NCLEX

Exam Questions NCLEX-PN

National Council Licensure Examination(NCLEX-PN)

NEW QUESTION 1
- (Topic 1)
While undergoing fetal heart monitoring, a pregnant Native-American woman requests that a medicine woman be present in the examination room. Which of the following is an appropriate response by the nurse?

A. ??I will assist you in arranging to have a medicine woman present.??
B. ??We do not allow medicine women in exam rooms.??
C. ??That does not make any difference in the outcome.??
D. ??It is old-fashioned to believe in that.??

Answer: A

Explanation:
This statement reflects cultural awareness and acceptance that receiving support from a medicine woman is important to the client. The other statements are culturally insensitive and unprofessional.
Reduction of Risk Potential

NEW QUESTION 2
- (Topic 1)
A batterer is usually someone who:

A. grew up in a loving, secure home.
B. was an only child.
C. was physically or psychologically abused.
D. admits he has a problem with anger.

Answer: C

Explanation:
Many batterers report having been abused as children.Psychosocial Integrity

NEW QUESTION 3
- (Topic 1)
A woman asks, ??How much alcohol can I safely drink while pregnant??? The nurse??s best response is:

A. ??The amount of alcohol that is safe during pregnancy is unknown.??
B. ??Consuming one or two beers or glasses of wine a day is considered safe for a healthy pregnant woman.??
C. ??Drinking three or more drinks on any given occasion is the only harmful type of drinking during pregnancy.??
D. ??You can have a drink to help you relax and get to sleep at night.??

Answer: A

Explanation:
The amount of alcohol that is safe during pregnancy is unknown. Fetal alcohol syndrome is a combination of mental and physical abnormalities present in infants born to mothers who have consumed alcohol during pregnancy.Psychosocial Integrity

NEW QUESTION 4
- (Topic 1)
A health care worker is concerned about a new mother being overwhelmed by caring for her infant. The health care worker should:

A. immediately contact child protective services.
B. provide the mother with literature about child care.
C. consult a therapist to help the mother work out her fears.
D. refer the mother to parenting classes.

Answer: D

Explanation:
Prevention of child abuse is centered on teaching the parents how to care for their child and cope with the demands of infant care. Parenting classes can help build self-confidence, self-esteem, and coping skills. Parents benefit by understanding the developmental needs of their children, while learning how to manage their home environment more effectively. The classes also increase the parents?? social contacts and teach about community resources.Psychosocial Integrity

NEW QUESTION 5
- (Topic 1)
Which of the following conditions is mammography used to detect?

A. pain
B. tumor
C. edema
D. epilepsy

Answer: B

Explanation:
Mammography is used to detect tumors or cysts in the breasts, not the other conditions.
Reduction of Risk Potential

NEW QUESTION 6
- (Topic 1)
Erythropoietin used to treat anemia in clients with renal failure should be given in conjunction with:

A. iron, folic acid, and B12.
B. an increase of protein in the diet.
C. vitamins A and C.
D. an increase of calcium in the diet.

Answer: A

Explanation:
The kidneys of a client in renal failure produce no erythropoietin, a hormone necessary for RBC production.
Erythropoietin can be given as replacement, but the client needs adequate iron, folate, and B12 to increase the effectiveness of EPO. Choice 2 is not necessary for RBC production and can increase uremia. Choices 3 and 4 are not necessary for RBC production.Physiological Adaptation

NEW QUESTION 7
- (Topic 1)
A client is having a seizure; his blood oxygen saturation drops from 92% to 82%. What should the nurse do first?

A. Open the airway.
B. Administer oxygen.
C. Suction the client.
D. Check for breathing.

Answer: A

Explanation:
The nurse needs to open the airway first when the oxygen saturation drops. The other actions might be appropriate, but the airway must be patent.Reduction of Risk Potential

NEW QUESTION 8
- (Topic 1)
Why must the nurse be careful not to cut through or disrupt any tears, holes, bloodstains, or dirt present on the clothing of a client who has experienced trauma?

A. The clothing is the property of another and must be treated with care.
B. Such care facilitates repair and salvage of the clothing.
C. The clothing of a trauma victim is potential evidence with legal implications.
D. Such care decreases trauma to the family members receiving the clothing.

Answer: C

Explanation:
Trauma in any client, living or dead, has potential legal and/or forensic implications.
Clothing, patterns of stains, and debris are sources of potential evidence and must be preserved. Nurses must be aware of state and local regulations that require mandatory reporting of cases of suspected child and elder abuse, accidental death, and suicide. Each Emergency Department has written policies and procedures to assist nurses and other health care providers in making appropriate reports. Physical evidence is real, tangible, or latent matter that can be visualized, measured, or analyzed. Emergency Department nurses can be called on to collect evidence. Health care facilities have policies governing the collection of forensic evidence. The chain of evidence custody must be followed to ensure the integrity and credibility of the evidence. The chain of evidence custody is the pathway that evidence follows from the time it is collected until is has served its purpose in the legal investigation of an incident.Physiological Adaptation

NEW QUESTION 9
- (Topic 1)
Which is the proper hand position for performing chest vibration?

A. cup the hands
B. use the side of the hands
C. flatten the hands
D. spread the fingers of both hands

Answer: C

Explanation:
The hands are flattened over the area of the body where chest percussion is used to conduct vibration through to the chest and loosen secretions. The other hand positions do not accomplish this task.
Reduction of Risk Potential

NEW QUESTION 10
- (Topic 1)
All of the following factors, when identified in the history of a family, are correlated with poverty except:

A. high infant mortality rate.
B. frequent use of Emergency Departments.

C. consultation with folk healers.
D. low incidence of dental problems.

Answer: D

Explanation:
Dental problems are prevalent because of the lack of preventive care and access to care.
High infant mortality is one of the most significant problems correlated with poverty. Pregnant women who do not have access to care might come to the Emergency Department when in labor. Those in poverty are likely to use Emergency Departments because they may not be turned away. Those in poverty might also turn to folk healers or other persons in their community for care who might be easier to access and might not demand payment.Health Promotion and Maintenance

NEW QUESTION 10
- (Topic 1)
A diet high in fiber content can help an individual to:

A. lose body weight fast.
B. reduce diabetic ketoacidosis.
C. lower cholesterol.
D. reduce the need for folate.

Answer: C

Explanation:
Fiber-rich foods (such as grains, apples, potatoes, and beans) can help lower cholesterol.
Nonpharmacological Therapies

NEW QUESTION 13
- (Topic 1)
Which sign might the nurse see in a client with a high ammonia level?

A. coma
B. edema
C. hypoxia
D. polyuria

Answer: A

Explanation:
Coma might be seen in a client with a high ammonia level.Reduction of Risk Potential

NEW QUESTION 14
- (Topic 1)
Which of the following physical findings indicates that an 11–12-month-old child is at risk for developmental dysplasia of the hip?

A. refusal to walk
B. not pulling to a standing position
C. negative Trendelenburg sign
D. negative Ortolani sign

Answer: B

Explanation:
The nurse might be concerned about developmental dysplasia of the hip if an 11–12- month-old child doesn??t pull to a standing position. An infant who does not walk by 15 months of age should be evaluated. Children should start walking between 11–15 months of age. Trendelenberg sign is related to weakness of the gluteus medius muscle, not hip dysplasia. Ortolani sign is used to identify congenital subluxation or dislocation of the hip in infants.Health Promotion and Maintenance

NEW QUESTION 16
- (Topic 1)
The kind of man who beats a woman is:

A. from a minority culture in a low-income group.
B. from a majority culture in a middle-income group.
C. one who was never allowed to compete as a child.
D. from any walk of life, race, income group, or profession.

Answer: D

Explanation:
Batterers cannot be predicted by demographic features related to age, ethnicity, race, religious denomination, education, socioeconomic status, or class. Ninety-five percent of domestic abuse cases
involve male perpetrators and female victims.Psychosocial Integrity

NEW QUESTION 21
- (Topic 1)
Assessment of a client with a cast should include:

A. capillary refill, warm toes, no discomfort.
B. posterior tibial pulses, warm toes.
C. moist skin essential, pain threshold.
D. discomfort of the metacarpals.

Answer: A

Explanation:
Assessment for adequate circulation is necessary. Signs of impaired circulation include slow capillary refill, cool fingers or toes, and pain.Basic Care and Comfort

NEW QUESTION 26
- (Topic 1)
Assessment of the client with an arteriovenous fistula for hemodialysis should include:

A. inspection for visible pulsation.
B. palpation of thrill.
C. percussion for dullness.
D. auscultation of blood pressure.

Answer: B

Explanation:
Thrill should be present. The client should be taught to check this daily at home. Pulsation is not typically visible. Percussion gives no information about the patency of a fistula. Blood pressure is not auscultated in a limb with an AVF. Auscultation of the AVF, for a bruit, is part of an assessment for patency.
Physiological Adaptation

NEW QUESTION 30
- (Topic 1)
Which of the following instructions should the nurse give a client who will be undergoing mammography?

A. Be sure to use underarm deodorant.
B. Do not use underarm deodorant.
C. Do not eat or drink after midnight.
D. Have a friend drive you home.

Answer: B

Explanation:
Underarm deodorant should not be used because it might cause confusing shadows on the X-ray film. There are no restrictions on food or fluid intake. No sedation is used, so the client can drive herself home.Reduction of Risk Potential

NEW QUESTION 31
- (Topic 1)
Ashley and her boyfriend Chris, both 19 years old, are transported to the Emergency Department after being involved in a motorcycle accident. Chris is badly hurt, but Ashley has no apparent injuries, though she appears confused and has trouble focusing on what is going on around her. She complains of dizziness and nausea. Her pulse is rapid, and she is hyperventilating. The nurse should assess Ashley??s level of anxiety as:

A. mild.
B. moderate.
C. severe.
D. panic.

Answer: C

Explanation:
The person whose anxiety is assessed as severe is unable to solve problems and has a poor grasp of what??s happening in his or her environment. Somatic symptoms such as those described by Ashley are usually present.
Vital sign changes are observed. The individual with mild anxiety might report being mildly uncomfortable and might even find performance enhanced. The individual with moderate anxiety grasps less information about the situation, has some difficulty problem-solving, and might have mild changes in vital signs. The individual in panic demonstrates markedly disturbed behavior and might lose touch with reality.
Psychosocial Integrity

NEW QUESTION 33
- (Topic 1)
A pregnant Asian client who is experiencing morning sickness wants to take ginger to relieve the nausea. Which of the following responses by the nurse is appropriate?

A. ??I will call your physician to see if we can start some ginger.??
B. ??We don??t use home remedies in this clinic.??
C. ??Herbs are not as effective as regular medicines.??
D. ??Just eat some dry crackers instead.??

Answer: A

Explanation:

This statement reveals cultural sensitivity. Ginger is sometimes used to relieve nausea.
The other statements are culturally insensitive and do not show an awareness of herbal pharmacology.
Physiological Adaptation

NEW QUESTION 36
- (Topic 1)
To remove hard contact lenses from an unresponsive client, the nurse should:

A. gently irrigate the eye with an irrigating solution from the inner canthus outward.
B. grasp the lens with a gentle pinching motion.
C. don sterile gloves before attempting the procedure.
D. ensure that the lens is centered on the cornea before gently manipulating the lids to release the lens.

Answer: D

Explanation:
To remove hard contact lenses, the upper and lower eyelids are gently maneuvered to help loosen the lens and slide it out of the eye. The lens must be situated on the cornea, not the sclera, before removal. An attempt to grasp a hard lens might result in a scratch on the cornea. Clean gloves are an option if drainage is present.Basic Care and Comfort

NEW QUESTION 37
- (Topic 1)
Which of the following injuries, if demonstrated by a client entering the Emergency Department, is the highest priority?

A. open leg fracture
B. open head injury
C. stab wound to the chest
D. traumatic amputation of a thumb

Answer: C

Explanation:
A stab wound to the chest might result in lung collapse and mediastinal shift that, if untreated, could lead to
death. Treatment of an obstructed airway or a chest wound is a higher priority than hemorrhage. The principle of ABC (airway, breathing, and circulation) prioritizes care decisions.Physiological Adaptation

NEW QUESTION 38
- (Topic 1)
Which of the following foods is a complete protein?

A. corn
B. eggs
C. peanuts Dsunflower seeds

Answer: B

Explanation:
Eggs are a complete protein. The remaining options are incomplete proteins.Health Promotion and Maintenance

NEW QUESTION 39
- (Topic 1)
The nurse explains to a client who underwent gastric resection that which of the following meals is most likely to cause rapid emptying of the stomach?

