NCLEX-RN 10-23-2022

Question 1 of 184
A nurse is providing teaching for a client recently diagnosed with major depression who has a new prescription for fluoxetine. Priority should be given to teaching about interactions with which of the following supplements used by this client?
A Echinacea
B. Ginseng
C. St. John's wort
D. Ginkgo biloba

Answer: C

Question 2 of 184

What is the most important nursing role in disaster planning?
A. Gather sterile supplies that are needed in a disaster
B. List phone numbers for external disaster agencies
C. Understand how to perform the specifics of the hospital disaster plan
D. Evaluate the writeup of the last community disaster

Answer: C

Question 3 of 184
A nurse is providing discharge teaching to a client who has been diagnosed with primary adrenal insufficiency and has a new prescription for hydrocortisone to be taken three times a day. Which of the following should the nurse instruct this client?
A. Only report fever if temperature is greater than 102 F.
B. Report any polyuria, polydipsia, or polyphagia that may indicate hyperglycemia.
C. If you become ill, decrease your dosage by half.
D. Discontinue the medication if you begin to gain weight.

Answer: B

Question 4 of 184
Which of the following postpartum clients is at highest risk of hemorrhage after delivery?
A. A primigravida
B. A client with pregnancy-induced hypertension
C. A client under age 25
D. A client of Hispanic ethnicity

Answer: B

Question 5 of 184
A healthcare provider orders a serum alpha: fetoprotein test for a pregnant client at 20 weeks' gestation. Which best describes the purpose of this test?
A. Identifying renal disease in the mother
B. Verifying the risk of maternal-fetal blood type incompatibility
C. Assessing for fetal hyperbilirubinemia
D. Excluding the presence of fetal neural tube defects

Answer: D

Question 6 of 184

a. Gently instill 30-50 mL of water or NS (depending on agency policy) with an irrigation syringe
b. Position the client with pillows behind the shoulders
c. Assess placement before irrigating.
d. Pull back on the syringe plunger to aspirate gastric contents to check patency, repeat if the tube flow is sluggish
e. Explain the procedure and its potential discomfort to the client
f. Document the procedure
(Use the following format: ABCD, all letters capitalized, no periods, commas, or spaces)

Answer: EBCDAF
Before performing any procedure, the nurse needs to explain the processes and benefits to the client in order. The client has the right to know about treatments and medications. Assess if the tube is in place after setting pillows behind the client. Check tube patency before starting the irrigation as per agency policy. Finally, document the date, time, secretion, and client's condition. Do not use the syringe to aspirate the irrigating solution unless ordered to do so; ordinarily, all solution used to irrigate and clear the tube will be returned in the suction drainage.
Vital Concept:
Gastrostomy devices are used for long-term nutritional support of 6-8 weeks or more.The tubes can be placed through the abdominal wall into the stomach using either a surgical or laparoscopic procedures or, in the case of percutaneous endoscopic gastrostomy (PEG), the tube is placed using an endoscope to visualize the inside of the stomach and puncture an opening through the skin and subcutaneous tissues, through which the PEG tube is inserted.

Question 7 of 184
A nurse is caring for a client who has a terminal illness and is using a ventilator. The client is alert and oriented and tells the nurse he wants to discontinue the use of the

ventilator. The nurse should identify that continued treatment against the client's wishes is a violation of which of the following ethical principles?
A. Veracity
B. Autonomy
C. Utility
D. Justice

Answer: B

Question 8 of 184
A nurse is developing a plan of care for a client who has cervical cancer and is scheduled for brachytherapy. Which of the following actions should the nurse include? (Select all that apply.)
A. Allow visitors to stay with the client for 30 min intervals.
B. Place the client on bed rest.
C. Insert an indwelling urinary catheter.
D. Administer a suppository to prevent constipation.
E. Dispose soiled linens in hamper outside client's room.

Correct Answers:
A. Allow visitors to stay with the client for 30 min intervals.
B. Place the client on bed rest.
C. Insert an indwelling urinary catheter.

Question 9 of 184
A nurse is caring for a client with major depressive disorder who has not responded to pharmacological and psychotherapeutic interventions over a period of months. The psychiatrist has recommended electroconvulsive therapy (ECT) for the client. Which of the following clients is at risk for complications or adverse outcomes associated with ECT?
A. A history of schizophrenia
B. A cerebral neoplasm
C. A history of acute mania
D. Hypocalcemia

Answer: B
Clients at risk for complications and adverse effects relating to electroconvulsive therapy include those with a cerebral neoplasm, increased intracranial pressure, a history of cerebrovascular accidents, or recent myocardial infarction. Acute mania, schizophrenia, and bipolar disorder with rapid cycling are sometimes treated with electroconvulsive therapy; these are indications for this treatment and not associated risk factors or contraindications.

