front 1

An ambulatory client calls the clinic to report edema around both ankles and feet during the day that disappears while sleeping at night. Which is an appropriate follow-up question for the nurse to ask?

"Have you been using more pillows to sleep comfortably?"

"Do you smoke or use other tobacco products?"

"Have you had a recent heart attack?"
"Do you become short of breath during your normal daily activities?"

back 1

"Do you become short of breath during your normal daily activities?"

The client is reporting a possible finding of heart failure, which can impair a person's normal daily function. The nurse's first question should focus on the client's functional ability as this would also be consistent with heart failure. Although it would be helpful to ask about the use of more pillows when sleeping, this is a finding that usually occurs after the development of dyspnea on exertion. The other options may be helpful, but they are not the primary focus.

front 2

The licensed practical nurse (LPN) is assigned to a client who is receiving intravenous potassium replacement. Which finding indicates that the LPN needs to advise the registered nurse (RN) to evaluate the client's potassium replacement?

Pain radiating down the outer part of the client's arm

Reports of abdominal pain and cramping

Repeated arrhythmia alarms on the monitor

Fast and bounding pulse

back 2

Repeated arrhythmia alarms on the monitor

Hyperkalemia may result in cardiac rhythm abnormalities. Moderate hyperkalemia can result in changes to the ECG monitor and set off the alarm. Pain down the outer arm is less likely cardiac in origin; cardiac pain is typically down the inside of the arm. Abdominal cramps or pain is more characteristic of low serum potassium levels. Bradycardia and a weak pulse are serious symptoms of hyperkalemia.

front 3

The nurse is collecting data on a client with portal hypertension. Which finding should the nurse expect?

Obesity

Blurred vision

Ascites

Expiratory wheezes

back 3

Ascites

Portal hypertension can occur in a client with right-sided heart failure or cirrhosis of the liver. Portal hypertension can lead to the accumulation of fluid in the peritoneal cavity (ascites) due to the increased portal pressure as well as a lowered osmotic pressure. Ascites can lead to shortness of breath, not expiratory wheezing.

front 4

A client is admitted in respiratory alkalosis after ingesting excessive amounts of aspirin. The nurse should recognize that respiratory alkalosis was most likely caused by which of the following findings?

Minimal use of accessory muscles

Diminished respiratory effort

Temperature of 96.8 F (36 C)

Respiratory rate of 34

back 4

Respiratory rate of 34

Stimulation of respiratory center leads to hyperventilation. Thus, decreased CO_2 levels result in respiratory alkalosis. Associate a fast respiratory rate with the loss of CO_2 and a loss of acid; the loss of acid results in alkaline states. Hypoventilation will cause respiratory acidosis.

front 5

The nurse detects blood-tinged fluid leaking from the nose and ears of a client diagnosed with head trauma. What is the appropriate nursing action?

Pack the nose and ears with sterile gauze

Position an ice pack at the back of the neck

Put manual pressure on the sites that are draining

Apply bulky, loose sterile dressings to the nose and ears

back 5

Apply bulky, loose sterile dressings to the nose and ears

Applying bulky, loose sterile dressings to the nose and ears permits the fluid to drain while providing a visual reference for the amount of drainage. With the history of trauma and locations of drainage, this may be cerebrospinal fluid (CSF). The drainage should be tested for glucose; if it's positive for glucose, the drainage would contain cerebrospinal fluid and the client would be at risk for a cerebral infection. The nurse should contact the RN charge nurse with these findings.

front 6

A neonate born 12 hours ago to a methadone-maintained woman is exhibiting a hyperactive Moro reflex and slight tremors. The newborn passed one loose, watery stool. Which action is a nursing priority?

Administer the ordered PRN paregoric to stop the diarrhea

Observe for neonatal abstinence syndrome

Offer fluids to prevent dehydration

Hold the infant at frequent intervals

back 6

Observe for neonatal abstinence syndrome

Neonatal abstinence syndrome (NAS) is a cluster of findings that signal the withdrawal of the infant from the opiates. The findings seen in methadone withdrawal are often more severe than for other substances. Initial findings are central nervous system hyperirritability and gastrointestinal findings. If withdrawal signs are severe, mortality risk is increased. Close monitoring of the infant ensures proper treatment during the period of withdrawal

front 7

A 72-year old client reports having discomfort immediately after a below-the-knee amputation. Which initial action by the nurse is most appropriate?

Wrap the stump snugly in an elastic bandage

Ensure that the stump is elevated

Administer opioid narcotics as ordered

Conduct guided imagery or distraction

back 7

Ensure that the stump is elevated

Elevating the stump is the priority intervention for the first 24 hours after surgery. This will help prevent pressure due to postoperative swelling, which will minimize pain or discomfort. Without this action, a firm elastic bandage, opioid narcotics, or guided imagery will have little effect. Analgesics appropriate to the level of pain should be administered as needed in the postoperative period to promote client comfort. After the first day, the residual limb should be flat on the bed.

front 8

The nurse is making rounds at the beginning of the shift and asks how each client is feeling. Which statement made by a client would require immediate action by the nurse?

"I feel pressure in the middle of my chest like an elephant is sitting on my chest."

"When I take in a deep breath, it stabs like a knife."

"When I turn in bed to reach the remote for the TV, my chest hurts."

"The pain came on after dinner. That soup seemed very spicy."

back 8

"I feel pressure in the middle of my chest like an elephant is sitting on my chest."

This is a classic description of chest pain in men caused by myocardial ischemia, requiring immediate assessment and intervention to prevent possible damage to the heart muscle. Pain after spicy food is often the result of irritation and gastric indigestion. The pain with a deep breath is typically from an inflammation of the pleural covering of the lung, called pleurisy. Pain with movement of the chest, such as turning in bed, is typically caused by costochondritis, which is inflammation of the cartilage between the ribs and the sternum, and can be reproduced by palpation of the the painful area.

front 9

The practical nurse (PN) is collecting data on a 1 month-old infant in the emergency department. Which finding should the nurse report to the registered nurse (RN) immediately?

Inspiratory grunting

Abdominal respirations

Increased heart rate with crying

Irregular breathing rate

back 9

Inspiratory grunting

Inspiratory grunting is abnormal and may be a sign of respiratory distress in this infant. The other options are expected findings in newborns.

front 10

The client is diagnosed with infective endocarditis (IE) and has been receiving antibiotic therapy for four days. Which finding suggests that the antibiotic therapy has not been effective and must be reported to the health care provider (HCP) immediately?

Temperature of 103 F (39.5 C)

Muscle tenderness

Streaks of red under the nails

Nausea with vomiting

back 10

Temperature of 103 F (39.5 C)

Findings of IE include skin rash (petechiae) and small areas of bleeding (splinter hemorrhages) under the fingernails. Muscle or joint pain or weakness are also common symptoms of IE. Nausea and vomiting may be side effects of the treatment; these findings probably would have appeared shortly after beginning treatment. Prolonged fever after 72 hours of antibiotic therapy indicates the antibiotic regime is not effective against the strain of microorganism - the nurse must call the HCP about this finding. Surgical intervention may be indicated for persistent sepsis after 72 hours of appropriate antibiotic treatment.

front 11

A client completes a fecal occult blood screening and the results come back positive. Which factor could have influenced this outcome? (Select all that apply.)
Teeth cleaning during regular dental visit

Aspirin (ASA) therapy

Eating green, leafy vegetables

Recent use of corticosteroids

Eating a steak dinner

Drinking fruit juices that contain vitamin C

back 11

Teeth cleaning during regular dental visit

Aspirin (ASA) therapy

Recent use of corticosteroids

Eating a steak dinner

Eating red meat, NSAIDs and steroid use can cause a false positive result; even bleeding gums can cause a false positive result. Using vitamin C supplements and fruit juices can cause a false negative result (because it interferes with the chemical reaction that indicates blood is present.) The test should be repeated and the client should be given specific instructions about special dental, dietary and drug restrictions.

front 12

The nurse is preparing a client scheduled for an intravenous pyelogram (IVP). What is the most important factor to be obtained by the nurse prior to the procedure?

Allergy history

Measurement of urine output

Time of the last meal

Comparison of the radial pulses

back 12

Allergy history

The nurse should review any allergies with the client, especially a reaction to previous tests using contrast media. The elderly and those with diabetes and/or heart disease are at greater risk of developing kidney failure following administration of the dye. To avoid this complication, kidney function should be tested (creatinine). The client may be instructed to use a laxative or enema prior to the test and to be NPO for 8-12 hours before the test is done. The client should void prior to the procedure.

front 13

A nurse is caring for a client who was recently admitted following an episode of status epilepticus. Which of the following data is most important to collect?

Level of consciousness (LOC)

Injuries to the extremities

Amount of intravenous fluid infused

Pulse and respiration

back 13

Level of consciousness (LOC)

Cerebral blood flow undergoes a significant increase during seizure activity with a depletion of oxygen at the neuronal level. Cerebral anoxia may result in progressive brain tissue injury and destruction. The nurse should continuously monitor the client's LOC. Even when seizures are controlled, the client may be unconscious for a period of time. Note that this is a neurological question and requires a neurological answer and monitoring LOC is the only neurological response.

front 14

An x-ray initially confirms the placement of a nasogastric (NG) feeding tube in the stomach. The nurse is now preparing to administer a medication through the tube. What action will the nurse take to verify tube placement?

Place the end of the tube in water and observe for bubbling

Auscultate for the sound of air produced by forcing air through the NG tube

Measure the pH of aspirated gastric contents

Assess for client coughing during administration of the medication

back 14

Measure the pH of aspirated gastric contents

Bubbling or coughing would indicate the possibility of the tube being in the airway, but neither are used to determine placement in the stomach. Forcing air through the NG tube and auscultating the abdomen for the sound of the air is an unreliable method to determine tube placement. Measuring the pH of aspirated stomach contents confirms gastric placement.

front 15

A respiratory therapist (RT) is collecting an arterial blood gas (ABG) sample. The RT must respond to an emergency and asks the nurse to manage the puncture site. Which actions should be completed? (Select all that apply.)