A. a high-protein meal
B. a high-fat meal
C. a large meal regardless of nutrient content
D. a high-carbohydrate meal

Answer: D

Explanation:
Meals that are high in carbohydrates promote rapid gastric emptying. The other options are associated with
decreased emptying time.Basic Care and Comfort

NEW QUESTION 43
- (Topic 1)
A young boy is recently diagnosed with a seizure disorder. Which of the following statements by the boy??s mother indicates a need for further teaching by the nurse?

A. ??I should make sure he gets plenty of rest.??
B. ??I should get him a medic alert bracelet.??
C. ??I should lay him on his back during a seizure.??
D. ??I should loosen his clothing during a seizure.??

Answer: C

Explanation:

A client having a seizure should be turned to the side to prevent aspiration of secretions.
The other statements are correct and indicate adequate understanding of teaching.Reduction of Risk Potential

NEW QUESTION 48
- (Topic 1)
A client comes to the clinic for assessment of his physical status and guidelines for starting a weight-reduction diet. The client??s weight is 216 pounds and his height is 66 inches. The nurse identifies the BMI (body mass index) as:

A. within normal limits, so a weight-reduction diet is unnecessary.
B. lower than normal, so education about nutrient-dense foods is needed.
C. indicating obesity because the BMI is 35.
D. indicating overweight status because the BMI is 27.

Answer: C

Explanation:
Obesity is defined by a BMI of 30 or more with no co-morbid conditions. It is calculated by utilizing a chart
or nomogram that plots height and weight. This client??s BMI is 35, indicating obesity. Goals of diet therapy are aimed at decreasing weight and increasing activity to healthy levels based on a client??s BMI, activity status, and energy requirements.Physiological Adaptation

NEW QUESTION 53
- (Topic 1)
Diagnostic genetic counseling, for procedures such as amniocentesis and chorionic villus sampling, allows clients to make all of the following choices except:
A. terminating the pregnancy.
B. preparing for the birth of a child with special needs.
C. accessing support services before the birth.
D. completing the grieving process before the birth.

Answer: D

Explanation:
If findings are ominous, the grieving process will not be completed before birth. If the couple elects to
terminate a pregnancy based on diagnostic tests, there will be grief and concerns for future pregnancies. Couples might choose to access support services and prepare for the birth of an infant with special needs. Some fetal conditions can be treated in utero.Health Promotion and Maintenance

NEW QUESTION 54
- (Topic 1)
A 10-month-old child is brought to the Emergency Department because he is difficult to awaken. The nurse notes bruises on both upper arms. These findings are most consistent with:

A. wearing clothing that is too small for the child.
B. the child being shaken.
C. falling while learning to walk.
D. parents trying to awaken the child.

Answer: B

Explanation:
Children who are shaken are frequently grasped by both upper arms. Symptoms of brain injury associated
with shaking include decreased level of consciousness.Psychosocial Integrity

NEW QUESTION 59
- (Topic 1)
Which of the following neurological disorders is characterized by writhing, twisting movements of the face and limbs?

A. epilepsy
B. Parkinson??s
C. muscular sclerosis
D. Huntington??s chorea

Answer: D

Explanation:
Huntington??s chorea is characterized by writhing, twisting movements of the face and limbs.
The remaining options are neurological disorders that do not have such movements as part of their disease process.Reduction of Risk Potential

NEW QUESTION 62
- (Topic 1)
A client with an ileus is placed on intestinal tube suction. Which of the following electrolytes is lost with intestinal suction?

A. calcium
B. magnesium
C. potassium
D. sodium chloride

Answer: D

Explanation:
Duodenal intestinal fluid is rich in K+, NA+, and bicarbonate. Suctioning to remove excess fluids decreases the client??s K+ and NA+ levels.Basic Care and Comfort

NEW QUESTION 65
- (Topic 1)
Which of the following methods of contraception is able to reduce the transmission of HIV and other STDs?

A. intrauterine device (IUD)
B. Norplant
C. oral contraceptives
D. vaginal sponge

Answer: D

Explanation:
The vaginal sponge is a barrier method of contraception that, when used with foam or jelly contraception, reduces the transmission of HIV and other STDs as well as reducing the risk of pregnancy. IUDs, Norplant, and oral contraceptives can prevent pregnancy but not the transmission HIV and STDs.
Clients using the contraceptive methods in Choices 1, 2, and 3 should be counseled to use a chemical or barrier contraceptive to decrease transmission of HIV or STDs.Health Promotion and Maintenance

NEW QUESTION 67
- (Topic 1)
Major competencies for the nurse giving end-oflife care include:

A. demonstrating respect and compassion, and applying knowledge and skills in care of the family and the client.
B. assessing and intervening to support total management of the family and client.
C. setting goals, expectations, and dynamic changes to care for the client.
D. keeping all sad news away from the family and client.

Answer: A

Explanation:
There are many competencies that the nurse must have to care for families and clients at the end of life.
Demonstration of respect and compassion as well as using knowledge and skills in the care of the client and family are major competencies.Basic Care and Comfort

NEW QUESTION 72
- (Topic 1)
An appropriate intervention for the client with suspected genitourinary trauma and visible blood at the urethral meatus is:

A. insertion of a Foley catheter.
B. in and out catheter specimen for urinalysis.
C. a voided urine specimen for urinalysis.
D. a urologist consult.

Answer: D

Explanation:
A urologist consult is appropriate for a client with visible blood at the urethral meatus and suspected trauma.
Choices 1 and 2 are contraindicated. A urinalysis might be ordered by the physician, but the question does not provide enough information to make Choice 3 the correct answer.Physiological Adaptation

NEW QUESTION 76
- (Topic 1)
Which of the following indicates a hazard for a client on oxygen therapy?

A. A No Smoking sign is on the door.
B. The client is wearing a synthetic gown.
C. Electrical equipment is grounded.
D. Matches are removed.

Answer: B

Explanation:
A synthetic gown might generate sparks of static electricity, which can be a fire hazard, particularly in the presence of oxygen. The client on oxygen therapy should wear a cotton gown. The remaining options are appropriate safety measures.Reduction of Risk Potential

NEW QUESTION 80
- (Topic 1)
Acyclovir is the drug of choice for:

A. HIV.
B. HSV 1 and 2 and VZV.
C. CMV.

D. influenza A viruses.

Answer: B

Explanation:
Acyclovir (Zovirax) is specific for treatment of herpes virus infections. There is no cure for herpes. Acyclovir is excreted unchanged in the urine and therefore must be used cautiously in the presence of renal impairment. Drugs that treat herpes inhibit viral DNA replication by competing with viral substrates to form shorter, ineffective DNA chains.Physiological Adaptation

NEW QUESTION 83
- (Topic 1)
Which of the following is likely to increase the risk of sexually transmitted disease?

A. alcohol use
B. certain types of sexual practices
C. oral contraception use
D. all of the above

Answer: D

Explanation:
STDs affect certain groups in groups in greater numbers. Factors associated with risk include being younger than 25 years of age, being a member of a minority group, residing in an urban setting, being impoverished, and using crack cocaine.Physiological Adaptation

NEW QUESTION 88
- (Topic 1)
A client with which of the following conditions is at risk for developing a high ammonia level?

A. renal failure
B. psoriasis
C. lupus
D. cirrhosis

Answer: D

Explanation:
A client with cirrhosis is at risk for developing a high ammonia level.Reduction of Risk Potential

NEW QUESTION 89
- (Topic 1)
How often should the nurse change the intravenous tubing on total parenteral nutrition solutions?

A. every 24 hours
B. every 36 hours
C. every 48 hours
D. every 72 hours

Answer: A

Explanation:
The nurse should change the intravenous tubing on total parenteral nutrition solutions every 24 hours, due to the high risk of bacterial growth.Health Promotion and Maintenance

NEW QUESTION 91
- (Topic 1)
A client, age 28, was recently diagnosed with Hodgkin??s disease. After staging, therapy is planned to include combination radiation therapy and systemic chemotherapy with MOPP— nitrogen mustard, vincristine (Onconvin), prednisone, and procarbazine. In planning care for this client, the nurse should anticipate which of the following side effects to contribute to a sense of altered body image?

A. cushingoid appearance
B. alopecia
C. temporary or permanent sterility
D. pathologic fractures

Answer: D

Explanation:
Pathologic fractures are not common to the disease process. Its treatment through osteoporosis is a potential complication of steroid use. Hodgkin??s disease most commonly affects young adults (males), is spread through lymphatic channels to contiguous nodes, and also might spread via the hematogenous route to extradal sites (GI, bone marrow, skin, and other organs). A working staging classification is performed for clinical use and care.
Physiological Adaptation

NEW QUESTION 96
- (Topic 2)
The vast majority of deaths resulting from unintentional poisoning occur in:

A. infants.
B. toddlers.
C. teens.
D. adults.

Answer: B

Explanation:
The vast majority of deaths resulting from unintentional poisoning occur in toddlers.Safety and Infection Control

NEW QUESTION 98
- (Topic 2)
The nurse teaching an obese client about nutritional needs and weight loss should include all of the following except:

A. knowledge of food and food products.
B. development of a positive mental attitude.
C. adequate exercise.
D. starting a fast weight-loss diet.

Answer: D

Explanation:
Start a fast weight-loss diet.Health Promotion and Maintenance

NEW QUESTION 101
- (Topic 2)
A hospitalized client has just been informed that he has terminal cancer. He says to the nurse, ??There must be some mistake in the diagnosis.?? The nurse determines that the client is demonstrating which of the following?

A. denial
B. anger
C. bargaining
D. acceptance

Answer: A

Explanation:
Denial (K??bler-Ross??s Stages of Grieving) is the refusal to believe that loss is happening.
Psychosocial Integrity

NEW QUESTION 105
- (Topic 2)
In performing a psychosocial assessment, the nurse begins by asking questions that encourage the client to describe problematic behaviors and situations. The next step is to elicit the client??s:

A. feelings about what has been described.
B. thoughts about what has been described.
C. possible solutions to the problem.
D. intent in sharing the description.

Answer: B

Explanation:
Questions should be asked in a precise order (specifically, from the most-simple description to the moredifficult disclosure of feelings). When the problems have been described, eliciting the client??s thoughts about the dilemmas provides further assessment data as well as the client??s interpretation of what has happened. Feelings, solutions and articulating intent are more complex processes.Psychosocial Integrity

NEW QUESTION 110
- (Topic 2)
A 4-year-old client is unable to go to sleep at night in the hospital. Which nursing intervention best promotes sleep for the child?

A. turning out the room light and closing the door
B. tiring the child during the evening with play exercises
C. identifying the child??s home bedtime rituals and following them
D. encouraging visitation by friends during the evening

Answer: C

Explanation:
Preschool-age children require bedtime rituals that should be followed in the hospital if possible. Choice 1 increases a child??s fear. Choices 2 and 4 do not promote sleep.Basic Care and Comfort

NEW QUESTION 114
- (Topic 2)
Using clich??s in therapeutic communication leads the client toward:

A. viewing the nurse as human.
B. accepting himself as human.
C. self-disclosing.
D. feeling discounted.

Answer: D

Explanation:
The use of clich??s in therapeutic communication is commonly construed by the client as the nurse??s lack of understanding, involvement, and caring, so the client might feel demeaned and discounted.
Psychosocial Integrity

NEW QUESTION 116
- (Topic 2)
A client recently lost a child due to poisoning. The client tells the nurse, ??I don??t want to make any new friends right now.?? This is an example of which of the following indicators of stress?

A. emotional behavioral indicator
B. spiritual indicator
C. sociocultural indicator
D. intellectual indicator

Answer: C

Explanation:
Stress can alter a person??s relationships with others.Psychosocial Integrity

NEW QUESTION 121
- (Topic 2)
In an obstetrical emergency, which of the following actions should the nurse perform first after the baby delivers?

A. Place extra padding under the mother to absorb blood from the delivery.
B. Cut the umbilical cord using sterile scissors.
C. Suction the baby??s mouth and nose.
D. Wrap the baby in a clean blanket to preserve warmth.

Answer: C

Explanation:
After the baby delivers, the nurse should clear the mouth and nose of the infant first.
Choice 4 is the next step. Choices 1 and 2 might be performed depending on the situation.Safety and Infection Control

NEW QUESTION 124
- (Topic 2)
The nurse is teaching a client about erythema infectiosum. Which of the following factors are not correct?

A. There is no rash.
B. The disorder is uncommon in adults.
C. There is no fever.
D. There is sometimes a ??slapped face?? appearance.