Question 10 of 184
A charge nurse on a medical-surgical unit has just been notified that the disaster protocol is being implemented following a natural disaster. Which of the following actions should the nurse take?
A. Make a list of clients who can be discharged
B. Reinforce discharge teaching to clients
C. Instruct the assistive personnel (AP) to focus on clients' ADLS.
D. Stock additional unit supplies.

Answer: A

Question 11 of 184
A nurse is caring for a school -age child who has a concussion. Which of the following manifestations are late indications of increased intracranial pressure (ICP). (Select all that apply.)
A. Réport of headache
B. Nausea
C. Decreased motor response
D. Increased sleeping
E. Bradycardia

Answer: C and E

Question 12 of 184
A nurse is assessing a newborn infant after a simple vaginal delivery. Which of the following findings on assessment should the nurse prioritize for follow-up?
A. An area of localized soft tissue edema on the scalp that crosses the suture line
B. White cheesy material in the genital region
C. A pigmented nevus with tuft of hair at the base of the lumbar spine
D. Acrocyanosis

Answer: C
A pigmented nevus at the base of the spine with a tuft of hair is often a sign of spina bifida occulta. This is a neural tube defect that is associated with a low intake of folic acid during the first trimester of pregnancy. Pregnant women with no family history of neural tube defect should take a folate supplement of at least 400 micrograms of folate daily. Although 95% of infants with neural tube defects are born to parents with no family history, a supplement of 4 mg daily is recommended for women with a family or personal history of a neural tube defect. Since folate supplementation has become widespread, the incidence of neural tube defects has diminished.

Question 13 of 184
A pediatric client with a respiratory rate over 45 is being triaged following a mass casualty event that occurred from a school bus wreck. Which category should the nurse place this client?
A. Expectant
B. Immediate
C. Delayed
D. Minor

Answer: B

Question 14 of 184
A client is hospitalized for the insertion of a low-dose radioactive implant. Which of the following nursing interventions should be used to promote safety for everyone?
A. Do not assign pregnant staff members to the client
B. Limit visitors to 1 hour daily
C. Keep visitors 3 feet from the client
D. Allow the client's grandchildren to visit for only 30 minutes per day

Answer: A

Question 15 of 184
A nurse is providing information for a client with major depressive disorder who is going to undergo electroconvulsive therapy. Which of the following is a side effect of electroconvulsive therapy that may be experienced by this client?
A Loss of appetite
B. Temporary loss of memory after treatment
C. Postural hypotension
D. Complete amnesia related to past episodes of abuse

Answer: B

Question 16 of 184
A nurse is drawing blood from a client's central venous catheter for routine lab work. Place in order the following steps for drawing blood from a central venous catheter using the syringe method.
Clamp the tubing if fluid is infusing into the central line
Disconnect tubing with fluid from the central line, keeping the tip sterile
Scrub the tubing port with an alcohol wipe.
Slowly flush the line with normal saline
Withdraw at least 2 mL of blood and discard
Attach an empty syringe and withdraw the ordered amount of blood for the specimen

Flush the line with normal saline after withdrawing blood
Reconnect the fluid line and start the infusion

Question 17 of 184

You are working on a surgical floor. Another nurse comes to tell you that your client needs to have a Foley catheter inserted prior to going to the OR. What is the first step you should
A. Ask client about any allergy to latex
B. Call the OR and ask what size catheter to insert
C. Check the client's chart for a healthcare provider's order to insert the catheter
D. Gather all the necessary equipment, including sterile gloves
E. Perform hand hygiene

Answer: C

Question 18 of 184
A charge nurse in the intensive care unit is assigning clients. Which of the following clients should be assigned to the most experienced nurse?
A. A client with a potassium level of 6.0 mEq/L who has peaked T waves
B. A client with type I diabetes with a blood glucose level of 280 mg/dL
C. A client with congestive heart failure who is scheduled for an echocardiogram
D. A client with COPD who has ABG values of: pH 7.38, Pa02 78, PaCO2 42, HC03 24