Apply snug gauze and secure with tape

Check for distal capillary refill

Thoroughly wash the site with saline, then apply an antibacterial solution

Apply pressure for 5 to 10 minutes

Remove dressing in one hour

back 15

Apply snug gauze and secure with tape

Check for distal capillary refill

Apply pressure for 5 to 10 minutes

Five to 10 minutes of pressure ensures adequate coagulation at the site. Checking capillary refill indicates if there are any changes to blood flow to the hand. The dressing can be removed prior to the next stick or within 24 hours.

front 16

A nurse notes that a 2 year-old child recovering from a tonsillectomy has a temperature of 98.2 F (36.7 C) at 11:00 am. At 1:00 pm the child's parent reports that the child "feels very warm" to touch. What should the nurse do first?

Reassess the child's temperature

Reassure the parent that this is normal

Offer the child cold oral fluids

Administer the prescribed acetaminophen

back 16

Reassess the child's temperature

The nurse should listen to and show respect for what the parent is saying, because the parent is more sensitive to the variations in the child's condition. However, the nurse knows that a low-grade fever (99-101 F or 37.2-38.3 C) is common after surgery, which is why the nurse should first reassess the temperature before implementing any intervention. Usually the surgeon is contacted if the temperature is higher than 101.5 F (38.6 C).

front 17

The 55 year-old female is scheduled for abdominal surgery. Which factor in the client's history indicates that the client is at risk for thrombus formation in the postoperative period?

Estrogen replacement therapy for the past three years

History of acute hepatitis A

Hypersensitivity to heparin 20 years ago

10 percent less than ideal body weight for past year

back 17

Estrogen replacement therapy for the past three years

Post-menopausal women using hormone replacement therapy have a higher risk of deep vein thrombosis and pulmonary embolism. The estrogen in hormone replacement therapy (and in birth control pills) can increase clotting factors in the blood, especially if the woman is a smoker and/or overweight. The other information in the client's history is unremarkable for postoperative complications.

front 18

The nurse is assisting with the admission of a toddler who had a seizure at home. Which statement by the child's parent would be important in determining the etiology of the seizure?

"My child was diagnosed with an ear infection two days ago."

"My child has been drinking more liquids than usual."

"My child has been eating more red meat lately."

"My child has been taking long naps for a week."

back 18

"My child was diagnosed with an ear infection two days ago."

Contributing factors of seizures in children include age (more common in the first two years of life), infections (late infancy and early childhood), fatigue, not eating properly and excessive fluid intake or fluid retention. Although drinking more fluids may be an indication of infection, the statement that the child has an active infection is the best response.

front 19

An older adult client diagnosed with active tuberculosis has difficulty in appropriately coughing up secretions for a sputum specimen. Which nursing intervention might be the most helpful at this time?

Force fluids for the next eight hours

Spray the oropharynx with saline

Ask the client to drink a warm liquid

Have the client sit up on the side of the bed

back 19

Have the client sit up on the side of the bed

Correct!Placing the client in sitting position will promote lung expansion and effective coughing, facilitating the sputum specimen collection. While drinking liquids helps to loosen secretions over time, they should not be given when collecting a specimen. Spraying the throat with saline may cause irritation, coughing, and reduce oxygenation. The specimen needs to come from deep in the lungs, not the nose or mouth.

front 20

A client is receiving heparin and warfarin (Coumadin) after a total hip replacement. Lab results show an international normalized ratio (INR) of 5.5. Which action should the nurse consider as a priority?

Check the prior INR reports

Stop the warfarin

Notify the health care provider (HCP)

Check for bruising or bleeding

back 20

Notify the health care provider (HCP)

INR is used to evaluate the therapeutic effectiveness of warfarin. The therapeutic range for INR is 2 to 3; a client with a 5.5 INR is at risk for bleeding (and the nurse will probably find bleeding with an INR at this level). The warfarin should be held until the nurse has communicated with the HCP. Because the half-life of warfarin is about 40 hours, there is no need to stop it prior to notifying the provider. Heparin has no influence on an INR.

front 21

The client is admitted with a diagnosis of ulcerative colitis. Which laboratory values should the nurse be sure to check? (Select all that apply.)

Hematocrit and hemoglobin

Albumin

T3 and T4 count

White blood cell count (WBC)

Blood urea nitrogen (BUN)

Erythrocyte sedimentation rate (ESR)

back 21

White blood cell count (WBC)

Hematocrit and hemoglobin

Albumin

Erythrocyte sedimentation rate (ESR)

Decreased hematocrit and hemoglobin may reveal the client has anemia as a result of the bloody diarrhea characteristic of this inflammatory bowel disease A low protein albumin level would indicate that the client is experiencing a nutritional deficit due to malabsorption. Increased numbers of white blood cells and an elevated erythrocyte sedimentation rate (ESR) indicate active inflammation. Blood urea nitrogen is related to kidney function and T3 and T4 are related to thyroid function; these lab values do not provide information related to the diagnosis.

front 22

A client is scheduled for a CT scan with contrast. What interventions should be taken by the nurse prior to sending the client to the imaging department? (Select all that apply.)

Reassess the client's allergies

Ensure the client is well-hydrated

Ask the client to remove all metal jewelry

Confirm that a signed consent is in the chart

Administer prescribed medication to sedate the client

back 22

Reassess the client's allergies

Ask the client to remove all metal jewelry

Confirm that a signed consent is in the chart

Usually the client is NPO prior to a CT scan, particularly when contrast material is being used. Allergies and past reactions to contrast media should be reviewed with the client. Any metal, including body piercings, jewelry, hearing aids and removable dental work should be removed and safely stored prior to the test. Sedation is necessary only in cases of extreme anxiety.

front 23

Following a surgical procedure, a pneumatic compression device is applied to the adult client. The client reports that the device is hot and the client is sweating and itching. Which of the following steps should the nurse take? (Select all that apply.)

Collaborate with health care provider for anti-embolism stockings to be worn under the sleeves of the device

Explain that the health care provider ordered the device and it cannot be removed

Confirm pressure setting of 45 mm Hg

Check for appropriate fit

Inform the client that removing the device will likely result in the formation of deep vein thrombosis

back 23

Collaborate with health care provider for anti-embolism stockings to be worn under the sleeves of the device

Confirm pressure setting of 45 mm Hg

Check for appropriate fit

In any situation in which a client has discomfort associated with a medical device, the nurse should ensure it is applied correctly and functioning safely. The usual safe and effective pressure range is 35 to 55 mm Hg. Explanations to the clients should support their informed decision-making capabilities and should not be phrased to intimidate or remove client autonomy. Applying anti-embolism stockings under the disposable sleeves of the device may help with the sweating and itching.

front 24

The order states: acetaminophen suspension 6 mL by mouth four times a day. The label on the container states: acetaminophen 80 mg per 5 mL. How many milligrams will the nurse administer?

back 24

96mg.

6 mL/1 x 80 mg/5 mL = 480/5 = 96 mg

Or

Ratio:
80 mg/5 mL = x/6 mL
5x = 480
x = 96 mg

front 25

A client diagnosed with Raynaud's disease and hypertension is prescribed nifedipine (Procardia). Which finding would indicate that the client may be having a side effect of the medication?

Facial flushing

Cyanosis of the lips

Decreased urinary output

Increased pain in fingers

back 25

Facial flushing

Treatment for Raynaud's and for hypertension is the use of a vasodilator such as nifedipine. As a result of the vasodilating effect facial flushing can occur. Cyanosis of the lips is not a documented finding. The urinary output may increase due to the vasodilation and the resulting increased blood flow through the kidneys. The pain in the fingers should decrease.

front 26

A client receives 3 units of insulin lispro at 11:00 am to cover a blood glucose finger stick of 322 mg/dL (17.89 mmol/L). When can the nurse expect this type of insulin to begin to act?

12 noon

3:00 pm

1:00 pm

11:15 am

back 26

11:15 am

The onset of action and peak for lispro (Humalog), a rapid-acting insulin is about 10 to 15 minutes. Other rapid-acting insulins are insulin aspart (NovoLog) and insulin glulisine (Apidra).

front 27

A client has been taking alprazolam for three days. Data collection by the nurse should reveal which expected effect of the medication?

Sedation, analgesia

Relief of insomnia, phobias

Diminished tachycardia, tremors associated with anxiety

Tranquilization, numbing of emotions

back 27

Tranquilization, numbing of emotions

Most antianxiety medications, such as alprazolam (Xanax), work quickly. They produce tranquilizing effects and may numb the emotions. Don't forget that if part of an answer is incorrect, the entire answer is incorrect. The three incorrect options each contain incorrect information (analgesia, phobias and tachycardia). Also note that the question is asking for "expected effects" and not side effects.

front 28

A client calls the clinic and states to the triage nurse: "I had an upset stomach and took Pepto-Bismol and now my tongue looks black. What's happening to me?" What would be the nurse's best response?

"This is a common and temporary side effect of this medication."

"Are your stools also black?"

"How long have you had an upset stomach?"

"Come to the clinic so you can be seen by the health care provider."

back 28

"This is a common and temporary side effect of this medication."

The best response would be to explain that a dark tint of the tongue is a common and temporary side effect of bismuth subsalicylate (Pepto-Bismol). Although it may also turn stools a darker color, do not confuse this with black, tarry stools, which is a sign of bleeding in the intestinal tract. After addressing the client's initial concern and the reason for the call, the nurse can ask about the upset stomach and then ask the client to come to the clinic if necessary.

front 29

A nurse notes an abrupt onset of confusion in an 85 year-old client. Which recently ordered medication would most likely have contributed to this change in mental status?

Anticoagulant

Antihistamine

Beta blocker

Thrombolytic

back 29

Antihistamine

Older adults are susceptible to the side effect of anticholinergic medications, such as antihistamines. Antihistamines often cause confusion, especially at higher doses. In fact, first-generation antihistamines are included in the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.

front 30

A client is recovering from hip replacement and is taking acetaminophen with codeine (Tylenol No. 3) every three hours for pain. Which finding associated with opioid analgesics does the nurse anticipate when assessing the client?