Answer: B

Explanation:
Fifth??s disease, erythema infectiosum, is uncommon in adults. All the other statements are correct.Safety and Infection Control

NEW QUESTION 126
- (Topic 2)
Someone who has received a recent tattoo should be screened for:

A. tuberculosis.
B. herpes.
C. hepatitis.
D. syphilis.

Answer: C

Explanation:
Tattooing puts a client at risk for blood-borne hepatitis B or C if strict sterile procedures are not followed.
Tuberculosis is an airborne pathogen, while herpes and syphilis are spread directly (such as through sexual contact).Safety and Infection Control

NEW QUESTION 130
- (Topic 2)
Health promotion activities are designed to help clients:

A. reduce the risk of illness.

B. maintain maximal function.
C. promote healthy habits related to health care.
D. all of the above.

Answer: D

Explanation:
Health promotion activities are designed to help clients reduce the risk of illness, maintain maximum function, and promote health habits related to health care.Health Promotion and Maintenance

NEW QUESTION 135
- (Topic 2)
The death of a beloved spouse places the surviving partner in which type of crisis?

A. maturational
B. reactive
C. nonreactive
D. situational

Answer: D

Explanation:
A situational crisis is an unexpected, unplanned event, such as the death of a spouse.
Option 1 is a normal maturational crisis; Choices 2 and 3 are not recognized crisis states.Coordinated Care

NEW QUESTION 140
- (Topic 2)
A client with asthma develops respiratory acidosis. Based on this diagnosis, what should the nurse expect the client??s serum potassium level to be?

A. normal
B. elevated
C. low
D. unrelated to the pH

Answer: B

Explanation:
Hyperkalemia occurs in a state of acidosis because potassium moves from injured cells into the bloodstream.
Physiological Adaptation

NEW QUESTION 143
- (Topic 2)
Which isolation procedure will be followed for secretions and blood?

A. Respiratory
B. Standard Precautions
C. Contact Isolation
D. Droplet

Answer: B

Explanation:
Standard precautions are taken in all situations for all clients and involve all body secretions except sweat and are designed to reduce the rate of transmission of microbes from one host to another or one source (environment such as the client??s bedside table) to another.Safety and Infection Control

NEW QUESTION 148
- (Topic 2)
The role of the incident report in risk management is:

A. liability protection.
B. to provide data for analysis by a risk manager to determine how future problems can be avoided.
C. to discipline staff for errors.
D. all of the above.

Answer: B

Explanation:
Incident reports are a tool for determining how future problems can be avoided. Incident reports do not provide liability protection. Incident reports are not meant to be used for disciplining staff.
Safety and Infection Control

NEW QUESTION 149
- (Topic 2)
A concern regarding maternal and infant mortality and morbidity is that:

A. a segment of the population is not receiving prenatal care.
B. families appear unconcerned about quality health care.

C. the personnel shortage in the maternity field will increase.
D. maternal-child health workers are not adequately prepared.

Answer: A

Explanation:
There is a concern that a segment of the population is not accessing prenatal care, affecting infant and maternal mortality and morbidity.Health Promotion and Maintenance

NEW QUESTION 151
- (Topic 2)
A 12-year-old male is brought to his primary care provider to determine whether sexual abuse has occurred. The mother states, ??Because there is no permanent physical damage, he does not need any more treatment.?? The nurse??s response should be based on which of the following pieces of information?

A. Male victims of sexual abuse seldom have long-term psychological problems.
B. Survivors of male sexual abuse might become confused about their sexual identity.
C. Unless treated, all male sex abuse survivors grow up to abuse other children.
D. All children who have been sexually abused have the same needs, regardless of gender.

Answer: B

Explanation:
Male children are sexually abused nearly as often as female children. Perpetrators are usually men but can be women. Needs of male children who have been sexually abused might be different from the needs of female survivors. Male survivors might respond in anger, question their sexuality, use alcohol and other drugs, and might try to prove their masculinity by performing daring acts.Psychosocial Integrity

NEW QUESTION 156
- (Topic 2)
A nurse observes a client sitting alone and talking. When asked, the client reports that he is ??talking to the voices.?? The nurse??s next action should be:

A. touching the client to help him return to reality.
B. leaving the client alone until reality returns.
C. asking the client to describe what is happening.
D. telling the client there are no voices.

Answer: C

Explanation:
Nurses might observe behavioral cues that can indicate the presence of hallucinations.
Talking about the hallucinations is reassuring and validating to the client who has them. Focusing on the symptoms and asking about the hallucinations helps the client gain control.Psychosocial Integrity

NEW QUESTION 157
- (Topic 2)
The most effective nursing strategy to assist a client in recognizing and using personal strength includes:

A. encouraging the client??s self-identification of strengths.
B. promoting the client??s active external thinking.
C. listening to the client and providing advice as needed.
D. assisting the client in maintaining an external locus of control.

Answer: A

Explanation:
Encouraging the client to identify his own strengths is the most effective strategy.
Psychosocial Integrity

NEW QUESTION 160
- (Topic 2)
A 2-year-old child diagnosed with HIV comes to a clinic for immunizations. Which of the following vaccines should the nurse expect to administer in addition to the scheduled vaccines?

A. pneumococcal vaccine
B. hepatitis A vaccine
C. Lyme disease vaccine
D. typhoid vaccine

Answer: A

Explanation:
Pneumococcal vaccine should be administered as a supplemental vaccine. Hepatitis A vaccine is for travelers and individuals with chronic liver disease. The Lyme disease vaccine is for people between the ages of 15 and 70 who are at risk for Lyme disease (transmitted by ticks primarily). The typhoid vaccine is for workers in microbiology laboratories who frequently work with Salmonella typhi.Health Promotion and Maintenance

NEW QUESTION 161
- (Topic 2)
A client has chronic respiratory acidosis caused by end-stage chronic obstructive pulmonary disease (COPD). Oxygen is delivered at 1 L/min per nasal cannula.

The nurse teaches the family that the reason for this is to avoid respiratory depression, based on which of the following explanations?

A. COPD clients are stimulated to breathe by hypoxia.
B. COPD clients depend on a low carbon dioxide level.
C. COPD clients tend to retain hydrogen ions if they are given high doses of oxygen.
D. COPD clients thrive on a high oxygen level.

Answer: A

Explanation:
COPD clients are compensating for low oxygen and high carbon dioxide levels. Hypoxia is the main stimulus to breathe in persons with chronic hypercapnia. Increasing the level of oxygen decreases the stimulus to breathe.
Physiological Adaptation

NEW QUESTION 162
- (Topic 2)
An elderly client denies that abuse is occurring. Which of the following factors could be a barrier for the client to admit being a victim?

A. knowledge that elder abuse is rare
B. personal belief that abuse is deserved
C. lack of developmentally appropriate screening tools
D. fear of reprisal or further violence if the incident is reported

Answer: D

Explanation:
Barriers to reporting elder abuse include victim shame, fear of reprisals, fear of loss of caregiver, and lack of knowledge of agencies that provide services. Many elders fear that reporting abuse results in their placement in long-term care because the current caregiver is the abuser. Choices 1 and 3 are incorrect. Choice 2 might be true but is not the best choice.Psychosocial Integrity

NEW QUESTION 166
- (Topic 2)
Quality is defined as a combination of all of the following except:

A. conforming to standards.
B. performing at the minimally acceptable level.
C. meeting or exceeding customer requirements.
D. exceeding customer expectations.

Answer: B

Explanation:
Compliance or performance at the minimally acceptable level is not considered quality care.Coordinated Care

NEW QUESTION 167
- (Topic 2)
The nurse observes bilateral bruises on the arms of an elderly client in a long-term care facility. Which of the following questions should the nurse ask this client?

A. ??How did you get those bruises???
B. ??Did someone grab you by your arms???
C. ??Do you fall often???
D. ??What did you bump against???

Answer: B

Explanation:
Using a direct approach is best when asking about suspected abuse. Clients are reluctant to report abuse because of shame and fear of reprisal.Psychosocial Integrity

NEW QUESTION 168
- (Topic 2)
The focus of a nurse case manager is:

A. nursing care needs at discharge.
B. the comprehensive care needs of the client for continuity of care.
C. client education needs upon discharge.
D. financial resources for needed care.

Answer: B

Explanation:
By definition, case management is a process of providing for the comprehensive care needs of a client for continuity of care throughout the health care experience.Coordinated Care

NEW QUESTION 173
- (Topic 2)
Client self-determination is the primary focus of:

A. malpractice insurance.
B. nursing??s advocacy for clients.
C. confidentiality.
D. health care.

Answer: B

Explanation:
Advocacy for clients by nurses is the primary focus of the client??s right to autonomy and self-determination.
Confidentiality involves the maintenance of the privacy of the client and information regarding him or her.
Malpractice insurance is a type of insurance for professionals.Coordinated Care

NEW QUESTION 176
- (Topic 2)
A client states, ??I eat a well-balanced diet. I do not smoke. I exercise regularly, and I have a yearly checkup with my physician. What else can I do to help prevent cancer??? The nurse
should respond with which of the following statements?

A. Sleep at least 6–8 hours a night.
B. Practice monthly self-breast examination.
C. Reduce stress.
D. All of the above.

Answer: D

Explanation:
All of the choices are methods of preventing cancer. Sleep is important in maintaining homeostasis, which
helps the body respond to disease. Monthly breast examination can indicate cancer or fibrocystic disease. The body has a physiological response to stress that can decrease the immune response and increase the risk of disease.Health Promotion and Management

NEW QUESTION 181
- (Topic 2)
Ms. Petty is having difficulty falling asleep. Which of the following measures promote sleep?

A. exercising vigorously for 20 minutes each night beginning at 9:30 p.m.
B. taking a cool shower and drinking a hot cup of tea
C. watching TV nightly until midnight
D. getting a back rub and drinking a glass of warm milk

Answer: D

Explanation:
These are appropriate measure to promote sleep. Choices 1, 2, and 3 are all stimulation actions that increase arousal and wakefulness.Basic Care and Comfort

NEW QUESTION 185
- (Topic 2)
A 45-year-old client with type I diabetes is in need of support services upon discharge from
a skilled rehabilitation unit. Which of the following services is an example of a skilled support service?

A. shopping for groceries
B. house cleaning
C. transportation to physician??s visits
D. medication instruction

Answer: D

Explanation:
The only skilled service listed is medication instruction. Grocery shopping, house-cleaning services, and transportation services are all examples of unskilled services offered by volunteer and fee- for-service agencies.
Coordinated Care

NEW QUESTION 188
- (Topic 2)
According to the ANA Code of Ethics for Nurses, professional nurses have an ethical obligation to:

A. clients (patients).
B. the profession of nursing.
C. provide high-quality care.
D. all of the above.

Answer: D

Explanation:
All the choices are elements of the ANA Code of Ethics for Nurses.Coordinated Care

NEW QUESTION 190
- (Topic 2)

Fat emulsions are frequently administered as a part of total parenteral nutrition. Which statement is true regarding fat emulsions?

A. They have a high energy-to-fluid-volume ratio.
B. Even though hypertonic, they are well tolerated.
C. They are a basic solution secondary to the addition of sodium hydroxide (NaOH).
D. The pH is alkaline, making them compatible with most medications.

Answer: A

Explanation:
They have a high energy-to-fluid-volume ratio. Fat emulsions are formulated in 10%, 20%, and 30% solutions and supply 1.1, 2, and 3 kilocalories respectively for each milliliter. A milliliter of 5% dextrose only supplies 0.17 kilocalories. Choices 2, 3, and 4 are incorrect because fat emulsions are essentially pH neutral and isotonic.Pharmacological Therapies

NEW QUESTION 193
- (Topic 2)
Vaccines provide what type of immunity?

A. active
B. passive
C. transplacental
D. active and passive

Answer: A

Explanation:
Vaccines provide active immunity. Passive immunity comes from antibodies produced in another human or host. Transplacental immunity comes from passive immunity transferred from mother to infant.Health Promotion and Maintenance

NEW QUESTION 195
- (Topic 2)
A syringe pump is a type of electronic infusion pump used to infuse fluids or medications directly from a syringe. This device is commonly used for:

A. solutions administered in obstetrics.
B. dilute antibiotics.
C. large volumes of IV solution.
D. the neonatal and pediatric populations.

