

**2022 RN HESI EXIT EXAM - Version 1
(V1) All 160 Qs & As Included -
Guaranteed Pass A+!!! (All Brand**

written by
solution

1 of 160

The nurse is completing the admission assessment of a 3-year-old who is admitted with bacterial meningitis and hydrocephalus. Which assessment finding is evidence that the child is experiencing increased intracranial pressure (ICP)?

- A. Tachycardia and tachypnea.
- B. Sluggish and unequal pupillary responses.
- C. Increased head circumference and bulging fontanel.
- D. Blood pressure fluctuations and syncope.

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A client with acute pancreatitis is admitted with severe, piercing abdominal pain and an elevated serum amylase. Which additional information is the client most likely to report to the nurse?

- A. Abdominal pain decreases when lying supine.
- B. Pain lasts an hour and leaves the abdomen tender.
- C. Right upper quadrant pain refers to right scapula.
- D. Drinks alcohol until intoxicated at least twice weekly.

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A child newly diagnosed with sickle cell anemia (SCA) is being discharged from the hospital. Which information is most important for the nurse to provide the parents prior to discharge?

- A. Instructions about how much fluid the child should drink daily.
- B. Signs of addiction to opioid pain medications.
- C. Information about non-pharmaceutical pain relief measures.
- D. Referral for social services for the child and family.

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To auscultate for a carotid bruit, the nurse places the stethoscope at what location (Select the correct location on the image. To change, click on a new location.)



#4: I placed the Red dot on the base of the neck on the right side.

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After receiving report on an inpatient acute care unit, which client should the nurse assess first?

- A The client with an obstruction of the large intestine who is experiencing abdominal distention.
- B The client who had surgery yesterday and is experiencing a paralytic ileus with absent bowel sounds.
- C The client with a small bowel obstruction who has a nasogastric tube that is draining greenish fluid.
- D The client with a bowel obstruction due to a volvulus who is experiencing abdominal rigidity.

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A teenager presents to the emergency department with palpitations after vaping at a party. The client is anxious, fearful, and hyperventilating. The nurse anticipates the client developing which acid base imbalance?

- A Respiratory acidosis.
- B Metabolic alkalosis.
- C Metabolic acidosis.
- D Respiratory alkalosis.

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A client with dyspnea is being admitted to the medical unit. To best prepare for the client's arrival, the nurse should ensure that the client's bed is in which position?

A



B



C



D



Submit and Continue

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The nurse is taking the blood pressure measurement of a client with Parkinson's disease. Which information in the client's admission assessment is relevant to the nurse's plan for taking the blood pressure reading? (Select all that apply.)

- A Frequent syncope.
- B Occasional nocturia.
- C Flatt affect.
- D Blurred vision.
- E Frequent drooling.

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While caring for a client's postoperative dressing, the nurse observes purulent drainage at the wound. Before reporting this finding to the healthcare provider, the nurse should review which of the client's laboratory values?

- A Serum albumin.
- B Culture for sensitive organisms.
- C Serum blood glucose (BG) level.
- D Creatinine level.

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A preschool-aged boy is admitted to the pediatric unit following successful resuscitation from a near-drowning incident. While providing care to the child, the nurse begins talking with his grandfather, brother who rescued the child from the swimming pool and initiated resuscitation. The nurse notices the older boy becomes withdrawn when asked about what happened. Which action should the nurse take?

- A Develop a water safety teaching plan for the family.
- B Ask the older brother how he felt during the incident.
- C Tell the older brother that he seems depressed.
- D Commend the older brother for his heroic actions.

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A male client with cirrhosis has jaundice and pruritus. He tells the nurse that he has been soaking in hot baths at night with no relief of his discomfort. Which action should the nurse take?

- A Encourage the client to use cooler water and apply calamine lotion after soaking.
- B Obtain a PRN prescription for an analgesic that the client can use for symptom relief.
- C Suggest that the client take brief showers and apply oil-based lotion after showering.
- D Explain that the symptoms are caused by liver damage and cannot be relieved.

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An older client with a long history of coronary artery disease (CAD), hypertension (HTN), and heart failure (HF) arrives in the Emergency Department (ED) in respiratory distress. The healthcare provider prescribes furosemide IV. Which therapeutic response to furosemide should the nurse expect in the client with acute HF?

- A Increased cardiac contractility.
- B Reduced preload.
- C Relaxed vascular tone.
- D Decreased afterload.

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Which intervention should the nurse include in the plan of care for a child with tetanus?

- A Encourage coughing and deep breathing.
- B Minimize the amount of stimuli in the room.
- C Reposition from side to side every hour.
- D Open window shades to provide natural light.

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An adolescent who was diagnosed with diabetes mellitus Type 1 at the age of 9, is admitted to the hospital in diabetic ketoacidosis. Which occurrence is the most likely cause of the ketoacidosis?

- A Ate an extra peanut butter sandwich before gym class.
- B Incorrectly administered too much insulin.
- C Had a cold and ear injection for the past two days.
- D Skipped eating lunch.

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A client with a prescription for "do not resuscitate" (DNR) begins to manifest signs of impending death. After notifying the family of the client's status, what priority action should the nurse implement?