No bowel movement for three days

Itching and bruising at the incision site

Dry, unproductive cough

Elevated serum glucose

back 30

No bowel movement for three days

Side effects of opioid analgesic use include respiratory depression, sedation and constipation. The incision site may be bruised after surgery and it may itch, pull or feel numb, but this is unrelated to oral opioid use. Dry mouth is a possible side effect of acetaminophen with codeine, but not necessarily dry cough.

front 31

An older adult client is to receive IV gentamicin. What diagnostic finding indicates the client may have difficulty eliminating this medication?

Reduced peristalsis

Gastric acid reflux

Protein deficiency

Borderline renal function

back 31

Borderline renal function

Gentamicin is not metabolized; it is excreted by glomerular filtration. This aminoglycoside is highly toxic to the kidneys and requires close monitoring of renal function, including creatinine levels. Aminoglycosides are used to treat severe infections, such as septicemia, and are only given for a short period of time due to their toxic effects.

front 32

The hospice nurse is visiting an 85 year-old client diagnosed with end-stage cancer. What should the nurse understand about chronic malignant pain management?

Maximum doses of analgesics are needed

Heart rate, respirations and blood pressure will be elevated

Pain therapy is based on a client's report of pain

Relief of temporary pain should be achieved quickly

back 32

Pain therapy is based on a client's report of pain

Every person’s unique pain experience must be assessed, understood and treated. Because older adults have a slower metabolism and a greater ratio of body fat to muscle fat than younger people do, smaller doses of analgesics may be sufficient to relieve pain and may be effective longer. Therefore, the amount of medication needed is dependent on the client's needs and reports of pain relief; the nurse should not automatically give the maximum ordered dose. Immediate pain relief relates more to acute pain than chronic pain management.

front 33

The nurse is assigned to a client diagnosed with a deep vein thrombosis who has been on heparin therapy for five days. The nurse notes that enoxaparin is added to the medication administration record (MAR). Which action should the nurse take?

Plan to check the aPTT result after the enoxaparin is given

Stop the heparin and begin the enoxaparin 30 minutes later

Notify the charge nurse that the client is already receiving heparin

Monitor the urine, stool and skin for bleeding

back 33

Notify the charge nurse that the client is already receiving heparin

Enoxaparin (Lovenox) and heparin should not be given together because of the increased anticoagulant effect. Enoxaparin can be given 30 minutes after the heparin is discontinued. The aPTT lab is not routinely assessed while a client is taking enoxaparin.

front 34

The nurse receives an order for several medications for a client. Which combination of medications would require the nurse to contact the provider to discuss the orders? (Select all that apply.)

Finasteride (Propecia, Proscar)

Amlodipine (Norvasc)

Lithium (Eskalith, Lithobid)

Furosemide (Lasix)

Insulin

back 34

Lithium (Eskalith, Lithobid)

Furosemide (Lasix)

Lithium generally should not be given with diuretics. Furosemide may reduce excretion of lithium, which could result in lithium toxicity. Additionally, side effects of lithium are polyuria and polydipsia. The nurse should clarify the order before administering lithium and furosemide together.

front 35

The nurse receives an order to give a client iron by deep injection. What does the nurse understand about the reason for using this method of administration?

Prevents the medication from tissue irritation

Enhances absorption of the medication

Provides more even distribution of the drug

Ensures that the entire dose of medication is given

back 35

Prevents the medication from tissue irritation

Deep injection, or Z-track, is a special method of giving medications via the intramuscular route. Use of this technique prevents irritating or staining medications from being tracked through tissue. Use of Z-track does not affect dose, absorption, or distribution of the medication. Oil-based or thick medication is commonly given in this manner for the same reason.

front 36

A nurse is reviewing and order that reads: administer conjugated estrogen 1.25 mg daily. The only available tablet strength is 625 mcg. How much medication will the nurse administer?

back 36

2tablet(s).

1.25 mg = 1250 mcg: 1250 mcg/625 mcg = 2 or 2 tablets. Using Dimensional Analysis: Tablet = (1.25 mg/625 mcg) X (1000 mcg/1 mg) = 2

front 37

A client is prescribed trimethoprim/sulfamethoxazole for recurrent urinary tract infections. Which comment by the nurse is correct about this medication?

"It is safe to take with oral contraceptives."

"Drink at least eight glasses of water a day."

"Stop the medication after five days."

"Be sure to take the medication with food."

back 37

"Drink at least eight glasses of water a day."

Trimethoprim/sulfamethoxazole (Bactrim, Septra, Sulfatrim) is a highly insoluble medication and requires a large volume of fluid intake. This medication can be taken with or without regard to food. The full prescribed amount should be taken at evenly spaced intervals until the medication is finished. Unlike many other antibiotics, trimethoprim/sulfamethoxazole does not seem to affect hormonal birth control such as pills, the patch or ring.

front 38

A nurse is reinforcing instruction to a client diagnosed with osteoporosis. What is the most important approach to exercise the nurse should reinforce for this client?

Incorporate daily exercise to reduce weight

Avoid exercise activities that increase the risk of fracture

Exercise to strengthen muscles with a protection of the bones

Exercise by doing weight-bearing activities

back 38

Exercise by doing weight-bearing activities

Weight-bearing exercises are beneficial in the prevention and treatment of osteoporosis. Although loss of bone cannot be substantially reversed, further loss can be greatly reduced and prevented if the client includes weight-bearing exercises, vitamin D and calcium supplements in the treatment protocol.

front 39

On the burn unit, the nurse is assigned to a child who weighs 30 kg. Which observation best indicates adequate fluid replacement?

Moist oral mucus membranes

Urinary output of 32 mL per hour

Normal skin turgor

No reports of being thirsty

back 39

Urinary output of 32 mL per hour

For children, the expected urine output is about 1 mL/kg/hour of urine. For a child who weighs 30 kg, 32 mL/hour is adequate urinary output. You will note that since the question is indirectly asking about intake (fluid replacement), the best response will probably have something to do with output.

front 40

A nurse is caring for a client with an unstable spinal cord injury at the T-7 level. Which nursing intervention should be a priority for this client?

Maintain caloric intake for nutritional balance

Place client on a pressure-reducing mattress

Increase fluid intake to prevent dehydration

Use skin care products designed for use with incontinence

back 40

Place client on a pressure-reducing mattress

The client with a spinal cord injury is risk for skin breakdown due to immobility and decreased sensation. A cushion should be used on the wheelchair and the bed should have a foam pad, air mattresses or a pressure-reducing mattress. Reducing the risk of skin breakdown also includes repositioning the client, using skin care products to protect the skin and adequate liquid and nutritional intake.

front 41

A client has been diagnosed with mild dysphagia. What is the appropriate nursing intervention for this client?

Alternate clear liquids with more solid foods

Tilt head back to facilitate the swallowing process

Position client in an upright position while eating

Offer finger foods such as crackers or pretzels

back 41

Position client in an upright position while eating

An upright position facilitates proper chewing and swallowing. To prevent aspiration, thicker foods should be offered or thickening should be added to liquids. Tilting the chin down helps swallowing. Dry foods such as crackers or pretzels may increase the risk for choking.

front 42

The nurse is preparing to manually remove the fecal impaction on an 80 year-old client. What information is the most important to understand before performing this procedure?

The procedure should be done prior to a bath

Increased dietary fiber, fluids and activity can minimize fecal impaction

The presence of hemorrhoids is a contraindication for manual removal of the impaction

The client may experience bradycardia during the procedure

back 42

The client may experience bradycardia during the procedure

Cardiac dysrhythmias, including bradycardia, can result from vagal nerve stimulation during fecal impaction removal. The risk is higher in older adults or clients who have had cardiac surgery. Although it is correct that removing a fecal impaction should be done prior to a bath and that diet, exercise and fluids can help prevent an impaction, these are not the priority for this client in this situation. The presence of hemorrhoids is not a contraindication for manually removing fecal impactions.

front 43

A client has a nasogastric tube draining bile-colored liquids. Which nursing intervention will provide the most comfort to the client?

Swab the mouth using glycerin swabs

Allow the client to melt ice chips in the mouth

Perform frequent oral care

Provide mints to freshen the breath

back 43

Perform frequent oral care

Frequent cleansing and stimulation of the mucous membrane is important for clients with a nasogastric tube to prevent development of lesions, infection and to promote comfort. Ice chips or mints may be contraindicated and need to be ordered specifically when NG tubes are present. Lemon and glycerin swabs have no mechanical or cleansing value and should not be used.

front 44

A 3 year-old child who is diagnosed with celiac disease attends a day care center. Which of the following foods would be an appropriate snack?

Vanilla cookies

Peanut butter sandwich

Cheese crackers

Potato chips

back 44

Potato chips

Children with celiac disease should eat a gluten-free diet. Gluten is found mainly in grains of wheat and rye and in smaller quantities in barley and oats. Corn, rice, soybeans and potatoes are digestible by persons diagnosed with celiac disease.

front 45

Upon examining the mouth of a 3 year-old child, the nurse discovers that the teeth have chalky white-to-yellowish staining with pitting of the enamel. Which condition would most likely explain these findings?

Ingestion of tetracycline within the past year

Excessive oral iron therapy over the past six months

Recent poor dental hygiene

Excessive fluoride intake on a regular basis

back 45

Excessive fluoride intake on a regular basis

The findings indicate fluorosis, a condition characterized by an increase in the extent and degree of the enamel's porosity. This problem can be associated with repeated swallowing of toothpaste with fluoride or drinking water with high levels of fluoride. You will notice that two of the options address medications but there is nothing in the stem of this question to indicate that the child is taking any medications. Poor dental hygiene can damage teeth, but it would not appear chalky-white.

front 46

The RN has provided care instructions to the parents of a toddler diagnosed with atopic dermatitis. Which of these actions will the LPN/VN now reinforce to the parents?

Wrap the child's hand in mittens or socks to prevent scratching

Clean the affected areas with tepid water and antibacterial soap

Keep the child away from other children for the duration of the rash

Dress the child warmly to avoid chilling

back 46

Wrap the child's hand in mittens or socks to prevent scratching

Toddlers with atopic dermatitis need to have fingernails cut short and hands covered so they will not be able to scratch the skin lesions. Prevention of new lesions is important due to the risk of possible secondary infections. The clue in the stem is that the client is a toddler. Because toddlers have a short attention span and minimal self-control, and dermatitis is inflammation of the skin, the best response is to place the child's hands in mittens or socks to prevent scratching.

front 47

The client is diagnosed with coronary artery disease (CAD). What information should the nurse emphasize when reinforcing nutritional information to this client?