Answer: D

Explanation:
Small volumes of medication or fluids are delivered and sometimes at slow rates to neonates and pediatric clients. The syringe pump allows precise infusion of small volumes. Choice 1 is incorrect because a syringe pump can be used in almost any setting, but is not generally for adult clients. Choices 2 and 3 are incorrect because large volumes of fluids are not administered with a syringe pump.Pharmacological Therapies

NEW QUESTION 199
- (Topic 2)
The 24-hour day-night cycle is known as:

A. circadian rhythm.
B. infradium rhythm.
C. ultradian rhythm.
D. non-REM rhythm.

Answer: A

Explanation:
Circadian rhythm is rhythmic repetition of patterns each 24 hours. The other options are incorrect.Basic Care and Comfort

NEW QUESTION 202
- (Topic 2)
The greatest time savers when planning client care include all of the following except:

A. reacting to the crisis of the moment.
B. setting goals.
C. planning.
D. specifying priorities.

Answer: A

Explanation:
The greatest time-savers when planning client care are activities that facilitate focus and completion of priority items. Time-savers include setting goals, establishing priorities, planning tasks, delegating where appropriate, re-assessment, and ongoing evaluation of needs.Coordinated Care

NEW QUESTION 206
- (Topic 2)

Support-system enhancement includes all of the following except:

A. determining the barriers to using support systems.
B. discussing ways to help with others who are concerned.
C. exploring life problems of the support-team members.
D. involving spouse, family, and friends in the care and planning.

Answer: C

Explanation:
The exploration of life problems of support-team members is not necessary to enhance the support system.
Choices 1, 2, and 4 are all enhancements for a support system.Psychosocial Integrity

NEW QUESTION 209
- (Topic 2)
Following the change of shift report, the nurse should analyze the information and set priorities accordingly. When the plan has been formulated, at what point during the shift can or should the nurse??s plan be altered or modified?

A. halfway through the shift
B. at the end of the shift before the nurse reports off
C. when needs change
D. after the top-priority tasks have been completed

Answer: C

Explanation:
The nurse changes the plan to respond to changes in needs.Coordinated Care

NEW QUESTION 210
- (Topic 2)
Which is the best way to position a client??s neck for palpation of the thyroid?

A. flexed toward the side being examined
B. hyperextended directly backward
C. flexed away from the side being examined
D. flexed directly forward

Answer: A

Explanation:
Flexed toward the side being examined.Health Promotion and Maintenance

NEW QUESTION 212
- (Topic 2)
The nurse wishes to decrease a client??s use of denial and increase the client??s expression of feelings. To do this the nurse should:

A. tell the client to stop using the defense mechanism of denial.
B. positively reinforce each expression of feelings.
C. instruct the client to express feelings.
D. challenge the client each time denial is used.

Answer: B

Explanation:
The nurse should positively reinforce each expression of feelings.Psychosocial Integrity

NEW QUESTION 215
- (Topic 2)
A client with massive chest and head injuries is admitted to the ICU from the Emergency Department. All of the following are true except:

A. B.the physician in charge of the case is the only person allowed to decide whether organ donation can occur.
B. C.the client??s legally responsible party may make the decision for organ donation for the donor if the client is unable to do so.
C. D.the organ procurement organization makes the decision regarding which organs to harvest.

Answer: C

Explanation:
The client??s legally responsible party may make the decision for organ donation if the client is unable to do so.
The donor (or legally responsible party for the donor), the physician, and the organ- procurement organization are all involved in the process regarding whether organ donation is appropriate for a specific donor.Coordinated Care

NEW QUESTION 220
- (Topic 2)
What is the primary theory that explains a family??s concept of health and illness?

A. Health Belief Model
B. Education-School-Completing Factor

C. Family Health Expert Factor
D. Disconnected Family Factor

Answer: A

Explanation:
The Health Belief Model describes readiness factors; the perceived feelings of susceptibility and seriousness of the health problem (the threat); and positive motivation to maintain, regain, or attain wellness.Health Promotion and Maintenance

NEW QUESTION 224
- (Topic 3)
A client with major head trauma is receiving bolus enteral feeding. The most important nursing order for this client is:

A. measure intake and output.
B. check albumin level.
C. monitor glucose levels.
D. increase enteral feeding.

Answer: A

Explanation:
It is important to measure intake (I) and output (O), which should be approximately equal.
Enteral feedings are hyperosmotic agents pulling fluid from cells into the vascular bed. Water given before feeding presents a hyperosmotic diuresis. I and O measures assess fluid balance.Basic Care and Comfort

NEW QUESTION 229
- (Topic 3)
Which of the following allergies might be a contraindication for a client to receive contrast enhancement for intracranial computed tomography?

A. penicillin
B. iodine
C. erythromycin
D. aspirin

Answer: B

Explanation:
Iodine allergy might be a contraindication for contrast media, not the other allergies.
Reduction of Risk Potential

NEW QUESTION 233
- (Topic 3)
After breast reconstruction secondary to breast cancer, the nurse should recognize which
of the following expected client outcomes as evidence of a favorable response to nursing interventions related to disturbed body image?

A. maintaining adequate tissue perfusion
B. demonstrating behaviors that reduce fears
C. restored body integrity
D. remaining free of infection

Answer: C

Explanation:
A sense of restored body integrity is an expected outcome for interventions related to disturbed body image.
Adequate tissue perfusion is an outcome for risk of injury and risk of infection, not disturbed body image.
Demonstrating behaviors that might reduce fears is an outcome for anxiety. Remaining free of infection is an outcome for risk of infection.Health Promotion and Maintenance

NEW QUESTION 234
- (Topic 3)
Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board. When the nurse who was not promoted first read the memo and learned that the other nurse had received the promotion, she left the room in tears. This behavior is an example of:

A. conversion.
B. regression.
C. introjection.
D. rationalization.

Answer: B

Explanation:
Crying is a regressive behavior. The ego returned to an earlier, comforting, and less- mature way of behaving in the face of disappointment. Conversion involves the transformation of anxiety into a physical symptom. Introjection involves intense unconscious identification with another person. Rationalization involves the unconscious process of developing acceptable explanations to justify unacceptable ideas, actions, or feelings.Psychosocial Integrity

NEW QUESTION 236
- (Topic 3)

The method of splinting is always dictated by:

A. location of the injury and whether it is open or closed.
B. the severity of the client??s condition and the priority decision.
C. the number of available rescuers and the type of splints.
D. all of the above.

Answer: B

Explanation:
The method of splinting is always dictated by the severity of the client??s condition and the priority decision.
Basic Care and Comfort

NEW QUESTION 237
- (Topic 3)
Tuberculosis (mycobacterium) usually effects which system?

A. stomach (GI)
B. heart (cardiac)
C. lungs (respiratory)
D. skin (integumentary)

Answer: C

Explanation:
Mycobacterium tuberculosis is an aerobic bacillus that requires a great deal of oxygen to grow and flourish. It needs highly oxygenated body sites, such as lungs, growing ends of bones, and the brain. The bacillus is airborne.
Physiological Adaptation

NEW QUESTION 239
- (Topic 3)
A client has a nasogastric (NG) tube in place following abdominal surgery. The purpose of this tube immediately following surgery is to:

A. simplify medication administration.
B. measure accurate input and output.
C. prevent accumulation of fluids and gas.
D. facilitate collection of specimens.

Answer: C

Explanation:
Immediately postop abdominal surgery, the NG tube keeps the stomach decompressed to prevent surgical-site disruption and fluid loss through vomiting.Basic Care and Comfort

NEW QUESTION 240
- (Topic 3)
A client, age 28, is 8 12 months pregnant. She is most likely to display which normal skin- color variation?

A. vitiligo
B. erythema
C. cyanosis
D. chloasma

Answer: D

Explanation:
Chloasma, also known as the mask of pregnancy, is described as tan-to-brown patches on the face. This hyperpigmentation results from hormonal changes.Health Promotion and Maintenance

NEW QUESTION 244
- (Topic 3)
A client receiving drug therapy with furosemide and digitalis requires careful observation and care. In planning care for this client, the nurse should recognize that which of the following electrolyte imbalances is most likely to occur?

A. hyperkalemia
B. hypernatremia
C. hypokalemia
D. hypomagnesemia

Answer: C

Explanation:
Diuretics such as furosemide might deplete serum potassium. Additionally, the action of digitalis might be potentiated by hypokalemia. These drugs are not associated with hyperkalemia. Diuretic therapy could cause hyponatremia, not hypernatremia. Choice 4 is generally associated with poor nutrition, alcoholism, and excessive GI or renal losses.Physiological Adaptation

NEW QUESTION 246

- (Topic 3)
The nurse is caring for a postpartum woman who has relinquished her baby for adoption. The care plan for the client should include which of the following priority strategies?

A. Make a referral for grief counseling.
B. Allow the woman to see her baby initially, and then discourage further visits.
C. Provide opportunities for the woman to express her feelings.
D. Inform the woman she has the right to change her mind about relinquishment.

Answer: C

Explanation:
Most women who relinquish their infants at birth have come to that decision with a great deal of love and
pain. They have made plans in advance. The nurse needs to first provide them with opportunities to express their feelings that might include grief, loneliness, and guilt. A referral for grief counseling might be appropriate if no other support system exists or the mother indicates that she wants assistance working through her grief. If the nurse assesses that the grief process is abnormal, a referral is also appropriate. The mother has probably already made a decision about whether or not she wants to see her baby. The nurse should ask her and make arrangements for that to happen if the mother requests it. Seeing the baby might aid in the grief process.
Until relinquishment
occurs, this is the mother??s baby and she should be allowed to see it as often as she wants.
The mother does have the right to change her mind until final legal arrangements are made. But suggesting this option might lead her to think that the nurse believes she shouldn??t relinquish her baby.Health Promotion and Maintenance

NEW QUESTION 251
- (Topic 3)
A client with sickle cell disease is worried about passing the disease on to children. Which of the following statements by the PN is most appropriate for this client?

A. ??You should discuss this with your physician.??
B. ??Sickle cell disease is genetically based and might be passed on to children.??
C. ??Sickle cell disease is genetically based and is not passed on to children.??
D. ??Sickle cell disease is caused by an infection and cannot be passed on to children.??

Answer: B

Explanation:
A client with sickle cell disease passes on the least sickle cell trait and possibly sickle cell disease, depending on the sickle status of the other parent. Choice 1 is not helpful to the client. Choices 3 and 4 are not true.
Physiological Adaptation

NEW QUESTION 253
- (Topic 3)
A client??s postoperative pain seems to be getting worse instead of better. When the nurse asks the client, ??Why do you think it??s getting worse??? the client replies, ??My wife died last month. It??s all I can think about.?? The nurse must now consider:

A. calling the physician for an increased dosage of pain medication.
B. calling the physician for a sedative.
C. referring the client for a psychiatric consult.
D. developing interventions for grief and loss.

Answer: D

Explanation:
The client??s pain is affective as well as sensory. Grieving his wife??s death is a normal response that does not necessarily require psychiatric consult. Choices 1 and 2 address the sensory, not the affective component of his pain.Basic Care and Comfort

NEW QUESTION 256
- (Topic 3)
Which medication might the physician order if the client expresses discomfort with being in the enclosed space of a CT scanner?

A. Valium (diazepam)
B. Clozaril (clozapine)
C. Catapress (clonidine)
D. Lasix (furosemide)

Answer: A

Explanation:
Valium is a sedative that might be given prior to receiving a CT scan. The other medications are not sedatives.
Reduction of Risk Potential

NEW QUESTION 257
- (Topic 3)
Which physiologic mechanism best describes the function of the sodium-potassium pump?

A. active transport
B. diffusion
C. filtration
D. osmosis

Answer: A

Explanation:
Active transport is a process requiring energy to transport ions against a concentration gradient, as is needed in the sodium-potassium pump. Choices 2, 3, and 4 are other regulatory mechanisms involved in fluid and electrolyte balance.Physiological Adaptation

NEW QUESTION 260
- (Topic 3)
A contraindication for topical corticosteroid use in a client with atopic dermatitis (eczema) is:

A. parasite infection.
B. viral infection.
C. fungal infection.
D. spirochete infection.

Answer: B

NEW QUESTION 262
- (Topic 3)
Which of the following procedures describes an opening between the colon and abdominal wall?

A. ileostomy
B. jejunostomy
C. colostomy
D. cecostomy

Answer: C

Explanation:
A colostomy is an opening between the colon and abdominal wall. The remaining terms describe other types of ostomies.Physiological Adaptation

NEW QUESTION 265
- (Topic 3)
Which of the following tests is commonly performed on newborns with jaundice?

A. blood urea nitrogen
B. magnesium
C. bilirubin
D. prolactin

Answer: C

Explanation:
A high bilirubin level is found with hepatic immaturity in newborns, from which jaundice results. The other choices are not.Reduction of Risk Potential

NEW QUESTION 268
- (Topic 3)
An elevation in which of the following enzymes is indicative of pancreatitis?