Answer: A

Question 19 of 184
A nurse is caring for a terminally ill client considering a Advanced Directive indicating Do Not Resuscitate status (DR) who remains uncertain. When providing information to the client, the nurse knows that which the following is legally and ethically equivalent to withholding life -sustaining treatment?
A. Assisted suicide
B. Allocation of resources
C. Withdrawal of life support
D. Active euthanasia

Answer: C
Withdrawal of life support in cases of futility is equivalent morally and legally to withholding life support, but it is often more difficult for family and for the healthcare staff to withdraw support than to withhold resuscitation. The client has various options, including DNR or an advance directive to withdraw life support. The client may appoint a surrogate to make the decision, or the decision can be made by the healthcare provider

in consultation with a colleague if it is clear that further life-sustaining measures are futile. Although medical science can sustain and prolong life, health cannot be restored in all cases. The nurse's role when life support is withdrawn is to provide comfort measures and support for the family.

Question 20 of 184
A nurse is assessing a client who states, "I am terrified of being outside alone." The nurse should identify that the client is experiencing which of the following phobias?
A. Murophobia
B. Acrophobia
C. Mysophobia
D. Agoraphobia

Answer: D

Question 21 of 184
A nurse is advising a young adult client on nutrition. Which of the following is a good source of complete protein?
A. Cruciferous vegetables
B. Brown rice
C. Eggs
D. Whole grain cereal

Answer: C

Question 23 of 184
A nurse is caring for a 1-day-old infant who has suspected Hirschsprung disease. Which of the following should the nurse anticipate on assessment of this child? (Select all that apply.)
A Nonbilious vomiting,
B. Bright red blood per rectum
C. No passage of meconium
D. Increased hunger
E. Abdominal distention

Answer: C and E
Hirschsprung disease (congenital aganglionic megacolon) is a congenital motor disorder of the intestine characterized by absence of neurons in sections of the colon. This is caused by the failure of nerve cells to migrate during fetal development, resulting in reduced gut motility and an inability to expel stool. Hirschsprung disease is 3-4 times as common in male children. It is associated with a variety of syndromes caused by

chromosomal abnormalities, including Downs syndrome. Hirschsprung disease is usually diagnosed in neonates.
Infants will manifest failure to pass meconium by 48 hours of life, bilious vomiting, and abdominal distention. Initial symptoms can include a fever and other signs of enterocolitis and toxic megacolon. Children who have less severe variants may not be diagnosed until after the age of 3

Question 24 of 184
A nurse is participating in a disaster simulation in which a toxic substance has been released into a crowded stadium. Multiple clients are transported to the facility. Which of the following actions should the nurse take first?
A. Prevent cross-contamination of clients
B. Complete a thorough client assessment
C. Treat clients arriving at the facility who have hello triage tags
D. Maintain a client tracking system

Answer: A- Prevent cross-contamination of clients.
Explanation: A disaster involving the release of a toxic substance indicates that the clients are at greatest risk for cross contamination between nonexposed clients and exposed clients. Therefore, the priority action is to promote the safety of the clients by separating them to prevent cross-contamination and limit the spread of the unknown toxin.

Question 25 of 184
A nurse is reading a client's tuberculin skin test at 48 hours and notes that the client has 6mm of redness and 3mm of induration. The client is HIV. Which of the following is the correct reading of the client's test?
A. 9 mm and negative
B. 6 mm and positive
C. 3 mm and positive
D. 3mm and negative

Answer:D 3 mm and negative. Explanation: The tuberculin skin test is performed by injection of tuberculin antigens or purified protein derivative (PPD) under the client's skin. In a client previously exposed to Mycobacterium tuberculosis, the bacteria that causes tuberculosis, a delayed hypersensitivity reaction will occur. With previous exposure, sensitized T cells aggregate at the site of injection and cause local vasodilation, edema, recruitment of inflammatory cells, and deposition of fibrin, causing an area of induration.

Question 26 of 184

Select the classification of a medication used for depression that is accurately paired with its possible adverse effects.
A. Tricyclic antidepressant: hypertensive crisis
B. Seductive serotonin reuptake inhibitor: Serotonin syndrome
C. Monoamine oxidase inhibitor: Cholinergic blockade
D. Selective serotonin reuptake inhibitor: Decreased seizure threshold

Answer: B Selective serotonin reuptake inhibitor: Serotonin syndrome.
Explanation: Selective serotonin reuptake inhibitors are associated with serotonin syndrome, central nervous system stimulation, hyponatremia, and gastrointestinal bleeding. Adverse effects of tricyclic antidepressants include decreased seizure threshold and cholinergic blockade; the adverse effects of monoamine oxidase inhibitors include hypertensive crisis, central nervous system stimulation, and orthostatic hypotension.