Avoid heavy, large meals

Eat three well-balanced meals a day

Add complex carbohydrates and proteins

Limit sodium to 5 grams per day

back 47

Avoid heavy, large meals

Controlling portion size is important for a heart-healthy diet. Eating large, heavy meals can pull blood away from the heart for digestion, possibly resulting in angina. Thus, it increases the risk of myocardial infarction. The client should also reduce sodium intake to about 2,300 mg/day (or less). Clients should also limit unhealthy fats and cholesterol; select low-fat protein sources; and eat more fruits, vegetables and whole grains.

front 48

A couple experiences intense anxiety after their home is destroyed by a fire. One of the partners escaped from the fire with only minor injuries. The nurse knows that the most important initial intervention should be to take which approach?

Suggest that the clients rent an apartment with a sprinkler system

Explore with the couple the feelings of grief associated with the loss

Provide a brochure on methods to promote relaxation

Determine available community and personal resources

back 48

Determine available community and personal resources

The couple has experienced a sudden loss event that has resulted in disequilibrium. The most important initial crisis intervention focuses on identifying resources and obtaining assistance for housing and other immediate needs. Information on home safety, relaxation exercises and grief counseling are of value after meeting the initial needs for shelter.

front 49

A teenaged client is paralyzed after being in a car accident. Which statement used by the client would indicate that the client is using "repression" as an ego-defense mechanism?

"I'm not ready to talk about it right now."

"It's all his fault! He was going 90 miles an hour on the freeway."

"My mother is heartbroken about this situation."

"I don't remember anything about what happened to me."

back 49

"I don't remember anything about what happened to me."

Repression is unconscious and involuntary forgetting of painful events, ideas, conflicts; there is no memory of the topic. One response is a statement indicating the use of suppression as an ego-defense mechanism, but this is incorrect because suppression is under conscious and voluntary control. Another incorrect response is an example of projection, where someone else is blamed for the situation.

front 50

The client diagnosed with paranoid-type schizophrenia sits alone alertly watching the activities of other clients and staff. The client is hostile when approached with medication and asserts that the medication controls the mind. Which option might best explain the reason for the client's behavior?

Feelings of increased anxiety related to paranoia

Sensory perceptual alteration related to withdrawal from environment

Impaired verbal communication related to impaired judgment

Social isolation related to altered thought processes

back 50

Social isolation related to altered thought processes

Hostility and absence of involvement are data supporting a diagnosis of social isolation. The psychiatric diagnosis and the client's idea of the purpose of the medication suggests altered thinking processes. When answering this question, be sure to compare the data in the stem to each of the options. Notice that the incorrect options can be eliminated because there's no mention of anxiety or difficulties with sensory or verbal communication.

front 51

After the death of a client, the family approaches a nurse and requests that a family member be allowed to perform a ritual bath on the deceased prior to moving the body. What would be the most appropriate response by the nurse?

"These procedures have to be carried out by our staff."

"A ritual bath will have to wait until after postmortem care"

"Is there anything you need from me to perform the ritual bath?"

"I will have to check on hospital regulations and policies."

back 51

"Is there anything you need from me to perform the ritual bath?"

Rituals are processes that allow the bereaved to acknowledge the reality of death. Religious rituals specifically offer meaning and provide hope within the context of the particular faith tradition. Nurses should inquire about rituals or observances following death and respect these. The other options are inappropriate and culturally insensitive.

front 52

The interdisciplinary team is reviewing charts for potential candidates for hospice care. Which of the following clients meet the criteria for hospice care? (Select all that apply.)

72 year-old with prostate cancer metastasized to the bone, who is receiving palliative radiation therapy

8 year-old client with acute myelogenous leukemia, for whom all treatment options have failed

91 year-old with Alzheimer's disease, who is no longer able to eat or drink oral fluids

53 year-old client with chronic, unrelieved pain, who is addicted to narcotics following a back injury

46 year-old with end stage liver disease, on a wait list for a donor organ

back 52

72 year-old with prostate cancer metastasized to the bone, who is receiving palliative radiation therapy

8 year-old client with acute myelogenous leukemia, for whom all treatment options have failed

91 year-old with Alzheimer's disease, who is no longer able to eat or drink oral fluids

Hospice care provides services for clients who are at the end of their life, usually with less than 6 months to live. There are no age requirements. Palliative care is provided by a multi-disciplinary team in a variety of settings, including the home, hospital or extended-care facilities. Clients actively seeking a cure or treatment for their disease do not meet the criteria for hospice care.

front 53

The postpartum Hispanic client refuses hospital food because it is "cold." What action should the nurse take initially?

Send the food to be reheated

Ask the client what foods are acceptable

Encourage the client to eat for strength

Consult with the dietitian as soon as possible

back 53

Ask the client what foods are acceptable

Many Hispanic clients subscribe to the rebalancing of "hot" and "cold" in the postpartum period. After giving birth, when a woman has lost blood, she is considered to be in a cold state; therefore, she needs to restore her humoral balance. What defines "cold" and "hot" can best be explained by the client and this needs to be incorporated into the plan of care. Note that the correct response is a “data collection” response, which allows for client feedback about what the client is really saying about the food. Notice that it is the only client-centered option.

front 54

The nurse is working to establish a therapeutic relationship with a client. A therapeutic nurse-client interaction occurs when the nurse takes which approach?

Advises about resources for resolving problems

Interprets any covert communications

Praises the client for appropriate behavior

Clarifies the meaning of client communication

back 54

Clarifies the meaning of client communication

Clarification is both a facilitating and therapeutic communication strategy. Approval, changing the focus or subject, and advising are non-therapeutic or barriers to effective communication.

front 55

A client has just been diagnosed with breast cancer. As the nurse enters the room, the client states "You are stupid." Which approach by the nurse would be the most therapeutic?

Make no comment or response

Explore what is going on with the client

Accept the client’s statement

Tell the client that the comment is inappropriate

back 55

Explore what is going on with the client

The nurse should assist this verbally aggressive client to put angry feelings into words and then to engage in problem solving. The client exhibits being in the angry stage of loss.

front 56

A client is admitted to the hospital following an automobile accident. Upon admission the client's blood alcohol concentration was 0.18%. Twelve hours after admission the client is diaphoretic, tremulous, and irritable; pulse and blood pressure measurements are elevated. The client states: "I have to get out of here." What is the most likely cause for these findings?

Early stage of alcohol withdrawal

Dissatisfaction with hospital care

Shock related to the injuries

Anxiety related to being hospitalized

back 56

Early stage of alcohol withdrawal

This client's blood alcohol concentration is more than twice the legal limit in most states. After a period of heavy or prolonged alcohol use, people will experience alcohol withdrawal symptoms, such as insomnia, tremors, hyperactivity, hypertension, tachycardia and diaphoresis. The client must be treated immediately to prevent progression to more severe alcohol withdrawal symptoms, including seizures (which may begin 6-48 hours after cessation of alcohol intake) and delirium tremens (DTs).

front 57

During a meeting with the nurse at the community clinic, an individual being battered in the home tells the batterer, "I need a little time away." How might the nurse expect the batterer to respond?

With acceptance and understanding that the relationship is in trouble

With fear of rejection resulting in increased rage toward the battered individual

With relief and anticipation of a separation as a way to have some personal time

With a new commitment to seek counseling to assist with problems

back 57

With fear of rejection resulting in increased rage toward the battered individual

In the absence or potential absence of the battered individual, the fear of rejection and loss only serve to increase the batterer's rage at the partner. Behaviors that are common in the batterer include extreme jealousy, refusing to take responsibility for the abuse and denying or minimizing the seriousness of the violence and its effects on the victim.

front 58

The client is diagnosed with post-traumatic stress disorder (PTSD). What are the some of the more common treatment options for PTSD? (Select all that apply.)

Opioid analgesics

Eye movement desensitization and reprocessing (EMDR)

Selective serotonin reuptake inhibitors (SSRIs)

Cognitive behavioral therapies

back 58

Eye movement desensitization and reprocessing (EMDR)

Selective serotonin reuptake inhibitors (SSRIs)

Cognitive behavioral therapies

The only two FDA approved medications for the treatment of PTSD are the SSRIs sertraline (Zoloft) and paroxetine (Paxil). There are other medications that are helpful for specific PTSD symptoms, but narcotics should not be used since they don't relieve psychogenic pain and there's a risk of dependence. Most people who experience PTSD undergo some type of psychotherapy, most commonly cognitive-behavioral therapy and/or group psychotherapy, EMDR and hypnotherapy.

front 59

A 14 year-old boy with a history of hemophilia A was admitted after a fall while playing basketball. In understanding his behavior and assisting in planning care for this client, what should the nurse recognize concerning the behavior of adolescents with a chronic disease?

Need to have structured activities

Often take part in active sports

Avoid physical risks after bleeding episodes

Share information about disease limitations with peers

back 59

Often take part in active sports

Adolescent hemophiliacs should be aware that contact sports may trigger bleeding. However, developmental characteristics of adolescents, such as impulsivity, inexperience and peer pressure, often place them in unsafe situations. Adolescents do not want to appear differently to their peers and would probably not willingly offer information about their disease to others.

front 60

A home health nurse is making an initial visit to a 70 year-old client. What should be the first action to meet the client's health needs?

Identify learning needs

Assist with meal planning

Discuss past health history

Review the list of medications

back 60

Identify learning needs

With the focus on health promotion, the nurse should first identify any learning needs. Once learning needs are identified, the nurse would know if meal planning assistance is needed. Reviewing medications and discussing health history are part of the initial assessment. Helpful hint: since this is a very general question, you should look for a response that's more general.

front 61

The registered nurse is preparing a client and her healthy newborn for discharge and provides information about hormonal effects in newborns. The licensed practical nurse understands that which finding in the newborn is due to the maternal hormones?