A. alkaline phosphatase
B. acid phosphatase
C. creatine phosphokinase
D. amylase

Answer: D

Explanation:
Amylase is elevated in conditions of pancreatic inflammation, such as pancreatitis. The other enzymes are associated with other types of tissue damage.Reduction of Risk Potential

NEW QUESTION 271
- (Topic 3)
When a client with a major burn experiences body image disturbance, which of the following is an appropriate nursing intervention classification?

A. grief work facilitation
B. vital signs monitoring
C. medication administration: skin
D. anxiety reduction

Answer: A

Explanation:
Grief work facilitation is a nursing intervention classification for disturbed body image in burn clients. The expected outcome is grief resolution. Vital signs monitoring is a nursing intervention classification for deficient fluid volume in clients with major burns. Medication administration: skin is a nursing intervention classification for impaired skin integrity for clients with major burns. Anxiety reduction is a nursing intervention classification for anxiety experienced by clients with major burns.Health Promotion and Maintenance

NEW QUESTION 275
- (Topic 3)
Which of the following statements is correct regarding rape?

A. Most rapes are reported.
B. Legally, a woman can be raped by her spouse.
C. Prosecution and conviction for rape is easy.
D. The most common location of rape is the victim??s own home.

Answer: B

Explanation:
The definition ofrapeis sexual intercourse against someone??s will. It is a degrading, brutal crime of violence and can occur between any two persons regardless of their marital status.Psychosocial Integrity

NEW QUESTION 280
- (Topic 3)
The best lab test to diagnose disseminated intravascular coagulation (DIC) is:

A. platelet count.
B. protime (PT).
C. partial thromboplastin time (PTT).
D. D-dimer.

Answer: D

Explanation:
In DIC, many small clots form throughout the body and are immediately broken down. D- dimer measures a
specific fibrin split (or degradation) product and is the most specific test for DIC. Choice 1 is incorrect because platelets are consumed in DIC, but this is not specific. Choices 3 and 4 are both elevated (because clotting factors have been used up) but, again, are not specific.Physiological Adaptation

NEW QUESTION 282
- (Topic 3)
Which of the following coping mechanisms protects an individual from anxiety?

A. denial and fantasy
B. rationalization and suppression
C. regression and displacement
D. reaction formation and projection

Answer: A

Explanation:
Denial, rationalization, regression, and fantasy are coping mechanisms that protect persons from anxiety.
Psychosocial Integrity

NEW QUESTION 285
- (Topic 3)
Which of the following lab values is elevated first after a client has a myocardial infarction?

A. LDH
B. troponin
C. CPK
D. SGOT

Answer: B

Explanation:
The troponin level is the first to rise in a client who has had a myocardial infarction, followed by CPK, SGOT, and LDH.Reduction of Risk Potential

NEW QUESTION 286
- (Topic 3)
When teaching parents how their children learn sex role identification, the nurse should include which of the following statements?

A. Sex role identification begins in infancy.
B. Sex role identification begins in the preschool years.
C. Sex role identification begins during the school-age years.
D. Sex role identification begins during early adolescence.

Answer: A

Explanation:
Sex role identification begins during infancy. Infants can identify body parts by the end of the first year. Preschoolers frequently engage in masturbation and sex play with peers. School-age children continue to gain awareness of their sexual identity. During this time they might continue to masturbate and engage in sex play. They might add behaviors such as hugging and kissing members of the opposite sex. Adolescent sex role identification is largely influenced by sexual maturation and trying out or assuming a sex role.Health Promotion and Maintenance

NEW QUESTION 287
- (Topic 3)
Which of the following foods present a problem for a client diagnosed with Celiac Disease?

A. butter
B. oats or barley cereal
C. fresh vegetables
D. coffee or tea

Answer: B

Explanation:
Celiac disease, orceliac sprue,is a malabsorption disorder affecting the small intestine in which there is a problem with the ingestion of gluten, a protein normally found in grain products such as wheat, rye, oats, or barley. The other choices reflect substances that do not contain gluten and should not pose problems for a client with this disorder.Basic Care and Comfort

NEW QUESTION 288
- (Topic 3)
When a client who is having trouble conceiving says to the nurse, ??I have started taking ginseng,?? the best response by the nurse is:

A. ??No studies show that ginseng is effective for infertility.??
B. ??Some studies show that ginseng enhances in vitro sperm motility.??
C. ??Why don??t you try acupuncture instea
D. Many studies have shown it to be effective for infertility.??
E. ??It??s probably not going to hurt you, but it??s also probably not going to hel
F. Let??s look at some other alternatives.??

Answer: B

Explanation:
Some studies have shown that ginseng and astragalus have enhanced in vitro sperm motility. Ginseng has long been used in traditional Chinese medicine to enhance male fertility. So, Choice 2 is correct and directly addresses the client??s comments. Many times couples struggling with infertility turn to alternative therapies in desperation. They can be very expensive, and some are harmful. Ginseng should not interfere with any of the traditional fertility treatments and might help the couple feel empowered that they are also doing something on their own. Choice 1 is not true. Choice 3 introduces another alternative therapy. It is true that acupuncture is a traditional Chinese medical therapy and has been shown in several clinical studies to be effective in treating infertility in both women and men. The best response by the nurse should address the therapy the client states she is using. Choice 4 dismisses the client??s attempts to work through her issues and contribute to the solution. One concern is always that more traditional therapies might be ignored, and time might be lost to alternative therapies. But this response causes the client to perceive the nurse as unsupportive and inhibits further discussion and disclosure.Health Promotion and Maintenance

NEW QUESTION 291
- (Topic 3)
Which statement best describes electrolytes in intracellular and extracellular fluid?

A. There is a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.
B. There is an equal concentration of sodium and potassium in extracellular fluid.
C. There is a greater concentration of potassium in extracellular fluid and sodium in intracellular fluid.
D. There is an equal concentration of sodium and potassium between intracellular and extracellular fluid.

Answer: A

Explanation:
There is a greater concentration of sodium in extracellular fluid and potassium in intracellular fluid.
Physiological Adaptation

NEW QUESTION 294
- (Topic 3)
Which of the following is true concerning human immunodeficiency virus (HIV)?

A. HIV infection involves CD4 receptor protein on the surface of helper T-cells.
B. The presence of circulating antibodies that neutralize HIV is evidence that the individual has immunity-HIV.
C. HIV replication occurs extracellularly.
D. DNA replication

Answer: A

Explanation:
The virus makes a DNA copy of its own RNA using the reverse transcriptase enzyme, and the DNA copy is inserted into the genetic material of the infected cell.Physiological Adaptation

NEW QUESTION 296
- (Topic 3)
The nurse should teach a client in the Emergency Department, who has suffered an ankle sprain, to:

A. use cold applications to the sprain during the first 24–48 hours.
B. expect disability to decrease within the first 24 hours of injury.
C. expect pain to decrease within 3 hours after injury.
D. begin progressive passive and active range of motion exercises immediately.

Answer:

A

Explanation:
Cold applications are believed to produce vasoconstriction and reduce development of edema. Disability and pain are anticipated to increase during the first 2–3 hours after injury. Progressive passive and active exercises may begin in 2–5 days, according to the physician??s recommendation. A sprain is a traumatic injury to the tendons, muscles, or ligaments around a joint, characterized by pain, swelling, and discoloration of the skin over the joint. The duration and severity of the symptoms vary with the extent of damage to the supporting tissues.
Treatment requires support, rest, and alternating cold and heat. X-ray pictures are often indicated to be certain that no fracture has occurred.Physiological Adaptation

NEW QUESTION 298
- (Topic 3)
When discussing the patterns of use of alcohol and other drugs, the nurse should include which piece of information?

A. Lifetime prevalence and intensity of alcohol use is greater in women than men.
B. Hispanics and African Americans have higher levels of alcohol use than Caucasians.
C. Overuse of alcohol and other drugs increases into the mid-20s, then levels off and decreases with age.
D. Heavy use is more common in higher socioeconomic groups because they can afford to buy the drugs.

Answer: C

Explanation:
Recent research reveals that 83% of all persons in the United States, age 12 or older, report using alcohol sometime in their lives. Use of alcohol and illicit drugs appears to increase into the mid-20s, and then levels off and decreases with age. Both lifetime prevalence and intensity of alcohol use are greater in males. Caucasians report higher levels of alcohol use than African Americans or Hispanics. Those with more education are more likely to use alcohol, but heavy use is more common among the less educated and the unemployed.Psychosocial Integrity

NEW QUESTION 302
- (Topic 3)
A client had a colostomy done one day ago. Which of the following is an abnormal finding when assessing the stoma?

A. mild edema
B. minimal bleeding
C. rose color
D. dark red color

Answer: D

Explanation:
A dark red color is an abnormal finding when assessing the stoma. It indicates inadequate blood supply. The other findings are normal one day postoperatively.Physiological Adaptation

NEW QUESTION 306
- (Topic 3)
Jane Love, a 35-year old gravida III para II at 23 weeks gestation, is seen in the Emergency Department with painless, bright red vaginal bleeding. Jane reports that she has been feeling tired and has noticed ankle swelling in the evening. Laboratory tests reveal a hemoglobin level of 11.5 g/dL. After evaluating the situation, the nurse determines that Jane is at risk for placenta previa, based on which of the following data?

A. anemia
B. edema
C. painless vaginal bleeding
D. fatigue

Answer: C

Explanation:
Placenta previa is a disorder where the placenta implants in the lower uterine segment, causing painless bleeding in the third trimester of pregnancy. The bleeding results from tearing of the placental villi from the uterine wall as the lower uterine segment contracts and dilates. It can be slight or profuse and can include bright red, painless bleeding. The abdomen might be soft, nontender, and relax between contractions.Physiological Adaptation

NEW QUESTION 308
- (Topic 3)
Which of the following isoenzymes is elevated in a client who has had a myocardial infarction?

A. CPK-BB
B. CPK-MM
C. CPK-MB
D. CPK-MI

Answer: C

Explanation:
CPK-MB is elevated in clients who have had a myocardial infarction. CPK-BB is elevated in clients who have brain damage, and CPK-MM is elevated in clients who have skeletal muscle damage.
CPK-MI does not exist.Reduction of Risk Potential

NEW QUESTION 310

- (Topic 3)
Distraction therapy is:

A. focusing one??s attention on stimuli other than pain.
B. cognitive reappraisal.
C. the replacement of positive images of pain with other images.
D. the use of medication and meditation.

Answer: A

Explanation:
The focus of distraction therapy is on positive stimuli rather than negative input.Basic Care and Comfort

NEW QUESTION 315
- (Topic 3)
Milieu therapy is best employed to perform which activity?

A. investigating the client??s view of the world
B. promoting socialization skills
C. focusing on inappropriate behavior
D. providing repetitive ordinary experiences on a daily basis

Answer: D

Explanation:
Milieu therapy provides repetitive ordinary experiences on a daily basis, controls the environment by minimizing change as much as possible, and decreases disruptive behavior by keeping tasks simple.Psychosocial Integrity

NEW QUESTION 320
- (Topic 3)
When working with multicultural populations, the nurse should consider all of the following when planning care for a client with an altered sexuality pattern except:

A. some members of the Hispanic and Native- American cultures are very open when discussing sexuality.
B. some cultures view the postpartum period as a state of impurity.
C. some women in the African-American culture view childbearing as a validation of their femaleness.
D. some Native-American women believe monthly menstruation maintains physical well- being and harmony.

Answer: A

Explanation:
Many cultures (including the Hispanic and Native-American cultures) are sometimes hesitant to discuss sexuality. Some Navajos, Hispanics, and Orthodox Jews view the postpartum period as a state of impurity and might seclude women as long as they are bleeding. The seclusion is usually ended with a ritual bath. Many white teenage girls approve of the prevention of pregnancy, and many African-American teenage girls value pregnancy. Many Native-American women believe in the importance of monthly menstruation to maintain physical wellbeing and harmony.Health Promotion and Maintenance

NEW QUESTION 324
- (Topic 4)
When assessing a client with early impairment of oxygen perfusion, such as pulmonary embolus, the nurse should expect to find restlessness and which of the following symptoms?