Question 27 of 184

A nurse is caring for a client who has major depressive disorder and was prescribed citalopram 2 weeks ago with a planned dosage increase after the first week. The client reports sleeping better at night, but still feels very depressed and is still experiencing anorexia and severe fatigue. Which of the following actions should the nurse take?
A. Speak to the provider about adding MAOI to the current medication regimen
B. Explain to the client that antidepressants often take several weeks to be fully effective.
C. Tell the client that the provider will need to replace the citalopram with a different medication
D. Recommend that the client take St. John's wort daily to help decrease depression

Answer: B. Explain to the client that antidepressants often take several weeks to be fully effective. Explanation: SSRIS, such as citalopram, are frequently prescribed to treat major depressive disorder nurse should explain to the client that it can take up to 4 weeks before therapeutic effects occur after beginning an antidepressant medication.

Question 28 of 184
A nurse is caring for a client who has experienced a left sided CVA.The nurse knows to intervene when the unlicensed nursing person assigned to help with feeding does which of the following?
A. Assist the client to sit upright at 90 degrees
B. Tilts the client's neck downward slightly during feeding
C. Thins pureed food with some milk to ease swallowing
D. Places food on the stronger side of the client's mouth

Answer. C Thins pureed food with some milk to ease swallowing.
Explanation: Clients can have difficulty swallowing (dysphagia) after a cerebral vascular accident (CVA),placing them at risk of aspiration pneumonia. Measures used to modify diet and rehabilitate swallowing to reduce the risk of aspiration include:

- Thickening liquids
- positioning the client upright during feeding at a 90-degree angle.
- Modifying food consistency to meet the client's needs (options include soft or pureed diet)
- Tilting the client's chin downwards to elevate the larynx and promote closure of the epiglottis
- Placing food on the side of the mouth that is stronger in order to allow the client to form a bolus for swallowing.

Question 29 of 184
A charge nurse is planning a staff education session to discuss medication used during the care of a client experiencing GI bleeding. Which of the following medications should the charge nurse include in the discussion?
A. Protamine sulfate
B. Vasopressin
C. Oxytocin
D. Vitamin K

Answer. B Vasopressin.
Explanation. Vasopressin is an analog of antidiuretic hormone used to treat diabetes insipidus and hemorrhagic shock unresponsive to other vasopressors. It works in gastrointestinal bleeding by constricting the arterioles and reducing inflow to the portal vein. Vasopressin also causes contraction of smooth muscles in the GI tract.
High pressures in the portal vein caused by cirrhosis lead to development of engorged vessels in the GI tract, known as varices. For treatment of GI hemorrhage, vasopressin is given in combination with intravenous nitroglycerin, which reduces the pressure in the portal vein. The use of this combination reduces the systemic effects of vasopressin, which could result in ischemia in other organs. Vasopressin is administered as a bolus followed by infusion.

Question 30 of 184
A nurse is assessing a 38-year-old female client who presents for a routine check-up. The client has primary hypoadrenalism (Addison's disease) and takes hydrocortisone 20mg daily since her diagnosis 2 years ago. Which of the following clinical findings should the nurse prioritize when reporting to the healthcare provider?
A. Weight gain of 8 lbs since the last visit 4 months ago
B. Hair growth in a male pattern on the upper lip and chin
C. Systolic blood pressure elevation from 140 mmHg since the last visit

D. Temperature of 100. 5 F
Answer: D. Temperature of 100.5^{0}F.

Explanation:Corticosteroids are used to treat individuals who have hypoadrenalism with impaired function of the adrenal gland. Corticosteroids suppress the immune system when given over a long period of time, which makes individuals susceptible to infection. Since corticosteroids have potent anti-inflammatory effects, they also reduce or suppress the signs of infection, including fever, tenderness, erythema (redness), and edema (swelling).Primary adrenal insufficiency (Addison's disease)is caused by destruction or malfunction of the adrenal glands. Clients who have Addison's disease may develop adrenal crisis, a life-threatening complication, in times of physiologic stress such as during a severe infection or after a serious injury, so it is important to monitor to determine if a higher doses of replacement hormones are necessary.

Question 31 of 184
A nurse is caring for a client who has undergone femoral angiogram and the nurse cannot palpate the pulse in the affected extremity on assessment. Which of the following is the priority nursing action?
A. Document "No pulse" in the affected extremity
B. Compare with the pulse in the upper extremity
C. Evaluate the pulse using a Doppler ultrasound
D. Elevate the extremity above the level of the heart.