Edema of the scrotum

Enlargement of the breasts

Mongolian spots

Lanugo on the extremities

back 61

Enlargement of the breasts

Of all the options, the most commonly expected physical finding due to maternal hormones is breast engorgement. This can occur in both boys and girls. Mongolian blue spots commonly appear at birth or shortly thereafter; they are flat, blue, or blue-gray skin markings near the buttocks. The newborn scrotum can be filled with clear fluid (which was squeezed into the scrotum during the birth process); it will be reabsorbed over the next few months. Lanugo is the fine downy hair that may be present on the backs and shoulders of newborns, particularly premature infants.

front 62

The nurse is discussing modifiable cardiac risk factors with a group of adults. Which topic should the nurse reinforce as the priority intervention?

Smoking cessation

Stress management

Physical exercise

Weight reduction

back 62

Smoking cessation

Stopping smoking is the priority for clients at risk for cardiac disease because of the effects of reduced oxygenation and constriction of blood vessels. Notice that three of the options are all actions that indirectly reduce cardiac risk factors. Ask yourself which of the options should happen first or which one would have an immediate impact on the body: weight, stress, exercise or smoking?

front 63

The nurse practices in a long-term care facility and understands that older adults are at greater risk for experiencing adverse effects from medications. What physiologic changes could contribute to these adverse effects?

Decrease in blood flow to the kidneys and increase in kidney mass

Decrease in total body water and an increase in proportion body fat

Increased peristalsis and increased production of gastric acid

Increase in blood flow to the liver and decrease in liver mass

back 63

Decrease in total body water and an increase in proportion body fat

Because older clients have a decline in lean body mass and changes in total body water in which to distribute medications, more medication remains in the circulatory system with potential for medication toxicity. Increased proportion of body fat results in greater amounts of fat-soluble medications being absorbed, leaving less in the circulation, and thus increasing the duration of action of the medication.

front 64

The nurse is measuring blood pressure at a community health fair. When the nurse tells someone that his blood pressure is 160/96 mm Hg, he states, “My blood pressure is usually much lower.” What is the best response to this statement?

"Check your blood pressure again in a few months."

"Get your blood pressure checked again within the next 48 to 72 hours"

"Make an appointment to see your health care provider next week"

"See your health care provider immediately."

back 64

"Get your blood pressure checked again within the next 48 to 72 hours"

The blood pressure reading is moderately high and should be rechecked within a few days. Since the client states it is "usually much lower" the elevated BP could be a concern but it is not clear what the client considers to be a "much lower" BP. The nurse should measure the blood pressure in the other arm and compare the two readings. Waiting two or three weeks for follow-up is too long.

front 65

The nurse is providing care for an adolescent. Which intervention best demonstrates the nurse's sensitivity to an adolescent's need for autonomy?

Explore an adolescent’s feelings of resentment to identify causes

Provide discussion of concerns without the presence of parents or guardians

Express identification of feelings about body image

Allow young siblings to interact via various communication routes

back 65

Provide discussion of concerns without the presence of parents or guardians

While the family is an important component in the care of an adolescent, it is also important to spend time alone with the adolescent. This is an opportunity for the nurse to hear the teen's perspective and to really listen to his/her concerns.

front 66

A nurse observes a newborn whose Apgar score was 8 at one minute and then 9 at the five-minute evaluation. These scores would be more commonly related to abnormalities in which of these areas?

Cry

Color

Heart rate

Muscle tone

back 66

Color

Acrocyanosis (blue hands and feet) is the most common Apgar score deduction and is a normal adaptation in the newborn in response to the environment. If the environment is cool, then the hands and feet would display a more bluish discoloration. On average it lasts for about 48 to 72 hours. Recall that the maximum score is 10 for Apgar, so 1 or 2 points lower would suggest a problem that is probably not as severe as a problem related to heart rate, muscle tone or cry (respirations).

front 67

An anxious parent of a 4 year-old discusses with the nurse how to answer the child's question: "Where do babies come from?" What is the best response by the nurse to the parent?

"This question indicates interest in sex beyond this age."

"When a child of this age asks a question, give a simple answer."

"Children ask many questions, but are not looking for answers."

"Full and detailed answers should be given to all questions."

back 67

"When a child of this age asks a question, give a simple answer."

During discussions related to sexuality, honesty is very important. However, honesty does not mean imparting every fact of life associated with the question. When children ask one question, they are looking for one answer. When they are ready, they will ask about the other pieces of information by the use of specific questions.

front 68

A client is forgetful and experiences short-term memory loss. When collecting data about short-term memory loss, which action should the nurse take first?

Ask the client to state when he was born

Confirm that no hearing loss

Observe the client during an activity

Suggest the client read from a newspaper

back 68

Confirm that no hearing loss

Hearing loss may result in the client answering questions inappropriately, which may be misinterpreted as a short-term memory loss. Asking clients to state their birthdate is used to assess long-term memory. Observing the client during activity may be done for mobility concerns or deficits. Having the client read something can be used to assess vision problems.

front 69

The nurse is reinforcing information about accidental poisoning in the home to a group of parents. What information should the nurse be sure to include?

Do not move the child if a toxic substance is inhaled

Empty the child's mouth in any case of suspected poisoning

Induce vomiting if the child is suspected of swallowing something poisonous

Start treatment before calling the Poison Control Center

back 69

Empty the child's mouth in any case of suspected poisoning

Emptying the mouth of the poison prevents any further ingestion. It should be done first to minimize further contact with the substance. Vomiting should never be induced unless told to do so by the Poison Control Center or a health care professional. First aid for inhaling toxic substances is to move the child to fresh air.

front 70

The nurse is collecting data about the home care for a client with Alzheimer's disease. Which piece of information should be the priority for the nurse to document?

The family’s use of respite care

Any nutritional intake changes

The use of over-the-counter medications

The presence of environmental hazards

back 70

The presence of environmental hazards

A safe environment for the client with increasing memory loss is a priority focus of home care. Note that the other options would be included in the documentation – with importance being in this order: "environmental hazards,""over-the-counter medications," "intake changes" and then "respite care." The question is asking the reader to prioritize, which usually means that all the responses are correct but one is more important than the rest.

front 71

An outpatient client is scheduled to receive an oral solution of radioactive iodine. In order to reduce hazards, the practical nurse should reinforce which information?

Wash laundry separately and rinse twice in hot water

Wait to have guests visit at home for 48 hours after the first dose

Urine and saliva will be radioactive for 24 hours after ingestion

No solid food may be eaten for six hours after ingestion of the solution

back 71

Urine and saliva will be radioactive for 24 hours after ingestion

The client's urine and saliva are radioactive for 24 hours after ingestion. The practical nurse should reinforce the RN's teaching to double flush the commode after use, use disposable utensils, and avoid close contact with children and pregnant women for 48 to 72 hours. Because the treatment may cause nausea, it's best if the client doesn't eat two hours before or after iodine administration. It is not necessary to wash laundry separately or in hot water.

front 72

At 3 months, the infant has cleft lip and soft palate repair. In the immediate postoperative period for a cleft lip repair, which action is the priority?

Initiate clear liquid feedings by mouth when alert and acting hungry

Provide written instructions about care of the suture line

Remove soft elbow/arm restraints every 2 hours under supervision

Position the infant on side or back

back 72

Remove soft elbow/arm restraints every 2 hours under supervision

The goal after surgery is to protect the new repair and stitches, which requires some temporary changes in feeding, positioning and activity for the infant. The priority is to wear arm restraints (for the first 10 days after surgery) to keep him from putting his hands in his mouth; the restraints can be removed only for bathing or for exercising the arms. When the infant acts hungry, he will be given a clear liquid feeding using either a syringe fitted with a special soft tubing or a special cleft lip feeder. The infant can be positioned on his side or back to keep him from rubbing his face in the bed. The RN will provide instructions about care of the incision line prior to discharge.

front 73

The child is newly diagnosed with hepatitis A. Which teaching instructions would the nurse reinforce with the child's parents?

Return to daycare two days after starting antibiotic treatment

Use gentle cleansers to protect jaundiced skin from breakdown

Wash hands thoroughly with soap and warm water after contact with the child

Bedrest for several weeks before gradually resuming activity

back 73

Wash hands thoroughly with soap and warm water after contact with the child

Hepatitis A virus spreads through contaminated food or water, as well as unsanitary conditions in childcare facilities or schools. The infection resolves spontaneously and symptom relief is usually the only treatment. The child does not have to be confined to bed and s/he can safely return to daycare or school one week after symptoms began. Infants and young children usually do not develop jaundice.

front 74

The nurse is in a crowded shopping area in an urban setting when a radiologic dispersal device (RDD) explodes scattering radioactive dust and material into the environment. What should the nurse instruct the victims in proximity to the explosion to do first?

Keep the nose and mouth covered

Remove all exposed clothing right away

Stay out of any buildings until help arrives

Lie down flat and cover the head with anything available

back 74

Keep the nose and mouth covered

An RRD, or "dirty bomb," generates radioactive dust and smoke, which can be dangerous if inhaled. The nurse should initiate measures to limit contamination, instructing victims to cover their noses and mouths. Neither lying down or covering the head does anything to limit exposure. Victims should move into a building where the walls and windows have not been broken and then remove their outer layer of clothing (sealing them in a plastic bag, if available) to help minimize exposure.

front 75

The client is diagnosed with active tuberculosis (TB) and the case has been reported to the health department. What is the most important reason for notifying the public health department?

Contacts need to be traced and screened

Treatment options need to be documented

The incidence of tuberculosis is tracked

Disease statistics need to be maintained

back 75

Contacts need to be traced and screened

Active tuberculosis is a reportable disease because people who had contact with the client must be traced, evaluated for the disease, and possibly treated prophylactically. Statistics are kept and trends documented, but that is not the primary reason for required reporting.

front 76

A severely injured client is moved into an examination area of the emergency department. The family member who accompanied the client to the ED is screaming at the nurse, saying that someone better start doing something right away. What is the best response by the nurse?

"I need you to go to the waiting area. You can come back when you're more in control."

"I know you are upset. But please control yourself and sit down. Otherwise I will have to call security."

"I can't think when you are yelling at me. Talk to me in a normal voice."

"I'm going to give you a few minutes alone so you can calm down."

back 76

"I know you are upset. But please control yourself and sit down. Otherwise I will have to call security."