A. warm, dry skin
B. bradychardia
C. tachycardia
D. eupnea

Answer: C

Explanation:
The cardinal signs of respiratory problems and hypoxia are restlessness, diaphoresis, tachycardia, and cool skin.
Bradycardia might occur much later in the process when the condition is severe. Eupnea is normal respirations in rate and depth.Physiological Adaptation

NEW QUESTION 327
- (Topic 4)
A client and his family facing the end stage of a terminal illness might be best served by:

A. a rehabilitation center.
B. an extended care facility.
C. Hospice.
D. a crisis intervention center.

Answer: C

Explanation:
Hospice has the belief that more humanized alternative care for dying clients is needed than is being provided in hospitals, which focus mostly on medical cures. No matter where the care is delivered, Hospice provides a specialized interdisciplinary team of health care professionals who work together to manage client care.HealthPromotion and Maintenance

NEW QUESTION 330
- (Topic 4)
The gag reflex test assesses which cranial nerves?

A. IX and X
B. V and VII
C. IX and XII
D. V and X

Answer: A

Explanation:
Gagging during the gag reflex test indicates that cranial nerves IX and X (the glossopharyngeal and vagus nerves) are intact.Health Promotion and Maintenance

NEW QUESTION 334
- (Topic 4)
There are many types of torts that can be committed against clients. They include all of the following except:

A. assault.
B. battery.
C. negligence.
D. felony.

Answer: D

Explanation:
Felonies are serious crimes punishable by time in prison. Types of torts are assault, battery, and negligence in addition to slander, invasion of privacy, false imprisonment, and fraud.Coordinated Care

NEW QUESTION 338
- (Topic 4)
In the United States, several definitions of death are currently being used. The definition that uses apnea testing and pupillary responses to light is termed:

A. whole brain death.
B. heart-lung death.
C. circulatory death.
D. higher brain death.

Answer: A

Explanation:
Most protocols require two separate clinical examinations, including induction of painful stimuli, papillary responses to light, oculovestibular testing, and apnea testing. Choices 2 and 4 have no specific test required. Choice 3 is not a current definition of death in the United States.Psychosocial Integrity

NEW QUESTION 343
- (Topic 4)
Which of the following attitudes is essential in a nurse who assists clients during crises?

A. viewing crisis intervention as the first step in solving bigger problems
B. wanting to help clients solve all problems identified
C. taking an active role in guiding the process
D. feeling that work requires identification with all of a client??s problems

Answer: A

Explanation:
Viewing crisis intervention as the first step in solving bigger problems is essential in a nurse who assists clients during crises. Assessment of the present problem should be viewed as necessary. Time and limitations of crisis work need to be remembered. Complete diagnostic assessment is unnecessary, and unrelated material should not be explored. Referrals might be necessary for other identified problems.Psychosocial Integrity

NEW QUESTION 347
- (Topic 4)
Paula is a 32-year-old woman seeking evaluation and treatment of major depressive symptoms. A major nursing priority during the assessment process includes which of the following?

A. meaning of current stressors
B. possibility of self-harm
C. motivation to participate in treatment
D. presence of alcohol or other drug use

Answer: B

Explanation:
Unless the client is first assessed for self-harm or suicide potential, the staff might not observe the necessary degree of vigilance needed in the client??s environment. Physical needs are the second most critical concern with a depressive client. Though the client may be encouraged to attend group therapy as part of the treatment plan, the client??s safety takes precedence. Response to medication takes time and is not an initial concern. Physiological Adaptation

NEW QUESTION 349
- (Topic 4)
How many temporary teeth should the nurse expect to find in a 5-year-old client??s mouth?

A. up to 10
B. up to 15
C. up to 20
D. up to 32

Answer: C

Explanation:
A child can have up to 20 temporary (deciduous or baby) teeth. The first tooth usually erupts by age 6 months and the last by age 30 months. All temporary teeth usually are shed between 6 and 13 years of age.Preventionand Early Detection of Disease

NEW QUESTION 351
- (Topic 4)
During a routine health screening, the nurse should talk to the parents of a 1-year-old child about which of the following?

A. the potential hazards of accidents
B. appropriate nutrition now that the child has been weaned from breast-feeding
C. toilet training
D. how to purchase appropriate shoes now that the child is walking

Answer: A

Explanation:
Accidents are the primary source of injury in children and can be life threatening. Appropriate nutrition should have been discussed during the weaning process and while the purchase of appropriate shoes is important, it is not life threatening. One year of age is too early to discuss toilet training.Health Promotion and Maintenance

NEW QUESTION 352
- (Topic 4)
A nurse is teaching a group of clients with a diagnosis of Schizophrenia who are nearing discharge from a residential care facility. An essential topic to include is:

A. pathophysiology of the disease and expected symptoms.
B. how to recognize and manage symptoms of relapse.
C. the need to take extra medication when feeling stressed.
D. the importance of contact with follow-up care daily.

Answer: B

Explanation:
Clients are usually aware of the symptoms that indicate relapse is occurring. The client needs to know how to find a safe environment and to seek help. The first two stages of relapse are more difficult to recognize because they do not present symptoms that indicate psychosis. Initially, the client feels anxious and overwhelmed, and might become withdrawn. This is the crucial period to intervene. The client needs to go to a safe environment with someone who is trusted, avoid negative people, and decrease stimuli and stress.Psychosocial Integrity

NEW QUESTION 354
- (Topic 4)
Which of the following symptoms is most characteristic of a client with cancer of the lungs?

A. exertional dyspnea
B. persistent changing cough
C. air hunger; dyspnea
D. cough with night sweats

Answer: B

Explanation:
The most common sign of cancer of the lung is a persistent cough that changes. Other signs are dyspnea, bloody sputum, and long-term pulmonary infection. Choice 1 is common with chronic obstructive pulmonary disease (COPD). Choice 3 is common with asthma. Choice 4 is common with tuberculosis.PhysiologicalAdaptation

NEW QUESTION 357
- (Topic 4)
A client with a pleural drainage system to suction has gentle bubbling of the water seal. What should the nurse do?

A. Notify the physician.
B. Clamp the chest tube.
C. Replace the system.
D. Document the finding.

Answer: D

Explanation:
Gentle bubbling is a normal finding for the client who has a pleural drainage system to suction, so it simply needs to be documented. If the bubbling becomes vigorous, it could indicate a leak, which the nurse needs to investigate. The remaining choices are not necessary.Reduction of Risk Potential

NEW QUESTION 362
- (Topic 4)
Acute hyphema is associated with what type of injury?

A. orthopedic
B. eye
C. insect sting or snakebite
D. gynecological trauma

Answer: B

Explanation:
An acute hyphema occurs as a result of a blunt injury to the eye and is manifested by a half-moon appearance or a horizontal line across the globe when the client is upright (due to blood collected in the anterior chamber).Safety and Infection Control

NEW QUESTION 363
- (Topic 4)
During surgery, it is found that a client with adenocarcinoma of the rectum has positive peritoneal lymph nodes. What is the next most likely site of metastasis?

A. brain
B. bone
C. liver
D. mediastinum

Answer: C

Explanation:
Colon tumors tend to spread through the lymphatics and portal vein to the liver. Although metastasis to the other sites listed is possible, the liver is most likely the first to be affected. Physiological Adaptation

NEW QUESTION 364
- (Topic 4)
Carrying a donor card for organ donation means that:

A. medical care is altered in the event of serious injuries to get organs for donation.
B. the family or legally responsible party of a client has no decision-making authority in the event that the client is considered for organ donation.
C. a client is allowed to revoke his decision for organ donation at any time.
D. a client is considered an organ donor for only one organ or tissue.

Answer: C

Explanation:
Revocation of the decision for organ donation may occur at any time, by either the client or his responsible party. When organ donation is considered, as many organs as the donor wished to donate are considered and accepted for donation if found appropriate. Medical care for an individual during immediate care and/or resuscitation is not altered to declare a client dead and ready for organ donation.Coordinated Care

NEW QUESTION 369
- (Topic 4)
The primary organ for drug elimination is the:

A. skin.
B. lung(s).
C. kidney(s).
D. liver.

Answer: C

Explanation:
Most drugs are excreted in the urine, either as the parent compound or as drug metabolites. Relatively few drugs are excreted in sweat. Some volatile gases are excreted with expiration. The liver primarily metabolizes drugs. Some of them are excreted in bile, especially those with a molecular weight above 300.PharmacologicalTherapies

NEW QUESTION 370
- (Topic 4)
A client is assessed by the nurse as experiencing a crisis. The nurse plans to:

A. allow the client to work through independent problem-solving.
B. complete an in-depth evaluation of stressors and responses to the situation.
C. focus on immediate stress reduction.
D. recommend ongoing therapy.

Answer: C

Explanation:
A crisis is an acute, time-limited state of disequilibrium resulting from a situational, developmental, or societal source of stress. Utilizing the nursing process, the nurse should assist clients to work through a crisis to its resolution and restore their precrisis level of functioning.Psychosocial Integrity

NEW QUESTION 373
- (Topic 4)
The nurse suspects an elderly client has been the victim of abuse. The client denies abuse and declines assistance. The nurse??s next action should be to:

A. do nothing; the client has the right to refuse treatment.
B. report the incident to the police.
C. arrange an appointment with the client??s next of kin.
D. educate the client about available services.

Answer: D

Explanation:
Although clients do have the right to refuse treatment, the nurse should remain nonjudgmental and inform the client of available services. Frequently elders are not aware of existing programs.Psychosocial Integrity

NEW QUESTION 377
- (Topic 4)
A client asks the nurse what risk factors increase the changes of getting skin cancer. The risk factors include all except:

A. light or fair complexion.
B. exposure to sun for great periods of time.
C. certain diet and foods.
D. history of bad sunburns.

Answer: C

Explanation:
Conditions that increase risks for skin cancer are: light or fair complexion, history of having bad sunburns or scars from previous burns, personal or family history of skin cancer, frequently working or playing outdoors with exposure to the sun, exposure to X-rays or radiation, exposure to certain chemicals through work or hobbies (coal, pitch, asphalt, petroleum), repeated trauma or injury to an area resulting in scars, older than age 50, male gender, and living in a geographic location near the equator or at high altitudes. Ways to prevent skin cancer are avoiding exposure to the sun, wearing a hat to protect the face, avoiding all sun lamps, and using a sunscreen with a minimum of 15 sun protection factor (SPF) if exposure to the sun is unavoidable. Teaching clients how to recognize a potential problem involves inspecting the skin frequently; noting all birthmarks, freckles, and moles; and seeking medical assistance if any of the following are noted: change in color, change in shape, change in surface texture, change in size, change in the surrounding skin, or a new mole or a sore that does not heal.HealthPromotion and Maintenance

NEW QUESTION 378
- (Topic 4)
Which of the following clients require airborne precautions?

A. a client with fever, chills, vomiting, and diarrhea
B. a client suspected of varicella (chickenpox)
C. a client with abdominal pain and purpura
D. a client diagnosed with AIDS

Answer: B

Explanation:
Chickenpox (varicella) is an acute, infectious, airborne illness that requires others in direct contact to wear a respirator mask.Safety and Infection Control

NEW QUESTION 379
- (Topic 4)
The ethical principle of keeping professional promises or obligations is:

A. veracity.
B. autonomy.
C. fidelity.
D. beneficence.

Answer: C

Explanation:
The ethical principle of veracity is truth-telling. Autonomy is client self-determination (that is, clients making their own decisions). Beneficence is the principle of doing good, which is a foundation of nursing care.
Coordinated Care

NEW QUESTION 381
- (Topic 4)
The tendency of a drug to combine with its receptor is called:

A. potency.
B. efficacy.
C. kinetics.
D. affinity.

Answer: D

Explanation:

Affinity is a close relationship, mutual attraction, or similarity. The tendency of a drug to combine with its receptor is called affinity. Affinity is a measure of the strength of the drug- receptor bonding. Choices 1 and 2 describe the capability of a drug to produce the desired effect. Choice 3 is the branch of science that deals with the effects of forces on the motions of material bodies or with changes in a physical or chemical system.Pharmacological Therapies

NEW QUESTION 385
- (Topic 4)
Which of the following needs immediate medical attention and emergency intervention? The client who:

A. complains of sharp pain upon taking a deep breath and excessive coughing.
B. exhibits yellow, productive sputum, lowgrade fever, and crackles.
C. has a shift of the trachea to the left, with no breath sounds on the right.
D. has asthma and complains of an inability to catch her breath after exercise.

Answer: C

Explanation:
Choice 3 is indicative of a tension pneumothorax, which is considered a medical emergency. The respiratory system is severely compromised and venous return to the heart is affected. The mediastinal shift is to the unaffected side. Choice 1 contains symptoms of pleurisy, and Choice 2 lists symptoms of bronchitis. Neither are emergencies. The client in Choice 4 should expect difficulty breathing after exercise when asthma is an existing condition and might need immediate attention if his rescue inhaler is ineffective. Physiological Adaptation

NEW QUESTION 387
- (Topic 4)
What is the reason for a contract between nurse and client?