Answer: C Evaluate the pulse using a Doppler ultrasound.
Explanation. An arterial occlusion can be identified by performing an angiogram, which is a radiologic study performed by injection of contrast into an artery before obtaining X-rays. Complications can include catheter site infection or hemorrhage or hematoma. Nursing assessments after angiography include neurovascular checks of the affected extremity. Changes indicating a complication include signs of deceased perfusion, including absent pulse, coolness, delayed capillary refill, changes in sensation and motor function in the affected extremity if compared to the contralateral extremity. A Doppler ultrasound should be used to determine if blood flow is maintained in the extremity if pulses are not palpable.

Question 32 of 184
Which of the following findings on a newborn assessment should be reported by the nurse to the healthcare provider?
A. Heart rate of 120/min
B. Respiratory rate of 35/min
C. Sacral dimple
D. Areas of purplish hyperpigmentation on the buttocks

Answer: C
Explanation.: A sacral dimple should be reported to the healthcare provider for further evaluation. It may be caused by Spina bifida occulta, which is a common neural tube defect in which the bones surrounding the meninges and spinal cord fail to close during gestation. A sacral dimple may represent a dermal sinus tract , or tract between the skin and the spinal cord. Assessment is needed. Some individuals may have variants of thickening of the nerve fibers at the base of the spinal bifida occurs in 10-20% of births, but many individuals with spina bifida occulta have no other significant findings or impairment.

Question 33 of 184
A nurse is caring for a client on a ventilator who had a chest tube placed for a pneumothorax. The water seal chamber has occasional bubbling. Which of the following is the most appropriate nursing intervention?

A. Check for an air leak
B. Increase the suction setting
C. Clamp the chest tube and notify the healthcare provider
D. No action is necessary since this finding is expected.

Answer: D
Explanation. The lungs are covered by two layers of pleura that have a potential space between them. If air or fluid enters the pleural space, the lung cannot fully expand, and a chest tube may be required for drainage chest tube is placed in the pleural space and connected to a sealed drainage system or 1-way valve to drain any collected fluid or blood and to create negative pressure and allow the lung to re-expand while preventing the entry of additional air into the system. A sterile water seal drainage system is used in most cases, with a closed chamber for drainage connected to a water seal chamber that prevents entry of air when the client inhales. Exhalation allows air to exit the chest cavity, so this air will intermittently bubble up through the water .Intermittent bubbling with respiration or coughing is an expected finding that usually resolves as the lungs re-expands. Continuous bubbling in the water seal chamber indicates a possible leak in the system, so the system should be assessed from the site of insertion back to the chest tube drainage system.

Question 34 of 184
A nurse is preparing to perform a gastric lavage for a client who was brought into the hospital after taking too many medications at home. Place the following steps in proper order for performing a gastric lavage with an NG (nasogastric) tube.

- Check the provider’s prescription and gather appropriate equipment
- Measure length of insertion of NGT by measuring from nose to ear to xiphoid process
- Insert tube and check for proper placement

- Position client on side, with the head down.
- Connect the NG tube to a Y-connector attached to both fluid and suction source
- Unclamp the fluid line and instill 200-300mL of fluid into adult client's stomach through NGT.
- Turn on the suction source and aspirate stomach contents and infused fluid
- Disconnect tube and remove.

Question 35 of 184
A nurse is caring for a client who is at 17 weeks of gestation and has a new diagnosis of molar pregnancy. Which of the following manifestations should the nurse expect?

A. Severe abdominal tenderness
B. Dark brown vaginal discharge
C. Elevated blood sugar levels
D. Fundal height measurement less than gestational age.

Answer**.** B Dark brown vaginal discharge.
Explanation**:** A client who has a molar pregnancy has dark red or brown vaginal bleeding because there is no placenta to receive the maternal blood. The blood collects in the uterus and eventually manifests as abnormal bleeding.

Question 36 of 184
A nurse must clean a blood pressure cuff that has been contaminated. Place in order the steps the nurse should take to clean it.

- Put on gloves
- Wash in hot water with soap
- Use a brush to clean the cuff, if necessary
- Rinse in hot water
- Hang dry
- Remove loves

Explanation**:** A blood pressure cuff is considered a "noncritical" item with respect to cleaning .The centers for Disease Control (CDC) recommends that noncritical client care devices should be disinfected any time they are visibly soiled and regular intervals. Low-level disinfectants can be used for cleaning noncritical client care devices. These devices must be disinfected after using on clients who are on contact precautions.