Most violent behavior is preceded by warning signs, such as yelling or swearing. The challenge for nurses is to apply interventions that de-escalate a person's response to stressful or traumatic events. The keys to effective limit setting are using commands to express the desired behavior and providing logical and enforceable consequences for noncompliance. Nurses should acknowledge the agitated person's feelings and be empathetic, reminding him or her that they are there to help.

front 77

A client reports feeling dizzy when getting up from a lying position. Which is the correct action for the nurse to take before assisting the client to ambulate?

Support the client in a standing position for several minutes before walking

Support the client in a sitting position until the dizziness subsides

Encourage the client to stand and slowly move to a chair

Apply a gait belt and ask another person to assist with ambulation

back 77

Support the client in a sitting position until the dizziness subsides

The findings suggest postural or orthostatic hypotension. The nurse should help the client to sit and dangle on the side of the bed until the dizziness subsides and the blood pressure stabilizes. This will prevent the client from potential injury.

front 78

The nurse attends an interdisciplinary meeting on the topic of fall prevention. What specific tactics can be used to reduce falls in health care settings? (Select all that apply.)

Regularly reorient clients

Identify vulnerable clients

Raise side rails

Use a "two to transfer" policy

Install and use bed alarms

back 78

Identify vulnerable clients

Use a "two to transfer" policy

Install and use bed alarms

Use "low beds" for at-risk clients

Fall prevention involves managing a client's underlying fall risk factors and then implementing strategies to reduce falls. Using restraints, including side rails, can actually increase the risk of fall-related injuries and deaths. Clients with neurocognitive disorders cannot process the information we provide when we attempt to reorient them to our reality. The other techniques listed are used (in combination) to help prevent falls in health care facilities.

front 79

The adult client is alert and cooperative. The client has a short leg cast and can only partially bear weight on the casted leg. Which technique can be safely used to transfer the client from the bed into a chair?

Two caregivers use a friction-reducing device and wide base of support when transferring the client

Two caregivers lift the client from the bed and move the client into the chair

One caregiver applies a gait belt and transfers the client toward the weak side

One caregiver applies a transfer belt and uses the stand-and-pivot technique

back 79

One caregiver applies a transfer belt and uses the stand-and-pivot technique

The algorithm for safe client handling and transferring an alert and cooperative client to a chair states: one caregiver applies a gait/transfer belt, uses the stand-and-pivot technique and transfers the client toward the strong side. A friction-reducing device is placed under the client to assist in turning or moving the person in bed, not transferring to a chair. A two person lift is unsafe.

front 80

A nurse is stuck in the hand by an exposed needle left in a client's bed linens. What immediate action should the nurse take?

Contact employee health services

Notify the supervisor and risk management

Immediately wash hands with vigor

Look up the policy on needle sticks

back 80

Immediately wash hands with vigor

The immediate action of vigorously washing the hands will help remove any possible contamination. If the site bleeds it will help remove the contaminate. Then, the sequence of actions would be options "notify," "look up" and "contact."

front 81

The nurse is assessing the client during a home health visit and the client states: "I had physical therapy yesterday. I thought it was supposed to help but my back hurts so much after each visit." The nurse's responsibilities include which of the following actions? (Select all that apply.)

Report the client's findings to the physical therapist

Offer to help the client make an appointment with the physician about the back pain

Tell the client to take the prescribed pain medication

Gather more information about the location, duration and intensity of the pain

Report the client's findings to the nursing supervisor for further assessment

back 81

Report the client's findings to the physical therapist

Gather more information about the location, duration and intensity of the pain

Report the client's findings to the nursing supervisor for further assessment

The needs of the client can be best addressed by further assessment of the client (collecting more information about the findings of pain) and then communicating the client's needs to the interdisciplinary team members. Before any medication is given or any appointments are made, more information about the pain is needed.

front 82

A client states: "I do not want to be interrupted for breakfast because it interferes with my meditation time." What is the next action for the nurse to take?

Consult with the nurse manager to get suggestions

Contact the client's provider

Contact the nutritionist or dietitian

Talk with the client to work out a mutual plan

back 82

Talk with the client to work out a mutual plan

The nurse should talk with the client to determine how the practice of meditation can be incorporated into the morning schedule. Respect for differences must be incorporated into a client's plan of care.

front 83

An 80 year-old client is hospitalized for a chronic condition. The client informs family members that a living will has been prepared and the client wants no life-prolonging measures performed. The client's condition deteriorates and the client becomes unresponsive. Which of the following nursing actions is most appropriate?

Consult the charge nurse and prepare to transfer the client to an intensive care unit

Notify the attending physician

Contact the family member indicated in the admission forms

Call the rapid response team

back 83

Notify the attending physician

The first action would be to notify the attending physician for further orders. Then the family member(s) can be contacted about his condition. When a client has an advanced directive, it is not appropriate to perform CPR on him.

front 84

During a discussion with the nurse manager, a staff nurse confides that she is attracted to a client regularly assigned to her. Which of the following actions should be implemented following this discussion?
The nurse transfers the care of the client to another nurse

The nurse reassigns all personal care of the client to the nursing assistant

The nurse waits until after discharge to tell the client about her feelings

The nurse continues to provide care for the client

back 84

The nurse transfers the care of the client to another nurse

Nurses must practice in a manner consistent with professional standards and be knowledgeable about professional boundaries. A nurse’s challenge is to be aware of feelings and to always act in the best interest of the client, avoiding inappropriate involvement. In this case, the nurse did all the right things - aware of her feelings, she consulted with her supervisor and together they decided it would be best if this client were no longer assigned to this nurse. If the nurse had acted on her feelings, this would have been a boundary violation and she could have been subject to board of nursing disciplinary action.

front 85

The practical nurse has been assigned to four residents. Which resident should be seen first on the initial shift rounds?

An 81 year-old female with a history of coronary artery disease (CAD) reporting dyspnea, nausea, and unusual discomfort in the upper back

An 86 year-old male diagnosed with hypertension whose last recorded BP was 180/90 after learning that a close friend was hospitalized

A 94 year-old female diagnosed with peripheral artery disease (PAD) reporting cramp-like pains in both calf muscles following physical therapy

A 70 year-old male with history of heart failure (HF) who reported going to the bathroom "too much" after taking a diuretic

back 85

An 81 year-old female with a history of coronary artery disease (CAD) reporting dyspnea, nausea, and unusual discomfort in the upper back

These findings suggest a myocardial infarction (MI). Older adults and women of any age may not always have the classic findings of chest, inner arm, or jaw pain, numbness or tingling of the left arm. The stress of a tragic event can elevate BP temporarily; the nurse can retake the client's BP at a later time. Increased urinary output is an expected finding after taking a diuretic and intermittent claudication is a common and expected finding in PAD.

front 86

A registered nurse in a charge position is reinforcing goals to the health care team. Which of these items best describes the goal of continuous quality improvement (CQI) in a health care setting?

Conduct chart audits for common error discovery

Improve the quality of care in a proactive manner

Create a flow chart of department or staff interactions

Perform actions based on reactive problem solving

back 86

Improve the quality of care in a proactive manner

Continuous quality improvement is used to identify ways to correctly do the right thing at the right time. It involves proactive problem-solving. The overall goal of CQI is to improve health care.

front 87

The client who recently experienced a stroke has an order to ambulate with assistance. Which statement by the nurse provides the best instructions to the unlicensed assistive person (UAP) to assist the client to ambulate?

"If the client gets dizzy when walking, ask the client to stop and take 10 fast, deep breaths."

"Have the client lift and move the walker out at arms length then walk into the walker."

"As you assist the client to the chair, let me know if the client uses the quad cane correctly."

"Stand on the client's strong side when you assist the client to the bathroom."

back 87

"Have the client lift and move the walker out at arms length then walk into the walker."

The nurse should give clear and concise information to the UAP about what is expected to safely complete any task, which is why the option about using the walker is correct. The person assisting the client to ambulate should walk on the client's weak, not strong, side. UAP cannot assess or evaluate a client ("let me know if the client uses the quad cane correctly"; only nurses can perform the steps of the nursing process. If a client gets dizzy, the UAP should assist the client to sit (or ease the client to the floor is s/he begins to fall.)

front 88

When walking past a client's room, the nurse hears an unlicensed assistive person (UAP) talking to another UAP. Which of these statements requires further intervention by the nurse?

"This client seems confused, we need to watch the client closely."

"I'll come back and make the bed after I go to the lab."

"If we work together we can get all of the client care completed."

"Since I am late for lunch, would you perform my client's blood glucose test?"

back 88

"Since I am late for lunch, would you perform my client's blood glucose test?"

Only registered nurses (RNs) and licensed practical or vocational nurses (LPN/VNs) can assign tasks and activities. UAPs cannot re-assign tasks or activities to other UAPs. Nurses are accountable for all nursing care; if UAPs cannot complete assignments, they should notify the nurse, who will reassign the task.

front 89

A 90 year-old is readmitted to the hospital, less than 2 weeks after being discharged, for the same health concern. What factors contribute to hospital readmissions among older adults? (Select all that apply.)

Client health status

Excellent primary care

Poor communication among providers

Family preferences

Reconciliation of medications

back 89

Client health status

Poor communication among providers

Family preferences

Avoidable hospitalization, especially among older adults living in skilled nursing facilities, usually results from multiple system failures. The reasons most often cited include inadequate primary care (including inadequate discharge planning and lack of reconciliation of medications), poor care coordination, poor skilled nursing facility quality of care, poor communication among providers and even family preferences. Not all illnesses can be anticipated and clients with more complex health issues are readmitted more often, regardless of quality or coordination of care.

front 90

A client with a diagnosis of bipolar disorder has been referred to a halfway house to be considered for placement. A social worker telephones the hospital unit and asks for information about the client's mental status and adjustment. What must the nurse understand in order to respond to this request for information?