A. Contracts state the roles the participants take.
B. Contracts are indicative of the feeling tone established between participants.
C. Contracts are binding and prevent either party from ending the relationship prematurely.
D. Contracts spell out the participation and responsibilities of both parties.

Answer: D

Explanation:
A contract emphasizes that the nurse works with the client, rather than doing something for the client.Working withsuggests that each party is expected to participate and share responsibility for outcomes. Contracts do not,however, stipulate roles or feeling tone, nor is premature termination expressly forbidden.Psychosocial Integrity

NEW QUESTION 391
- (Topic 4)
Nursing care for a client undergoing chemotherapy includes assessment for signs of bone marrow depression. Which finding accounts for some of the symptoms related to bone marrow depression?

A. erythrocytosis
B. leukocytosis
C. polycythemia
D. thrombocytopenia

Answer: D

Explanation:
Thrombocytopenia is an abnormal decrease in the number platelets, which results in bleeding tendencies. Erythrocytosis is an abnormal increase in the number of circulating red blood cells. Leukocytosis is an increase in the number of white blood cells in the blood. Polycythemia is also an excess of red blood cells and is a synonym for erythrocytosis. With chemotherapy there is a decrease in red and white blood cells, not an increase.
Physiological Adaptation

NEW QUESTION 393
- (Topic 4)
A risk management program within a hospital is responsible for all of the following except:

A. identifying risks.
B. controlling financial loss due to malpractice claims.
C. making sure that staff follow their job descriptions.
D. analyzing risks and trends to guide further interventions or programs.

Answer: C

Explanation:
Risk management is an organizationwide program to identify risks and control incidents and legal liability.
It does not have any direct supervisory or management responsibility for staff.Safety and Infection Control

NEW QUESTION 398
- (Topic 4)
One day postoperative, the client complains of dyspnea, and his respiratory rate (RR) is 35, slightly labored, and there are no breath sounds in the lower-right base. The nurse should suspect:

A. cor pulmonale.
B. atelectasis.
C. pulmonary embolus.

D. cardiac tamponade.

Answer: B

Explanation:
The first three symptoms could be indicative of any of the conditions. The distinguishing symptom is the lack of breath sounds in the lower-right base, which is assessed when a portion of the lung has collapsed.Physiological Adaptation

NEW QUESTION 403
- (Topic 4)
The advanced directive in a client??s chart is dated August 12, 1998.The client??s daughter produces a Power of Attorney for Health Care, dated 2003, which contains different care direction(s). The nurse is supposed to:

A. follow the 1998 version because it??s part of the legal chart.
B. follow the 1998 version because the physician??s code order is based on it.
C. follow the 2003 version, place it in the chart, and communicate the update appropriately.
D. follow neither until clarified by the unitmanager.

Answer: C

Explanation:
The document dated 2003 supersedes the previous version and should be used as a basis for care direction.
Choices 1 and 2 are incorrect because the 1998 version is now outdated. Choice 4 is incorrect because the nurse can be held negligent for not responding to the 2003 document as directed.Coordinated Care

NEW QUESTION 406
- (Topic 4)
The nurse and a colleague are on the elevator after their shift, and they hear a group of health caregivers discussing a recent client scenario. Which client right might be breached?

A. right to refuse treatment
B. right to continuity of care
C. right to confidentiality
D. right to reasonable responses to requests

Answer: C

Explanation:
The right to confidentiality of client information might be breached when client care situations are discussed in public areas or without regard to maintaining the information as private and confidential. The other rights listed have not been breached in this instance. Coordinated Care

NEW QUESTION 409
- (Topic 4)
The nurse??s first action upon discovery of an electrical fire should be which of the following?

A. Disconnect the electrical power if it can be performed safely.
B. Smother the source with an object such as a blanket.
C. Saturate the source with water or other readily available liquid.
D. Activate the fire alarm immediately.

Answer: A

Explanation:
If it is safe to do so, the nurse should disconnect electrical devices from the power source.
Smothering with a blanket is not indicated in an electrical fire and might serve to fuel the fire,just as water or other liquids might incite an explosion or flames. The fire alarm should be activated promptly, and this should be the next action after disconnecting the electrically powered equipment.Safety and Infection Control

NEW QUESTION 414
- (Topic 4)
A serious complication of a total hip replacement is displacement of the prosthesis. What is the primary sign of displacement?

A. pain on movement and weight bearing
B. hemorrhage
C. affected leg appearing 1–2 inches longer
D. edema in the area of the incision

Answer: A

Explanation:
Pain on movement and weight bearing indicates pressure on the nerves or muscles caused by the dislocation. Other symptoms of dislocation include an inability to bear weight and a shortening of the affected leg. Edema is not a primary sign of displacement.Physiological Adaptation

NEW QUESTION 416
- (Topic 4)
A client goes to the mental health center for difficulty concentrating, insomnia, and nightmares. The client reports being raped as a child. The nurse should assess the client for further signs of:

A. general anxiety disorder.
B. schizophrenia.
C. post-traumatic stress disorder.
D. bipolar disorder.

Answer: C

Explanation:
Childhood sexual abuse is associated with adult-onset depression and with an increased risk for lifetime and current post-traumatic stress disorder (PTSD). About one-third of all victims of sexual abuse meet the diagnostic criteria for PTSD. A person with PTSD has three main types of symptoms: (1) Re-experiencing the traumatic event with flashbacks, nightmares, and exaggerated reactions to triggers that remind the person of the event. (2) Emotional numbing is evidenced by avoidance of activities, places, thoughts, feelings, or conversations related to the trauma; feelings of detachment from others; and restricted or blunted emotions. (3) Increased activity is seen in bursts of anger, difficulty sleeping, hypervigilence, difficulty concentrating, and an exaggerated startle response. Other problems associated with PTSD are panic attacks, suicidal thoughts and feelings, substance abuse, eating disorders, feelings of alienation and isolation, and feelings of mistrust and betrayal.Psychosocial Integrity

NEW QUESTION 420
- (Topic 4)
Activities of effective supervisors can be taskrelated or people-related activities. An example of a task-related supervisory activity is:

A. coaching.
B. evaluating.
C. delegating.
D. facilitating.

Answer: C

Explanation:
Delegating is the act (or task) of assigning work to those that are capable and competent to do the work. Coaching, evaluating, and facilitating are supervisory activities that are people related.Coordinated Care

NEW QUESTION 422
- (Topic 4)
A community health nurse is asked to organize a health promotion project that plans to provide glucose screening. This activity is most beneficial within what realm?

A. testing that is performed by volunteers at a local department store and is open to the public
B. at a professional health fair activity available for selected persons who have been screened as being at risk
C. mass-marketing vouchers for free fingersticks at a local drug store, where the pharmacist makes recommendations on the findings
D. testing that is performed by a nurse professional, who immediately provides education regarding the findings

Answer: B

Explanation:
Public glucose screening has been found to be an ineffective way to screen for diabetes unless based on health risk screening for those persons identified to be at risk or displaying symptoms.Safety and InfectionControl

NEW QUESTION 423
- (Topic 4)
Hearing screening of prematurely born infants is an effective means of identifying disease and is an example of:

A. primary prevention.
B. secondary prevention.
C. tertiary prevention.
D. disability prevention.

Answer: B

Explanation:
The three levels of prevention address disease and disability across all phases, from absence of disease and at risk for disease, to preventing further impairment. Hearing impairment associatedwith prematurity cannot be prevented by screening, but identifying the infants with hearing loss might prevent sequelae and further impairment by allowing early intervention.Safety and Infection Control

NEW QUESTION 426
- (Topic 4)
The power a nurse exerts when he or she works to accomplish goals and effect change in an agency or in policy is considered what type of power?

A. political
B. personal
C. positional
D. professional

Answer: A

Explanation:
Political power results from one??s ability to work within systems, agencies, or through policy to affect change. Personal power is based on one??s charisma and self-confidence and is often found in informal leadership situations. Positional power is based on designated authority in a legitimized position within which the power is exercised. Professional power is based on one??s professional skills and abilities resulting from one??s recognized expertise in an area of

practice.Coordinated Care

NEW QUESTION 427
- (Topic 4)
A day care center has asked the nurse to provide education for parents regarding safety in the home. What type of preventive care does this represent?

A. primary
B. secondary
C. tertiary
D. health promotion

Answer: A

Explanation:
Primary prevention involves activities that are utilized to promote wellness or prevent illness or injury. There are many dangers in the home for small children. Providing education regarding the need for safety measures to prevent injury in the home is considered primary prevention. Secondary prevention involves early detection of a disease or illness and quick intervention to aid the client in maintenance of the disease or injury. Tertiary prevention involves the reduction of a disability and the promotion of the highest level of functioning for a client in relation to his or her disease or injury. Health promotion is any activity that increases a client??s health and wellness.Health Promotion and Maintenance

NEW QUESTION 428
- (Topic 5)
All of the following are clinical manifestations indicating male climacteric except:

A. hot flashes.
B. loss of reproductive ability.
C. headaches.
D. heart palpitations.

Answer: B

Explanation:
The likelihood of fathering children does decrease with aging and decreased testosterone production, but men do not lose their ability to reproduce during the climacteric. Many men do not experience any physical symptoms of climacteric but some men do report hot flashes, headaches, and heart palpitations, among other symptoms.Health Promotion and Maintenance

NEW QUESTION 429
- (Topic 5)
A physician orders a serum creatinine for a hospitalized client. The nurse should explain to the client and his family that this test:

A. is normal if the level is 4.0 to 5.5 mg/dl.
B. can be elevated with increased protein intake.
C. is a better indicator of renal function than the BUN.
D. reflects the fluid volume status of a person.

Answer: C

Explanation:
A serum creatinine level should be 0.7 to 1.5 mg/dl, and it does not vary with increased protein intake, so it is a better indicator of renal function than the BUN.Physiological Adaptation

NEW QUESTION 430
- (Topic 5)
Which is an appropriate outcome for the nursing diagnosis of Body Image Disturbance for a client with anorexia nervosa?

A. The client verbalizes knowledge of a maintenance diet.
B. The client demonstrates assertiveness with family.
C. The client verbalizes her body size accurately.
D. The client demonstrates control of obsessive behaviors.

Answer: C

Explanation:
Part of the problem for anorexic clients is an altered view of their body appearance (visualizing themselves as fat even when they are emaciated). Choice 1 involves a knowledge deficit. Choice 2 involves possible resolution of family-dynamic issues. Choice 4 involves psychological adaptation.Basic Care and Comfort

NEW QUESTION 431
- (Topic 5)
What is pica?

A. dependency on alcohol
B. increased iron in the diet
C. the sickle cell trait
D. eating ice

Answer: D

Explanation:
Pica represents the ingestion of nonfood substances that leads to a clinical iron deficiency and might actually be the first sign of a problem. Clients eat a wide range of nonfood items, including ice, clay, dirt, and paste.Physiological Adaptation

NEW QUESTION 432
- (Topic 5)
What are the implications for a client with renal insufficiency who wants to start a low- carbohydrate (CHO) diet?

A. As long as the client eats a minimum of 30g of CHO/day, there should be no problem.
B. The client??s clinical condition is a contraindication to starting a low CHO diet.
C. Calcium supplements should be utilized to prevent the development of osteoporosis while on a low CHO diet.
D. As long as the client eats foods that are high biologic protein sources, a low CHO diet can be followed.

Answer: B

Explanation:
A client with renal insufficiency should not start a low CHO diet because it could result in an increased renal solute load. Clients who have renal disease (renal failure, endstage renal disease [ESRD], dialysis, and transplant) or liver disease (liver failure, hepatic encephalopathy, cirrhosis, transplant, and hepatitis) require some form of protein control in dietary patterns to preventcomplications from an inability to handle protein solute load. Proteins used in the diet must be of high biologic value, and protein intake is usually weight based, starting at 0.8 g/kg of dry weight, depending on the client??s underlying clinical condition. Protein levels may be increased as necessary to account for metabolic response to dialysis and regeneration of liver tissue (1.5–2.0 g/kg/day). A minimum level of CHOs are needed in the diet (50–100 g/day) to spare protein. Vitamin and mineral supplements might be indicated with clients who have liver failure. The dietician is instrumental in calculating specific nutrient requirements for these clients and reviewing fluid intake and output, medication profile, and daily weight to monitor client outcomes in conjunction with dialysis technicians and nurses.Physiological Adaptation

NEW QUESTION 436
- (Topic 5)
When assessing a client in the Emergency Department whose membranes have ruptured, the nurse notes that the fluid is a greenish color. What is the cause of this greenish coloration?