- A The impending signs of death should be documented.
- B The client's status should be conveyed to the chaplain.
- C The client's need for pain medication should be determined.
- D The nurse manager should be updated on the client's status.

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Which self care measure is most important for the nurse to include in the plan of care of a client recently diagnosed with type 2 diabetes mellitus?

- A Self-injection techniques.
- B Blood glucose monitoring.
- C Diabetic diet meal planning.
- D A realistic exercise plan.

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A client who gave birth 48 hours ago has decided to bottle feed the infant. During the assessment, the nurse observes that both breasts are swollen, warm, and tender on palpation. Which instruction should the nurse provide?

- A Apply ice to the breasts for comfort.
- B Wear a loose-fitting bra during the day to prevent nipple irritation.
- C Run warm water over breasts.
- D Express small amounts of milk from the breasts to relieve pressure.

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The nurse is preparing a client who had a below-the-knee (BKA) amputation for discharge to home. Which recommendations should the nurse provide this client? (Select all that apply.)

- A Avoid range of motion exercises.
- B Use a residual limb shrinker.
- C Apply alcohol to the stump after bathing.
- D Inspect skin for redness.
- E Wash the stump with soap and water.

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A toddler presenting with a history of intermittent skin rashes, hives, abdominal pain, and vomiting that occurs after ingesting of milk products arrives to the clinic accompanied by the parents. Which type of testing should the nurse provide education to the toddler's family about?

- A Serum immunoglobulin E (IgE).
- B Intradermal test.
- C Atopy patch test.
- D Placebo-controlled food challenge.

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A client who is scheduled for a bronchoscopy in the morning is anxious and asking the nurse numerous questions about the procedure. In preparing the client for the procedure, which intervention has the highest priority?

- A Allow client to gargle with warm salt water.
- B Administer a sedative to alleviate anxiety.
- C Instruct client to write down the questions.
- D Deny client's request for a midnight snack.



#20 – check my answer, I wasn't sure about this one

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The nurse assesses a client one hour after starting a transfusion of packed red blood cells and determines that there are no indications of a transfusion reaction. What instruction should the nurse provide the uncensored assistive personnel (UAP) who is working with the nurse?

- A Notify the nurse when the transfusion has finished, so further client assessment can be done.
- B Continue to measure the client's vital signs every thirty minutes until the transfusion is complete.
- C Monitor the client carefully for the next three hours and report the onset of a reaction immediately.
- D Since a reaction did not occur, the priority is to maintain client comfort during the transfusion.

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The healthcare provider prescribes a sepsis protocol for a client with multi-organ failure caused by a ruptured appendix. Which intervention is most important for the nurse to include in the plan of care?

- A Assess warmth of extremities.
- B Keep head of bed raised 45 degrees.
- C Monitor blood glucose level.
- D Maintain strict intake and output.

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A client presses the call bell and requests pain medication for a severe headache. To assess the quality of the client's pain, which approach should the nurse use?

- A Ask the client to describe the pain.
- B Observe body language and movement.
- C Identify effective pain relief measures.
- D Provide a numeric pain scale.

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A client presents to the labor and delivery unit with a report of leaking fluid that is greenish-brown vaginal discharge. Which action should the nurse take first?

- A Start an intravenous infusion.
- B Administer oxygen via facemask.
- C Perform a vaginal exam.
- D Begin continuous fetal monitoring.

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A client asks the nurse for information about how to reduce risk factors for benign prostatic hyperplasia (BPH). Which information should the nurse provide?

- A Consume a high protein diet.
- B Increase physical activity.
- C Take vitamin supplements.
- D Obtain a prostate-specific antigen blood level test.

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The healthcare provider prescribes a fluid challenge of 0.9% sodium chloride 1,000 mL to be infused intravenously (IV) over 4 hours. The IV administration set delivers 10 gtt/mL. How many gtt/minute should the nurse regulate the infusion? (Enter numeric value only. If rounding is required, round to the nearest whole number.)

21

#26: check this answer I think I typed the wrong answer here. Double check my work.

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Following a cardiac catheterization and placement of a stent in the right coronary artery, the nurse administers prasugrel, a platelet inhibitor, to the client. To monitor for adverse effects from the medication, which assessment is most important for the nurse to include in this client's plan of care?

- A Observe color of urine.
- B Measure body temperature.
- C Assess skin turgor.
- D Check for pedal edema.

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A client fell in the bathroom when left unattended by the unlicensed assistive personnel (UAP). Which information should the nurse include in the client's health record?

- A The UAP left the client to assist another client.
- B The last time client was assisted to the bathroom.
- C The unit was understaffed when the client fell.
- D The client fell sustaining a fracture to the left hip.

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The nurse is reviewing the diagnostic tests prescribed for a client with a positive skin test. Which subjective findings reported by the client supports the diagnosis of tuberculosis?

- A Barking cough and vomiting.
- B Mucopurulent cough and night sweats.
- C Dry cough and chest tightness.
- D Chronic cough and fatty stools.

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In assessing a client with type 1 diabetes mellitus, the nurse notes that the client's respirations have changed from 16 breaths/minute with a normal depth to 32 breaths/minute and deep, and the client has become lethargic. Which assessment data should the nurse obtain next?

- A Temperature.
- B Breath sounds.
- C Blood glucose.
- D White blood cell count.