Question 37 of 184
A nurse administers a doxorubicin infusion through a peripheral IV and assesses the site. The nurse thinks the client has had extravasation and stops the infusion , disconnecting the IV tubing. What actions should the nurse take next?

A. Apply a cold compress
B. Try to remove any residual drug with a syringe (1-3mL).
C. Apply a warm compress.
D. Elevate the arm for 12 hours.

Answer. B Try to remove any residual drug with a syringe (1-3mL).
Explanation: Extravasation is characterized by the escape of a medication into the extravascular space through direct infiltration or leakage from a vessel. Some chemotherapy medications like doxorubicin are known as vesic.

Question 38 of 184
What is the correct order of steps that the nurse should follow to irrigate the ears of a 70-year-old client with hearing impairment? (Move the steps into the box on the right, placing them in order of performance.

- Assess the client for injury to the tympanic membrane, evidence of ear infection, or fever.
- Place the client in the sitting position and tilt the head to the affected ear
- Place a towel and emesis basin under the client's ear
- Pull the pinna up and back to straighten the ear canal
- Gently irrigate the ear canal with solution, using a slow and steady flow.

Ear irrigation may be prescribed to remove impacted cerumen or excess cerumen. Obstruction of the ear canal by cerumen can sometimes contribute to hearing loss and is often an initial step in the management of individuals with hearing impairment of gradual onset. First, the client should be assessed for any contraindications to irrigation, which include fever and ear infection. The tympanic membrane should be assessed with an otoscope to verify that it is before proceeding with irrigation. The nurse should explain the procedure before managing the client by placing the client in a siting position with the head tilted to the side that will be irrigated .

Question 39 of 184
A nurse who volunteers to serve on a commitment that addresses community disaster preparedness and response understands that secondary prevention in disaster response include which of the following?

A. Participation in community disaster exercises
B. Conducting community outreach
C. Assessment of disaster survivors
D. Providing community service linkages to families for recovery assistance.

Answer: C Assessment of disaster survivors.
Explanation: Secondary prevention consists of minimizing the effects of the disaster. The term refers to measures in a disaster designed to reduce morbidity and mortality after a disaster has occurred, in order to minimize harm from the disaster. Secondary measures include logistical coordination, rescue, immediate care, supportive care, and evacuation.

Question 40 of 184
A nurse is performing an indirect fist percussion on the back of a client. Put the following steps of this process in order.

- Assist the client to a sitting position
- Expose the client's back
- Place the palm of the non-dominant hand over the area to examine
- Draw the dominant hand into a closed fist.
- Hit the back of the flat hand using the ulnar aspect of the fist.
- Check with the client for the result

Question 41 of 184
A nurse is teaching a female client who has a new prescription for oxcarbazepine to treat partial seizures. Which of the following instructions should the nurse include in the teaching? (Select all that apply).
A. " Do not drink alcohol while taking this medication."
B. " Consider using an alternate form of contraception if you are using oral contraceptives."
C. " Chew gum to increase saliva production."
D. "Avoid driving until you see how the medication affects you."
E. " Notify your provider if you develop a skin rash."

Correct Answers are:
A. " Do not drink alcohol while taking this medication."
B. " Consider using an alternate form of contraception if you are using oral contraceptives."
D. "Avoid driving until you see how the medication affects you."
E. " Notify your provider if you develop a skin rash."
Incorrect answers:
C. Chewing gum to increase salivation is not indicated because the medication does not cause dry mouth.
Explanation: Alcohol and other CNS depressants increase the risk for CNS depression when taken with oxcarbazepine. An alternate form of contraception is recommended for clients taking oral contraceptives because oxcarbazepine decrease oral contraceptive levels.
The clients should avoid driving if CNS effects, such as dizziness, drowsiness, and double vision, develop. The client should notify the provider if a skin rash occurs because Stevens Johnson syndrome , a life-threatening skin disorder, can develop.

Question 42 of 184
A physician has ordered a PCA pump for pain control for a client. Place the following steps in the proper order for setting up a PCA machine.
- Check the order and gather the appropriate equipment
- Assess the client's IV site for potency
- Insert the medication vial into the machine
- Set the parameters for PCA use

- Double check the settings for the PCA pump with another nurse.