The request for information can be given to the social worker in the case of a referral

Only the health care provider can give referral information

Information can be released if there is written consent from the client

Information about a client is never given to anyone by telephone

back 90

Information can be released if there is written consent from the client

HIPAA guidelines are strict as to who has access to and can relay information. In order to release written, verbal or electronic information about a client there must be a signed consent form (unless the client is a threat of harm to self or others). In addition, a written request for information is commonly asked for prior to release of any client information.

front 91

The nurse is using the SBAR technique to communicate with the health care provider. Which of the following phrases would be associated with "B-Background"?

"Vital signs are..."

"I'm not sure what the problem is, but the client's condition is deteriorating."

"I would like you to..."

"The client's treatments are..."

back 91

"The client's treatments are..."

The correct option gives the health care provider background information about the client, including age, primary diagnosis, treatments, etc. Stating that the client's condition is deteriorating is the situation (S). Stating, "I would like you to..." is the request or recommendation (R). Vital signs are part of the assessment (A). Using SBAR is an effective technique used to improve communication with other members of the health care team. This, in turn, helps to foster a culture of safety.

front 92

A nurse must use an interpreter to collect data from a client. Which action should the nurse take to help communicate with the client?

Face the client while asking questions as the interpreter translates the information

Include a family member and direct comments to that person

Talk to the interpreter in advance and leave the client and interpreter alone for discussion

Speak directly to the interpreter while asking questions

back 92

Face the client while asking questions as the interpreter translates the information

Communication is important, especially when the nurse and client do not share the same cultural heritage. Even if the nurse uses an interpreter, it is critical that the nurse use conversational style and spacing, personal space, eye contact, touch, and orientation to time strategies that are acceptable to the client. Therefore, the nurse should face the client and allow the interpreter to translate the content. Facing the client allows nonverbal communication to take place between the client and nurse. Notice that only one option includes the content of this question (collecting data from a client). The other options focus on the "interpreter or the family." Usually, the client-centered option is the best choice.

front 93

The nurse, who is caring for a client with complex and unique health needs, describes the nature of the illness in an online social forum for nurses. Neither the client's real name nor any other personal identifiers are used. What, if any, consequence could result from posting this information online?

There won't be any consequences because the information was posted on a website for nursing professionals

There won't be any consequences because the client's real name was not used

The nurse could be fired for breach of confidentiality

The nurse could be reprimanded for not clearing the information first with hospital administration

back 93

The nurse could be fired for breach of confidentiality

Even though the client was not identified by name, someone could probably figure out who the nurse was writing about. Many health care facilities have adopted a social media policy; it is important to understand that nurses can be fired for posting personal information about clients online, because this is an invasion of privacy. In addition to being a HIPAA violation, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) gives states attorneys the right to pursue violations of patient privacy.

front 94

Which nursing practice best reduces the chance of communication errors that might otherwise lead to negative client outcomes?

Speak using a professional tone on the telephone

Maintain respectful working relationships with all staff

Use standardized forms for client handoffs

Document nursing care at the end of the shift

back 94

Use standardized forms for client handoffs

Standardized forms improve information for communication between caregivers. Most problems/poor outcomes involve some element of poor communication. The options of keeping good working relationships and using a professional tone of voice on the phone is good practice but not as useful for minimizing the chance of errors. Documenting at the end of the shift is incorrect practice and may lead to poor communication, as critical findings may be forgotten and not recorded.

front 95

The client states to the nurse: "I am ready to stop all of these treatments. I just want to go home and enjoy my family for the little bit of time I have left." Which action is most appropriate?

Tell the family members that the client's preference is to go home to die

No action is needed at this time unless the client repeats the statement to another caregiver

Encourage the client to discuss this decision with the health care provider and family

Call in a referral to a social worker and explain that the request will need to be discussed in more detail at a later time

back 95

Encourage the client to discuss this decision with the health care provider and family

The client has the right to stop treatment and should be supported in clearly communicating this decision with the health care provider and family. The nurse needs to act as an advocate for the client. It is factually incorrect to wait until the request is repeated; clients should not need to express their wishes repeatedly before caregivers listen to them. The nurse should not be the one to share sensitive information with the family; the client controls that information. Social services may get involved but time is of the essence for those who are terminally ill.

front 96

Two members of the interdisciplinary team are arguing about the plan of care for a client. Which action could any one of the members of the team use as a de-escalation strategy?

Bring the communication focus back to the client

Adjourn the meeting and reschedule when everyone has calmed down

Interrupt, apologize for interruption, and change the subject

Tell the violators they must calm down and be reasonable

back 96

Bring the communication focus back to the client

Bringing the subject of the communication back to the client refocuses attention on the client's care, instead of the manner of communication. It is the most effective strategy because it is an example of collaboration. The other options are non-productive and may even make matters worse.

front 97

During a discussion about a living will with a 75 year-old client and the client's son, the son says, “I do not understand the need for a living will.” Which of these statements would be accurate and appropriate for the nurse to say in a response to this question?

“Specific instructions are listed for specific diseases.”

“Health care decisions can be made based on the client's wishes."

“Do-not-resuscitate orders (DNR) are automatic under these conditions.”

“A designated family member can make all decisions.”

back 97

“Health care decisions can be made based on the client's wishes."

Health wishes are written in a legal document such as a living will or advanced directives. These wishes are obtained when clients are medically and cognitively able to do so. Such instructions are to be followed if clients are no longer able to make decisions because of cognitive impairment or unconsciousness. One incorrect response defines a health care surrogate or a durable power of attorney. Another incorrect response defines medical directives and not part of a living will. The final incorrect response is associated with the DNR, which may be predetermined by the client as written in a legal document.

front 98

The client is admitted with a diagnosis of hyperglycemia and poor glycemic control. Which task can the nurse assign to an unlicensed assistive person (UAP)?

Reinforce findings of hypoglycemia when the client asks

Measure blood pressure, pulse and respirations

Check sensation in the extremities

Observe for mental status changes every four hours

back 98

Measure blood pressure, pulse and respirations

UAP can perform standard tasks with predictable outcomes, such as measuring vital signs. They are trained to assist the client with activities of daily living. UAPs cannot assess, plan, teach or evaluate clients.

front 99

The licensed practical nurse (LPN) is reassigned to work on an acute care unit. Which of these clients would be most appropriate for the LPN to accept?

A client, admitted for a possible stroke, with unstable neurological findings

A trauma victim with multiple lacerations requiring complex dressings

A confused client whose family complains about the nursing care given after the client’s surgery

An older adult client diagnosed with cystitis who has an indwelling urethral catheter

back 99

An older adult client diagnosed with cystitis who has an indwelling urethral catheter

LPNs who are reassigned to work on a different unit should be assigned to clients who are stable. The older adult diagnosed with cystitis is the most stable and the outcomes for care are fairly predictable. The other clients have more complex problems, as well as a higher risk for instability. LPNs should not accept an assignment that is beyond their knowledge or skills.

front 100

The nurse is named in a lawsuit. Which of these factors will offer the best protection for the nurse in a court of law?

Complete and accurate documentation of assessments and interventions

Above-average performance reviews prepared by nurse manager

Sworn statement that health care provider orders were followed

Clinical specialty certification by an accredited organization

back 100

Complete and accurate documentation of assessments and interventions

The medical record is a legal document. Documentation should include all steps of the nursing process; it must be complete, accurate, concise and in chronological order. Inaccurate or incomplete documentation will raise red flags and may indicate the nurse failed to meet the standards of care. The attorney will review the medical record with the nurse before giving a deposition (sworn pretrial testimony.) Above-average performance reviews could be considered supporting information. Certification is an "extra" based on the nurse's initiative; it is, however, unrelated to accurate charting.

front 101

The client had a colon resection two days ago. Which statement should the nurse use when assigning an unlicensed assistive person (UAP) to help ambulate this client?

"If the client is dizzy upon standing, ask the client to look up and hold onto you."

"When you help the client to walk, ask if the pain increases or decreases."

"Have the client sit on the side of the bed for three to five minutes before standing."

"Help the client to sit in a chair in the room as often as desired."

back 101

"Have the client sit on the side of the bed for three to five minutes before standing."

It is important to give clear and concise information when assigning a task or activity to the UAP. The nurse should also ask the UAP to report client concerns after completing the task but the UAP cannot assess the client; only nurses can assess, plan and evaluate client care.

front 102

A LPN complains to the charge nurse that an unlicensed assistive person (UAP) consistently leaves the work area untidy and does not restock supplies. What is the best initial response by the charge nurse?

Write down potential solutions to the problems today by shift's end

Add this concern to the agenda of the next unit meeting

Assure the staff nurse that the complaint will be investigated

Explore for further identification about the nature of the problem

back 102

Explore for further identification about the nature of the problem

Helping staff manage conflict is part of the charge nurse's role. It is appropriate to work with the LPN in order to work out problems with minimal intervention from administration when possible. Further definition of the problem and associated issues would be a first step. The nursing process can be used to collect more data before plans or interventions are made.

front 103

A newly licensed nurse is concerned about time management. Which action should be most effective in the initial development of a time management plan?

Ask for additional assistance when necessary to complete tasks

Keep a time log for what was done during the hours worked

Complete each task before beginning another activity

Set daily goals with the establishment of priorities

back 103

Keep a time log for what was done during the hours worked

The first step in planning for time management is to establish what tasks were done and when they were completed. This provides a baseline for needed changes in any activities and time use log. The key words in this question are “time management," “most effective," and “initial development.” Remember the first step in the nursing process is data collection - this applies to both caring for clients and developing management skills.

front 104

The nurse manager identifies that time spent charting is excessive. The nurse manager states that "staff will form a task force to investigate and develop potential solutions to the problem and then report on this at the next staff meeting." What is the nurse manager's leadership style?

Transformational

Autocratic

Dynamic

Affiliative

back 104

Transformational

A transformational style of management involves staff members in the decision-making processes. Staff members review current policies and provide feedback to their leader in the pursuit of the common good.

front 105

The health care provider has written an order for "morphine sulfate 2 mg IV push every 3 to 4 hours as needed for pain" for a 75 year-old client in an extended care facility. The licensed practical nurse (LPN) in charge has no other licensed persons working that shift. Which action should the LPN take first?

