adequate fluid intake and output.
- Verbalizes abdominal comfort without pressure.
- Drinks 240 mL of fluid five times during the shift. **Correct**
- Voids at least 1000 mL between 7 am and 3 pm.

The nurse should evaluate the client's outcome by observing the client's performance of each expected behavior, so drinking 240 mL of fluid five or six times during the shift (D) indicates a fluid intake of 1200 to 1440 mL, which meets the objective of at least 1000 mL during the designated period. (A) uses the term "adequate," which is not quantified. (B) is not the objective,

which establishes an intake of at least 1000 mL. (C) is not an evaluation of the specific fluid intake.

20.ID: 6974873553

The nurse plans a teaching session with a patientbut postpones the planned session based onwhich nursing problem?

- Knowledge deficit regarding impending surgery.

- Ineffective management of treatment regimen.
- Activity intolerance related to postoperative pain. **Correct**
- Noncompliance with prescribed exercise plan.

Pain, fatigue, or anxiety can interfere with the ability to pay attention and participate in learning, so the nursing diagnosis in (A) indicates a need to postpone teaching. (B, C, and D) indicate a need for instruction.

21.ID: 6974875106

A patientwho has active tuberculosis (TB) is admitted to the medical unit. What action is mostimportant for the nurse to implement?

- Fit the patientwith a respirator mask.
- Assign the patientto a negative air-flow room. **Correct**
- Don a clean gown for patientcare.
- Place an isolation cart in the hallway.

Active tuberculosis requires implementation of airborne precautions, so the patientshould be assigned to a negative pressure air-flow room (D). Although (A and C) should be implemented for clients in isolation with contact precautions, it is most important that air flow from the room is minimized when the patienthas TB. (B) should be implemented when the patientleaves the isolation environment.

22.ID: 6974873585

A patientis receiving atenolol (Tenormin) 25 mg PO after a myocardial infarction. The nursedetermines the client's apical pulse is 65 beats per minute. What action should the nurse implement next?

- Measure the blood pressure.
- Reassess the apical pulse.
- Notify the healthcare provider.
- Administer the medication. **Correct**

Atenolol, a beta-blocker, blocks the beta receptors of the sinoatrial node to reduce the heart rate, so the medication should be administered (C) because the client's apical pulse is greater than 60. (A, B, and D) are not indicated at this time.

23.ID: 6974875175

The nurse is assessing a patientand identifies a bruit over the thyroid. This finding is consistentwith which interpretation?

- Hypothyroidism.
- Thyroid cyst.
- Thyroid cancer.
- Hyperthyroidism. **Correct**

Hyperthyroidism (D) is an enlargement of the thyroid gland, often referred to as a goiter, and a bruit may be auscultated over the goiter due to an increase in glandular vascularity which increases as the thyroid gland becomes hyperactive. A bruit is not common with (A, B, and C).

24.ID: 6974876270

A 6-year-old child is alert but quiet when brought to the emergency center with periorbitalecchymosis and ecchymosis behind the ears. The nurse suspects potential child abuse and continues to assess the child for additional manifestations of a basilar skull fracture. Whatassessment finding would be consistent with a basilar skull fracture?

- Hematemesis and abdominal distention.
- Asymmetry of the face and eye movements.
- Rhinorrhoea or otorrhoea with Halo sign. **Correct**
- Abnormal position and movement of the arm.

Raccoon eyes (periorbital ecchymosis) and Battle's sign (ecchymosis behind the ear over the mastoid process) are both signs of a basilar skull fracture, so the nurse should assess for possible meningeal tears that manifest as a Halo sign with CSF leakage from the ears or nose (D). (A) is consistent with orbital fractures. (B) occurs with wrenching traumas of the shoulder or arm fractures. (C) occurs with blunt abdominal injuries.

25.ID: 6974873555

The nurse is assessing a patientwho complains of weight loss, racing heart rate, and difficultysleeping. The nurse determines the patienthas moist skin with fine hair, prominent eyes, lid retraction, and a staring expression. These findings are consistent with which disorder?

- Grave's disease. **Correct**
- Multiple sclerosis.
- Addison's disease.

- Cushing syndrome.

This patientis exhibiting symptoms associated with hyperthyroidism or Grave's disease (A), which is an autoimmune condition affecting the thyroid. (B, C, and D) are not associated with these symptoms.

26.ID: 6974875146

The nurse is assessing an older patientand determines that the client's left upper eyelid droops,covering more of the iris than the right eyelid. Which description should the nurse use to document this finding?

- A nystagmus on the left.
- Exophthalmos on the right.
- Ptosis on the left eyelid. **Correct**
- Astigmatism on the right.

Ptosis is the term to describe an eyelid droop that covers a large portion of the iris (A), which may result from oculomotor nerve or eyelid muscle disorder. (B) is characterized by rapid, rhythmic movement of both eyes. (C) is a distortion of the lens of the eye, causing decreased visual acuity. (D) is a term used to describe a protrusion of the eyeballs that occurs with hyperthyroidism.

27.ID: 6974875126

The nurse is assessing a child's weight and height during a clinic visit prior to starting school. The nurse plots the child's weight on the growth chart and notes that the child's weight is in the95th percentile for the child's height. What action should the nurse take?