Explanation: A PCA is a method of providing pain control on the client's time frame, rather than waiting for the nurse to bring the medication. Because the client has control over how much pain medication he uses, the nurse must be very careful when setting up a PCA and should check the parameters with another nurse to avoid overdose or a medication error. The machine will lock the client out if he/she tries to use too much .The nurses should regularly assess the machine to ensure it is working correctly.
Client preparation and teaching are necessary for safe and effective use of PCA devices. Clients need to understand the PCA and be physically able to locate and press the button when analgesia is needed. Be sure to instruct family members not to "push the button" for the client. Client control only of PCA is an essential safety feature.

Question 43 of 184
When testing extraocular movements (EOM), the nurse is testing which cranial nerve (s)? (Select all that apply).

A. 2-Optic
B. 3-Oculomotor
C. 4-Trochlear
D. 5-Trigeminal
E. 6-Abducens

Correct answers:

B. 3-Oculomotor
C. 4-Trochlear
E.6-Abducens

Question 44 of 184
A nurse is caring for an older client with a history of heart failure who is hospitalized for breathing difficulties and fluid overload. Vitals signs: HR 58 bpm; BP 92/58mmHg, RR 12/min; T 98.1^{0}F (36.7^{0}C).The nurse is scheduled to administer a dose of 500mcg of digoxin at 0800.Which of the following actions of the nurse is most appropriate based on the information provided?

A. Administer the digoxin at 0800 as ordered
B. Hold the medication and contact the healthcare provider
C. Hold the medication and contact the pharmacy
D. Hold the medication and administer 2L of oxygen by mask.

Correct answer: B. Hold the medication and contact the healthcare provider
The nurse should not give the digoxin and should contact the healthcare provider for further orders. In this case, the client's heart rate is 58 bpm; taking the digoxin will cause the heart rate to drop even lower, which could be dangerous for the client. The nurse should first check hat the client has a stable heart rate before administering this medication.

Question 45 of 184
A nurse is caring for a client who requires strict bed rest following back surgery. The client activates the call button for the nurse to assist with use of the bedside commode, but the nurse does not arrive until ten minutes later. In the meantime, the client attempts to use the bedside commode without assistance and falls, causing dehiscence of the incision. The nurse has committed which of the following torts?

A. Battery
B. Malpractice
C. Invasion of privacy
D. Assault

Correct answer: B Malpractice.
Unintentional torts are those acts which fall below the established standard of care or duty owed to a client and include negligence and malpractice. Malpractice is an unintentional tort, defined as the failure to provide the expected standard of care , resulting in injury to the client. The expected standard of care for this client at this time is strict bed rest. The nurse did not intend to injure the client, but an injury resulted, nevertheless.

Question 46 of 184
A nurse is assisting with insertion of a pulmonary artery catheter for a client who needs invasive hemodynamic monitoring. Place each of the following steps in the proper order for assisting with insertion of a PAC.

- Prime IV tubing and the transducer flush lines
- Zero the transducers
- Connect transducers to the distal and proximal lumens
- Assist the provider with insertion by passing lines and catheters as needed
- Inflate the balloon on the catheter once inserted
- Secure the catheter to the client

Explanation: The pulmonary artery catheter (PAC) is used to measure pressures in the right atrium; pulmonary artery systolic and diastolic pressures; mean pulmonary artery pressure, and pulmonary artery wedge pressure. A pulmonary artery catheter is passed through the vena cava to the right atrium , where the balloon tip is inflated. The catheter is then carried rapidly through the tricuspid valve to the right ventricle of the heart, then through the pulmonary valve and into a pulmonary artery branch.

Question 47 of 184
A nurse is assessing a client's hearing by conducting a Rinne test using a tuning fork. Which of the following actions should the nurse take?

A. Place the base of the vibrating tuning folk in the center of the client's forehead
B. Place the stem of the vibrating tuning fork on the scalp above the client's ear
C. With the tuning fork still vibrating, move it to 1 to 2 cm (0.4 in to 0.8 in) from the client's ear canal.

D. Determine the results by combining the number of seconds for loss of sound from the each of the two for positions.

Correct answer: C. With the tuning fork still vibrating, move it to 1 to 2 cm (0.4 in to 0.8 in) from the client's ear canal.

Explanation: The nurse should quickly move the vibrating tuning fork from the mastoid process to the ear canal. The nurse should count the seconds it takes until the client no longer hears sound.

Question 48 of 184

A nurse is caring for a hospitalized client with schizophrenia who appears upset and states, " the voices are telling me I am in trouble. "Which of the following is the most appropriate response by the nurse?