Hold the medication and contact the health care provider

Administer the prescribed dose as ordered

Give the medication orally and follow up with the health care provider

Check with the pharmacist

back 105

Hold the medication and contact the health care provider

LPNs do not give IV push medications. The LPN will need to contact the health care provider and ask to have the medication delivered by another route.

front 106

A client diagnosed with schizophrenia states, "I don't need medication. It makes me sleepy." The client insists that the nurse explain the use and side effects of the medication. What should the nurse understand before responding to the client?

A decision to reinforce or not reinforce information about medications should be made by the nurse

Clients have a right to know about any prescribed or over-the-counter medications

It is dangerous for clients who are diagnosed with schizophrenia to know about their medications

A referral needs to be sent to the psychiatrist with a request for discussion of the client's medication

back 106

Clients have a right to know about any prescribed or over-the-counter medications

Clients diagnoses have no influence on their right to know about the medications that they are prescribed. Clients have a right to refuse treatment and to be informed about the use and side effects of their medications.

front 107

Information about case management and the role of the case management nurse is presented during an orientation session for new nurses. Which statement correctly describes an important fact about case management?

The interdisciplinary team makes all the decisions for the client and family

Case management is a collaborative process designed to meet complex client needs

Case management strategies focus on the client's needs during hospitalization

Physicians are responsible and accountable for client outcomes

back 107

Case management is a collaborative process designed to meet complex client needs

Case management is a collaborative process of organizing and coordinating resources and services within and across multiple settings. The focus is on cost-savings as well as quality and continuity of care. Case management nurses work closely with physicians, nurses, social workers to meet the complex health needs of the client, Case management is "client-centric" and all members of the team, including the client, work together to achieve desired outcomes. Cases that involve high-risk diagnoses (such as AIDs/HIV, cancer, people with cognitive deficits) or high-volume cases (such as total hip or total knee replacements) are often selected for case management.

front 108

A client refuses to take the medication prescribed because the client prefers to take an herbal preparation. What is the first action the nurse should take?

Report the behavior to the charge nurse

Discuss with the client to find out about the preferred herbal preparation

Explain the importance of the medication to the client

Contact the client's health care provider about the refusal

back 108

Discuss with the client to find out about the preferred herbal preparation

Remember, the collection of additional data is typically the initial approach when problems arise. Although the client has the right to refuse the medication, it's possible that the herbal preparation does not have the intended purpose of the prescribed medication or may even have unintended side effects

front 109

The licensed practical nurse (LPN) who is in charge hears a health care provider loudly criticizing one of the unlicensed assistive persons (UAP) within the earshot of others. The UAP does not react or respond to the health care provider's complaints. What should be the charge nurse's first action after hearing this?

Request an immediate private meeting with the health care provider and the UAP

Walk up to the health care provider and quietly state: “This unacceptable behavior has to stop.”

Allow the UAP to handle this situation without interference for the next few minutes

Notify the nursing administrator and chief of the medical staff within the hour about the breach of professional conduct

back 109

Request an immediate private meeting with the health care provider and the UAP

Assertive communication respects the needs of all parties to express themselves in a private location, but not at the expense of others. The PN charge nurse needs first to protect clients and other staff from this display of inappropriate behavior and come to the assistance or defense of the employee.

front 110

The nurse asks another staff nurse to sign for a wasted narcotic, which was not witnessed by anyone. This type of request seems to be a recent pattern of behavior for this nurse. What is the appropriate initial action of the second staff nurse?

Confront the nurse about suspected medication misuse

Sign the narcotic sheet but document the request by an incident report

Counsel the colleague about the risky behaviors

Report this immediately to the nurse manager

back 110

Report this immediately to the nurse manager

The incident must be reported to the appropriate supervisor, either the charge nurse or the nurse manager, for both ethical and legal reasons. This is not an incident that a coworker can resolve without referring to an appropriate authority. The key words here are “appropriate initial action” and “recent pattern of behavior” regarding wasted narcotics. Ask yourself about your legal responsibility in this situation.

front 111

The nurse, who is located in a large urban area, uses telecommunications to provide health care and education to clients in remote locations. What is the best reason for using telehealth?

Empowers clients to take a greater interest in their illness

Standardizes electronic data sharing of health information

Reduces health care costs

Removes time and distance barriers from the delivery of care

back 111

Removes time and distance barriers from the delivery of care

Telehealth is the use of technology to deliver health care, health information, or health education at a distance. People in rural areas or homebound clients can communicate with providers via telephone, email or video consultation, thereby removing the barriers of time and distance for access to care. Although increased access to information and collaboration between the client and provider can be empowering, this is not the primary reason for using telecommunications/telehealth.

front 112

The LPN/VN assists the RN in evaluating the plan of care for clients. What action does the LPN focus on during the evaluation phase?

Selection of interventions that are measurable and achievable

Achievement or status of progress related to prior goals

Establishment of goals to ensure continuity of care

Identification of any findings of physical and psychosocial stressors

back 112

Achievement or status of progress related to prior goals

Evaluation process of the clinical problem-solving process (the nursing process) should focus on the clients' status, progress toward goal achievement and ongoing re-evaluation of the plan of care. LPN/VN's gather, observe, record and communicate client responses to nursing interventions.

front 113

A home health nurse is providing care for a client. Which client statement should the nurse consider to be a priority and report immediately to the case manager?

"I really don't want the service of Meals on Wheels. I am just not hungry."

"My neighbors just don't get along with me since I refuse to let them walk across my lawn."

"I just didn't sleep well the last few nights. I have thoughts running through my mind."

"When I emptied my urine catheter bag it looked like rusty colored water."

back 113

"When I emptied my urine catheter bag it looked like rusty colored water."

Although nurses need to report diverse information to case managers through phone calls and documentation, they need to immediately report findings that suggest serious changes in a clients' condition. The change in the color of urine to "rusty" suggests blood, a potential danger sign. This requires immediate reporting, documentation and further assessment.

front 114

A Bosnian Muslim woman who does not speak English seeks care at a community center. Through physical gestures, the woman indicates that she has pain originating in either the pelvic or genital region. Assuming several people are available to interpret, who would be the most appropriate choice?

A female interpreter who does not know the client

A female neighbor of the client who is also from Bosnia

A Bosnian male, who is a certified medical interpreter

The client's adult daughter

back 114

A female interpreter who does not know the client

When the nurse and the client do not speak the same language, or have limited fluency, the services of an interpreter is needed. But, it may be inappropriate to have a male interpreter for a female client because the client may not be as forthcoming. The client may also feel it is inappropriate to have private matters interpreted by her daughter (especially if they are of a sexual nature or involve infidelity). To avoid a breach of confidentiality, the nurse should avoid using an interpreter from the same community as the client. The best response is to have a female interpreter who does not know the client.

front 115

The client has a musculoskeletal disorder and has been newly fitted for a lower limb orthotic. Which activity can be assigned to the unlicensed assistive personnel (UAP)?

Assist the client while transfering from the bed to a chair

Check the client's skin for any redness or irritation

Provide instruction for independent ambulation with the orthotic

Monitor the client's response to activity

back 115

Assist the client while transfering from the bed to a chair

The UAP can assist with routine activities of daily living, including transferring clients from a bed to a chair or wheelchair. When performed correctly, these routine tasks usually have a predictable outcome. The option about checking the client's skin involves assessment and monitoring the client's response is evaluation, both of which are nursing-only activities. A physical therapist would teach the client to ambulate with an orthotic.

front 116

During the management of a client's pain, a nurse should consider ethical practice. Which of these items best describes the ethical considerations made by a nurse?

The client's self-report of pain is the most important consideration

Cultural sensitivity is fundamental to pain management

Clients have the right to have their pain relieved

Nurses should not prejudge a client's pain based on the nurse's values

back 116

The client's self-report of pain is the most important consideration

Pain is a complex phenomenon that is perceived differently by each individual. Pain is whatever the client says it is and when it is. To help answer this question, consider that the correct response is the only one that is client-centered.

front 117

Upon completing a review of the admission documents, a nurse identifies that an 87 year-old client does not have an advance directive. What action should the nurse take?

Record this information on the chart

Inform charge nurse and give information about advance directives

Assume that the client wishes a full code

Refer this issue to social services department

back 117

Inform charge nurse and give information about advance directives

For each admission, nurses should verify a copy of the current advance directive. If there is none, the practical nurse should inform the charge nurse and offer written information about advance directives to the client. It is then the client's choice to sign it. The witness of signature for an advanced directive must be someone not involved in direct care of the client. Social service staff are approved nationwide to witness signatures on advance directives. One option only deals with recording the information and is not sufficient. In another option the nurse should avoid making assumptions that the client has been informed of health care choices. Another option represents an action to be done after written information is given.

front 118

The home health nurse is visiting a client diagnosed with type 1 diabetes and osteoarthritis. The client has difficulty drawing up the insulin dosage. The nurse should refer the client to which community resource person?

Physical therapist

Occupational therapist

Home health aide

Social worker

back 118

Occupational therapist

An occupational therapist can assist a client to improve the fine motor skills needed to prepare an insulin injection. An occupational therapist works with the tasks that are needed for smaller movements to maintain activities of daily living or for work actions. A physical therapist works with general movement problems, mobility stability, range of motion or strength training exercises. The key terms in this question are "difficulty drawing up the insulin dosage" and "osteoarthritis." Combined, these terms should call to mind the need for fine motor skills.

front 119

The practical nurse (PN) is assigned to care for several clients on the 7:00 pm to 7:00 am shift. Which client should be checked immediately after getting shift report?

The client with pancreatitis who was admitted yesterday

The client diagnosed with chronic renal failure who returned from dialysis five hours ago

The client diagnosed with asthma who is scheduled for discharge

The client diagnosed with a peptic ulcer who has been vomiting most of the day

back 119

The client diagnosed with a peptic ulcer who has been vomiting most of the day

The client with the peptic ulcer should be checked immediately and findings reported to the charge nurse and/or health care provider. A perforated peptic ulcer could cause nausea, vomiting and abdominal distention, and may be a life-threatening situation.

front 120

Before the client signs a surgical consent form, the nurse must ensure the client has the ability to understand the information in the document.

T/F

back 120

True

The nurse reviews the information in the consent form with the client and witnesses the client's signature. The nurse verifies the client has the capacity to make choices and understands the consequences prior to the client signing the consent.