A. blood
B. meconium
C. hydramnios
D. caput

Answer: B

Explanation:
Greenish amniotic fluid passed when the fetus is in a cephalic (head) presentation might indicate fetal distress. A fetus in the breech presentation passes meconium due to compression on the intestinal tract.Physiological Adaptation

NEW QUESTION 439
- (Topic 5)
Increased cortisol levels might be found in a client with which condition?

A. Cushing??s syndrome
B. Addison??s disease
C. renal failure
D. congestive heart failure

Answer: A

Explanation:
Cushing??s syndrome produces elevated cortisol levels. Addison??s disease produces decreased cortisol levels. The other conditions are not associated with cortisol levels. Reduction of Risk Potential

NEW QUESTION 442
- (Topic 5)
Which of the following statements indicates adequate dietary understanding in a client with constipation?

A. ??I should decrease my intake of fluids.??
B. ??I should decrease my level of activity.??
C. ??I should increase my intake of apples.??
D. ??I should increase my intake of milk.??

Answer: C

Explanation:
Apples are a source of high fiber, which decreases constipation. A constipated client needs to increase fluids and activity level. Milk is not a high-fiber food.Reduction of Risk Potential

NEW QUESTION 445
- (Topic 5)
Padding on a restraint helps:

A. with pressure distribution so that bony prominences do not receive pressure when a client pulls against the restraints.
B. the client feel more secure.

C. to keep infection and wounds down.
D. to keep restraints in place.

Answer: A

Explanation:
Padding distributes pressure so that bony prominences do not receive the brunt of pressure when a client pulls against the restraints. Pressure, especially over bony prominences, causes tissue damage due to ischemia.Safetyand Infection Control

NEW QUESTION 448
- (Topic 5)
Physical examination of a client regarding mobility status should:

A. begin with gait.
B. be oriented to time, place, and person.
C. begin with the Romberg test.
D. begin with the Tandem Walk test.

Answer: A

Explanation:
Gait is usually assessed as the client walks into the room. Normal gait is smooth, flowing, and rhythmic without assistive devices.Basic Care and Comfort

NEW QUESTION 450
- (Topic 5)
For a client requiring total oral care, it is important for the nurse to:

A. assemble all equipment, assist the client tosemi-Fowler??s position, and place a towel on his chest.
B. place client in Fowler??s position, prepare the equipment, and tell the client what to do.
C. assemble all equipment, place the client in a side-lying position, and place a towel under his chin.
D. use gloves and clean the client??s mouth, including the tongue.

Answer: C

Explanation:
Assemble all equipment first; place the client in a side-lying position so that fluid can easily flow out or pool in the side of the mouth for suctioning (to prevent aspiration); and then place a towel under the client??s chin and a curved basin against the chin. Gloves should be worn.Basic Care and Comfort

NEW QUESTION 454
- (Topic 5)
Which of the following home-care strategies is most likely to negatively impact the body image of a client with Cushing??s syndrome?

A. providing safety measures to prevent falls
B. taking medications as prescribed
C. wearing a medical ID indicating Cushing??s syndrome
D. having regular health assessments

Answer: C

Explanation:
All of the strategies listed are included in home care for the client with Cushing??s syndrome. Choice 3 is the best answer because wearing a medical ID is a visible sign that something is wrong and a constant reminder to the client that he or she has a loss of body function.
Choice 1 might enhance body image because it prevents falls that could cause further injury and debilitation. Taking medications as prescribed should enhance body image because it decreases the symptoms present. Having regular health assessments indicates an enhanced body image because it signals the desire to take care of the body and keep it at its best.Health Promotion and Maintenance

NEW QUESTION 456
- (Topic 5)
Which cultural group has the highest incidence of inflammatory bowel disease (IBD)?

A. Asians
B. Caucasians
C. Hispanics
D. African Americans

Answer: B

Explanation:
Caucasians have the highest incidence of inflammatory bowel disease (IBD).Reduction of Risk Potential

NEW QUESTION 457
- (Topic 5)
Which of the following nursing diagnoses is most appropriate for a client with a new colostomy?

A. Excess Fluid Volume
B. Risk for Aspiration

C. Disturbed Body Image
D. Urinary Retention

Answer: C

Explanation:
Disturbed Body Image is the most appropriate nursing diagnosis for a client with a new colostomy, due to the adjustments that need to be made with the physical alteration of a colostomy. The other diagnoses are not applicable.Reduction of Risk Potential

NEW QUESTION 459
- (Topic 5)
What does client and family communication and education concerning restraints do?

A. confuses both groups more
B. helps with coping and stress levels
C. encourages cooperation with the client and family
D. puts the responsibility on the client and family, not the nurse

Answer: C

Explanation:
Cooperation is more likely if the client and family understand the purpose of and expected gains from restraints.
Well-meaning family members might release restraints if their purpose is not clear.Safety and Infection Control

NEW QUESTION 463
- (Topic 5)
The teaching plan for a postpartum client who is about to be discharged should include which of the following instructions?

A. ??It is normal for your breasts to be tende
B. You should call the physician if you also have redness and fatigue.??
C. ??Because your baby was delivered vaginally, you might have to urinate more frequently.??
D. ??It is normal to run a low-grade temperature for a few day
E. If it is higher than 100?? F, call your physician.??
F. ??Be sure to call your physician if your vaginal discharge becomes bright red.??

Answer: D

Explanation:
The vaginal discharge after birth is called lochia, and it changes from red (rubra) to serosa (clear) on the third postpartum day. If it returns to red or contains clots, it could signal impending hemorrhage or infection and the physician should be notified. It is not normal for the breasts to be tender. If the breasts become engorged, they might be tender and the mother might need to be given additional instructions on breast care. Tenderness, redness, and fatigue are clinical manifestations of mastitis and should be reported to the physician. A woman should void in normal patterns and frequency after birth. Increased frequency is a sign of a urinary tract infection and should be reported to the physician. By the time of discharge, the woman??s temperature should be normal. Elevations should be reported to the physician.Health Promotion and Maintenance

NEW QUESTION 464
- (Topic 5)
In alcoholics with anemia:

A. pernicious anemia is more common than folic acid deficiency.
B. iron deficiency and folic acid deficiency can coexist.
C. the alcohol interferes with iron absorption.
D. oral vitamin replacement is contraindicated.

Answer: B

Explanation:
The ingestion of nonfood substances (alcohol) can lead to a clinical iron deficiency and might actually be the first sign of a problem. The client might substitute alcohol for a nutrition program that fosters a positive health habit.Physiological Adaptation

NEW QUESTION 467
- (Topic 5)
Neural tube defects in the fetus have been primarily associated with which deficiency in the mother?

A. iron
B. folic acid
C. vitamin B12
D. vitamin E

Answer: B

Explanation:
Folic acid is essential for the development of the neural tube and might prevent the defect or failure of the tube to close (congenital anomalies).Physiological Adaptation

NEW QUESTION 471
- (Topic 5)

Which of the following statements describes the purpose of client restraint?

A. Restraints are a nursing measure used to maintain client control.
B. Restraints are an emergency intervention taken as a last resort to protect a client from imminent danger.
C. Restraints are a therapeutic measure designed to positively reinforce client behavior.
D. Restraints are an emergency measure that can only be taken by a nurse under the direct supervision of a physician.

Answer: B

Explanation:
The use of restraints as an emergency measure is taken primarily as a last resort to protect a client from harm. Typically, the nurse acts under a physician??s order, but in an emergency, the nurse may restrain a client out of necessity for one hour prior to the client being seen by a physician or an advanced practice mental health provider.Safety and Infection Control

NEW QUESTION 476
- (Topic 5)
A client tells the nurse that his wife??s nagging really gets on his nerves. He asks the nurse to talk with her about her nagging during their family session tomorrow afternoon. Which of the following responses is the most therapeutic for the client?

A. ??Tell me more specifically about her complaints.??
B. ??Can you think why she might nag you so much???
C. ??I??ll help you think about how to bring this up yourself tomorrow afternoon.??
D. ??Why do you want me to initiate this in tomorrow??s session rather than you???

Answer: C

Explanation:
The client needs to learn how to communicate directly with his wife about her behavior. The nurse??s assistance enables him to practice a new skill and communicates confidence in his ability to confront this situation. Choices 1 and 2 inappropriately direct attention away from the clientand toward his wife, who isn??t present. Choice 4 implies that there might be a legitimate reason for the nurse to assume responsibility for something that rightfully belongs to the client. Instead of focusing on his problems, he??ll waste precious time convincing the nurse that he or she should do his work.Psychosocial Integrity

NEW QUESTION 481
- (Topic 5)
Nonpharmacological pain management involves all of the following except:

A. hypnosis alone.
B. psychological care, including support groups.
C. physical and psychological modalities.
D. pain-reducing drugs only.

Answer: D

Explanation:
All physical and psychosocial therapies can be used concurrently with drugs and other modalities to manage pain. These interventions can be carried out by the nurse with the client and family.Basic Care and Comfort

NEW QUESTION 486
- (Topic 5)
Which of the following is not a primary function of the kidneys?

A. blood pressure control
B. vitamin D activation
C. erythropoietin production
D. reabsorbing waste products

Answer: D

Explanation:
All of the choices are functions of the kidneys except reabsorbing waste products. The kidneys excrete waste products.Physiological Adaptation

NEW QUESTION 491
- (Topic 5)
The nurse is turning a client who has a new prosthetic hip. Which position should be avoided to prevent injury to the new prosthetic hip?

A. abduction of the hip
B. adduction of the hip
C. flexing the hip at 80?? flexion
D. flexing the hip at 90??

Answer: B

Explanation:
New prosthetic hips should have an abduction pillow in place to avoid adduction.Basic Care and Comfort

NEW QUESTION 492
- (Topic 5)

Which of the following is not a function of parathyroid hormone?

A. moving calcium from bones to the bloodstream
B. promoting renal tubular reabsorption of phosphorus
C. promoting renal tubular reabsorption of calcium
D. enhancing renal production of vitamin D metabolites

Answer: B

Explanation:
Parathyroid hormone depresses renal tubular reabsorption of phosphorus. All of the other choices are functions of parathyroid hormone.Reduction of Risk Potential

NEW QUESTION 496
- (Topic 5)
A client who recently lost 50 pounds just received news that she is pregnant. A possible nursing diagnosis is:

A. Actual Chronic Low Self-Esteem (related to obesity).
B. Potential Chronic Low Self-Esteem (related to obesity).
C. Actual Situational Low Self-Esteem (related to fear of weight regain and pregnancy).
D. Potential Situational Low Self-Esteem (related to fear of weight regain and pregnancy).

Answer: D

Explanation:
If there are indications of a body image disturbance, the nursing care plan should include body disturbances, related to a functional or physical problem. The disturbance might be an anticipated one—that is, weight gain and pregnancy. Stressors can include a change in physical appearance, sexuality concerns, or an unrealistic ideal self.
Psychosocial Integrity

NEW QUESTION 499
- (Topic 5)
Client room environments should include:

A. a made bed, fresh water, thermostat regulation, and clean floors in all occupied client areas.
B. a made bed, comfort and safety, a clutter-free area, hygiene articles nearby.
C. accident prevention, comfort, a room (including furniture) that has been cleaned with chloroseptic wash, a bed that is made every other day.
D. odor control (by spraying the room with deodorizers), closet storage of all client objects, a clean roo
E. (Gloves should be worn when cleaning.)

Answer: B

Explanation:
Preparing a client??s room environment should include making the client??s bed, ensuring comfort and safety at all times, keeping the area free of clutter, and keeping the client??s hygiene articles nearby. All procedures should be explained before they are performed, and the client should assist with personal arrangement of articles.Basic Care and Comfort

NEW QUESTION 502
- (Topic 5)
The nurse should utilize data about which of the following to provide information about the nutritional status of a client being evaluated for malnutrition?

A. triceps skinfold measurement
B. fasting blood glucose level
C. hemoglobin A1c level
D. serum lipid profile results

Answer: A

Explanation:
Objective anthropometric measurements such as triceps skinfold and mid-arm circumference (MAC), along with weight, are usually used to diagnose malnutrition. While all the other choicesrepresent tests that might provide useful information, they also might be affected by variables other than malnutrition.Physiological Adaptation

NEW QUESTION 503
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