- Question the type and quantity of foods eaten in a typical day. **Correct**
- Encourage giving two additional snacks each day to the child.
- Recommend a daily intake of at least four glasses of whole milk.
- Assess for signs of poor nutrition, such as a pale appearance.

The child is overweight for height, so assessment of the child's daily diet (C) should be determined. The child does not need (A or B), both of which will increase the child's weight. Poor nutrition (D) is commonly seen in underweight children, not overweight.

28.ID: 6974876202

A child is receiving maintainance intravenous (IV) fluids at the rate of 1000 mL for the first 10 kg of body weight, plus 50 mL/kg per day for each kilogram between 10 and 20. How many milliliters per hour should the nurse program the infusion pump for a child who weighs 19.5 kg?(Enter numeric value only. If rounding is required, round to the nearest whole number.)

- 24 **Incorrect**
- 61 **Correct**
- 73
- 58

The formula for calculating daily fluid requirements is: 0 to 10 kg, 100 mL/kg per day; or 10 to 20 kg, 1000 mL for the first 10 kg of body weight plus 50 mL/kg per day for each kilogram between 10 and 20. To determine an hourly rate, divide the total milliliters per day by 24. 19.5 kg x 50 mL/kg = 475 mL + 1000 mL = 1475 mL / 24 hours = 61 mL/hour

29.ID: 6974877920

The nurse obtains the pulse rate of 89 beats/minute for an infant before administering digoxin(Lanoxin). Which action should the nurse take?

- Withhold the medication and contact the healthcare provider. **Correct**
- Give the medication dosage as scheduled.
- Assess respiratory rate for one minute next.
- Wait 30 minutes and give half of the dosage of medication.

Bradycardia is an early sign of digoxin toxicity, so if the infant's pulse rate is less than 100 beats/minute, digoxin should be withheld and the healthcare provider should be notified (D). Assessing the respiratory rate (A) is not indicated before administering Lanoxin. (B and C) place the infant at further risk for digoxin toxicity.

30.ID: 6974873567

The nurse is developing a teaching plan for an adolescent with a Milwaukee brace. Whichinstruction should the nurse include?

- Wear the brace over a T-shirt 23 hours per day. **Correct**
- Dress with the brace over regular clothing.
- Shower with the brace directly against the skin.
- Remove the brace just before going to bed.

Idiopathic scoliosis is an abnormal lateral curvature of the spine in adolescent females. Early treatment uses a Milwaukee brace that places pressure against the lateral spinal curvature, under the neck, and against the iliac crest, so it should be worn for 23 hours per day over a T-shirt (D)

which reduces friction and chafing of the skin. (A, B, and C) reduce the effectiveness of the brace.

31.ID: 6974873594

A 9-year-old is hospitalized for neutropenia and is placed in reverse isolation. The child asks the nurse, "Why do you have to wear a gown and mask when you are in my room?" How should thenurse respond?

- “To protect you because you can get an infection very easily.” **Correct**
- "Your condition could be spread to staff and other clients in the hospital.”
- “There are many forms of bacteria and germs in the hospital.”
- “After taking medication for 24 hours a gown and mask won't be needed.”

Reverse isolation precaution implement measures to protect the patientfrom exposure to microorganisms from others (B). Although microbes are prevalent in all environments, (A) does not adequately answer the child's question. Reverse isolation should be implemented until the client's white blood cell increases (C). Neutropenia in this child does not place others (D) at risk for infection.

32.ID: 6974876230

The nurse is giving discharge instructions to the parents of a newborn with a prescription for home phototherapy. Which statement by a parent indicates understanding of the phototherapy?

- “I should leave the baby under the light all of the time.”
- “I should dress the baby in light clothing when the baby is under the light.”

- "I need to change the baby's position every four hours."
- "I will keep the baby's eyes covered when the baby is under the light."**Correct**

Neonatal jaundice is related to subcutaneous deposition of fat-soluble (indirect) bilirubin, which is converted to a water-soluble form when the skin is exposed to an ultraviolet light, so the infant's eyes should be protected (C) by closing the eyes and placing patches over them before placing the baby under the phototherapy light source. The baby's position should be changed about every two hours, not (A), so that the light reaches all areas of the body to promote conversion to a water-soluble form of bilirubin, which is excreted in the urine. The infant can be removed from the light for feedings and diaper changes, but should receive phototherapy exposure for 18 hours a day (B). The baby should be naked or dressed in only a diaper to expose as much skin as possible to the light (D).

33.ID: 6974876242

A male patientwho had abdominal surgery has a nasogastric tube to suction, oxygen per nasal cannula, and complains of dry mouth. Which action should the nurse implement?

- Apply a water soluble lubricant to the lips, oral mucosa and nares.**Correct**
- Put petroleum jelly on the lips and around the nasogastric tube.
- Offer the patientice chips and instruct patientto spit out the water.
- Allow the patientto drink water and record on the I and O record.

To ease the client's discomfort, a water soluble lubricant to the lips and nares assists to keep the mucous membranes moist (D). (A) is a petroleum-based product and should not be used because it is flammable. (B and C) should not be given to the patientwith a nasogastric tube to suction