A. " Don't listen to those voices; they are not real."
B. " What are the voices saying to you."
C. " I can ask your healthcare provider for medication to help you calm down."
D. "Tell the voices they are not real and watch some television in the day noon."

Correct answer: B.

This client is experiencing auditory hallucinations, which are common in psychosis. Hallucinations are false perceptions that are experienced without external stimuli. They involve auditory, visual, tactile, gustatory (taste) , or olfactory (smell) sensation. The hallucinations cause distress and may lead the client to harm himself/herself or others.

Question 50 of 184

The nurse is teaching a community class on home-based preparation for a disaster. Which of the following should be included?

A. How to turn off power and water
B. How much bread and water to have
C. Which hotels are nearby for evacuation
D. Which physician names and numbers to list

Answer: A

Question 51 of 184

The nurse is providing information to client entering perimenopause. Which of the following is true about this periodic change in the client? (Select all that apply).

A. Vaginal rugae increases
B. Vaginal pH increases
C. Vaginal lubrication increases
D. Vasomotor instability occurs
E. Estrogen increases
F. Vulvar tissue atrophies
G. Pelvic pain

Answer: B, D, and F
Menopause is the cessation of menses. The occurrence of menopause is an unavoidable life event in a woman's life. It is physiological process due to aging. The perimenopausal period sees the gradual cessation of reproductive function. Menopause in general is not a disease but a condition arising out of physiologic processes. The symptoms that arise from this life event are due to decrease in the hormone estrogen. The signs and symptoms include erratic menstrual cycles, vulvar tissue atrophy, rising of vaginal pH, decrease in vaginal lubrication, vasomotor instability, and decrease in vaginal rugae. Psychological symptoms such as moodiness, nervousness, insomnia, headache, irritability, anxiety, inability to concentrate, and depression may also occur. Hot flashes and night sweats are physiological reactions from decrease in estrogen. Pelvic pain does not usually occur with menopause unless another condition is present.

Question 52 of 184
An elderly client in a skilled nursing home asks the nurse on duty to serve as a witness to his signature on a living will. Which of the following is the most appropriate response by the nurse
A. " I will consult the nursing supervisor about specific guidelines in our facility."
B. “I can't witness your signature."
C. "Someone on staff can witness your signature."
D. " will call the hospital attorney to witness your signature.”

Answer: A

Question 53 of 184
A nurse is caring for a newborn who is small for gestational age (SGA) who is being monitored for possible respiratory distress. Vital signs are within normal limits. Which of the following factors may be a contributing factor in the neonate's size at birth?
A. Placenta previa
B. Cephalopelvic disproportion
C. Maternal inactivity
D. Warm climate
E None of the above

Answers: A

Question 54 of 184
A nurse is caring for a client in the ICU who has acute renal failure. Which of the following ECG findings indicate hyperkalemia?
A. Prominent delta waves
B. Peaked T wave

C. Prominent U waves
D. Osbourne J waves

Answers: B

Question 55 of 184
The nurse is providing hygiene and grooming to a client with schizophrenia. Which of the following is true about this condition?
A. It is caused by environmental factors
B. There is an increase in dopamine
C. There are extrapyramidal symptoms
D. It is initiated by anxiety

Answer: B
Schizophrenia is a condition where there is abnormal social behavior and inability to recognize reality. It is characterized by symptoms such as hallucinations, delusions, social withdrawal, disorganized thinking, and inactivity. The different types of schizophrenia are catatonic, paranoid, undifferentiated, and disorganized. It is caused by multiple contributing factors such as environment, genetic predisposition, prenatal development, and substance abuse. There is no single cause that can explain this condition. There is an increase in dopamine neurotransmitters produces many of the symptoms manifested by the client. For this reason, the pharmacologic treatment is aimed at reducing the impact of dopamine by blocking the dopamine receptors in the nervous system.

Question 56 of 184
A nurse is caring for a client with Addison's disease. Which of the following symptoms does the nurse expect? (Select all that apply)
A. Weakness
B. Hypopigmentation
C. Postural hypotension
D. Constipation
E. Diarrhea
F. Bradycardia
G. Muscle wasting

Answer: A, C, D, E, and G
Addison's disease is a condition that arises due to the destruction or dysfunction of the adrenal cortex resulting in chronic deficiency of cortisol, aldosterone, and androgens. There are numerable causes of this type of condition, such as autoimmune disorder, infection, trauma, and genetic abnormality. Aldosterone deficiency promotes sodium loss and decrease in blood volume causing postural hypotension, syncope, and symptoms of