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NEW QUESTION: 1

A 1000-mL dose of lactated Ringer's solution is to be infused in 8 hours. The drop factor for the tubing is

10 gtt/mL. How many drops per minute should the nurse administer?

- A. 125 gtt/min
- B. 48 gtt/min
- C. 20 gtt/min
- D. 21 gtt/min

Answer: D ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) This answer has not been rounded off to an even number. (D) 20.8, or 21 gtt/min.

NEW QUESTION: 2

Home-care instructions for the child following a cardiac catheterization should include:

- A. Notify the physician if a slight bruise develops around the insertion site.
- B. Use sponge bathing until stitches are removed.
- C. Give aspirin if the child complains of pain at the insertion site.
- D. Keep a clean, dry dressing on the insertion site for 2 days.

Answer: (SHOW ANSWER)

Explanation

(A) A small bruise may develop around the insertion site and is not a reason for alarm. (B) It is best to keep the child out of the bathtub until the sutures are removed. (C) Acetaminophen, not aspirin, is the drug of choice if there is pain at the insertion site. (D) The insertion site should be kept clean and dry and open to air.

NEW QUESTION: 3

The nurse teaches a pregnant client that a high-risk symptom occurring at any time during pregnancy that needs to be reported immediately to a healthcare provider is:

- A. Constipation
- B. Urinary frequency
- C. Breast tenderness
- D. Abdominal pain

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) Constipation is a result of decreased peristalsis due to smooth muscle relaxation related to changing progesterone levels that occur during pregnancy. (B) Urinary frequency is a common result of the increasing size of the uterus and the resulting pressure it places on the bladder. (C) With the increased vascularity and hypertrophy of the mammary alveoli due to estrogen and progesterone level changes, the breasts will increase in size and may become tender. (D) Abdominal pain may be an indication of early spontaneous abortion, preterm delivery, or a placental abruption.

NEW QUESTION: 4

Two weeks after a client's admission for depression, the physician orders a consult for electroconvulsive therapy (ECT). Which of the following conditions, if present, would be a contraindication for ECT?

- A. Brain tumor or other space-occupying lesion
- B. History of mitral valve prolapse
- C. Surgically repaired herniated lumbar disk
- D. History of frequent urinary tract infections

Answer: (SHOW ANSWER)

Section: Questions Set F

Explanation:

(A) A contraindication for ECT is a space-occupying lesion such as a brain tumor. During ECT, intracranial pressure increases. Therefore, ECT would not be prescribed for a client whose intracranial pressure is already elevated. (B) Any cardiac dysrhythmias or complications that arise during ECT are usually attributed to the IV anesthetics used, not to preexisting cardiac structural conditions. (C) Musculoskeletal injuries during ECT are extremely rare because of the IV use of centrally acting muscle relaxers. (D) A history of any kind of infection would not contraindicate the use of ECT. In fact, concurrent treatment of infections with ECT is not uncommon.

NEW QUESTION: 5

The nurse caring for a client who has pneumonia, which is caused by a gram-positive bacteria, inspects her sputum. Because the client's pneumonia is caused by a gram-positive bacteria, the nurse expects to find the sputum to be:

- A. Bright red with streaks
- B. Rust colored
- C. Green colored
- D. Pink-tinged and frothy

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) Bright red sputum with streaks is associated with pneumonia caused by gram-negative bacteria, such as *Klebsiella pneumoniae*. (B) Pneumococcal pneumonia, caused by gram-positive bacteria, has a characteristic productive cough with green or rust-colored sputum. (C) Green-colored sputum is more characteristic of *Pseudomonas* than of gram-positive bacterial pneumonia. (D) Pink-tinged and frothy sputum is more characteristic of pulmonary edema than of gram-positive bacterial pneumonia.

NEW QUESTION: 6

A 60-year-old woman exhibits forgetfulness, emotional lability, confusion, and decreased concentration. She has been unable to perform activities of daily living without assistance. After a thorough medical evaluation, a diagnosis of Alzheimer's disease was made. An appropriate nursing intervention to decrease the anxiety of this client would include:

- A. Allowing the client to perform activities of daily living as much as possible unassisted
- B. Confronting confabulations
- C. Reality testing
- D. Providing a highly stimulating environment

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set D

Explanation:

(A) This answer is correct. The more the client is able to control her daily routine, the less anxiety she will experience. (B) This answer is incorrect. Confrontation tends to increase anxiety. (C) This answer is incorrect.

Reality testing is an assessment tool. It does not decrease anxiety. (D) This answer is incorrect. A highly stimulating environment increases distractibility and anxiety.

NEW QUESTION: 7

A client delivered her first-born son 4 hours ago. She asks the nurse what the white cheeselike substance is under the baby's arms. The nurse should respond:

- A. "This is a normal skin variation in newborns. It will go away in a few days."
- B. "Let me have a closer look at it. The baby may have an infection."
- C. "This material, called vernix, covered the baby before it was born. It will disappear in a few days."

D. "Babies sometimes have sebaceous glands that get plugged at birth. This substance is an example of that condition."

Answer: C (LEAVE A REPLY)

(A) This response identifies the fact that vernix is a normal neonatal variation, but it does not teach the client medical terms that may be useful in understanding other healthcare personnel. (B) This response may raise maternal anxiety and incorrectly identifies a normal neonatal variation. (C) This response correctly identifies this neonatal variation and helps the client to understand medical terms as well as the characteristics of her newborn. (D) Blocked sebaceous glands produce milia, particularly present on the nose.

NEW QUESTION: 8

A client sustained second- and third-degree burns to his face, neck, and upper chest. Which of the following nursing diagnoses would be given the highest priority in the first 8 hours' postburn?

- A. Fluid volume deficit secondary to alteration in skin integrity
- B. Alteration in comfort secondary to alteration in skin integrity
- C. Alteration in sensation secondary to third-degree burn
- D. Alteration in airway integrity secondary to edema of neck and face, which in turn is secondary to alteration in skin integrity

Answer: D (LEAVE A REPLY)

Explanation

(A) Fluid deficit is a high priority not only during the first 8 hours postburn, but also during the first 36 hours postburn. (B) Alteration in comfort is a high priority during the entire length of the client's hospitalization and on discharge. (C) Alteration in sensation is a high priority during the first 48-72 hours postburn. Lack of sensation may be indicative of lack of circulation. (D) Alteration in airway integrity is the highest priority for this client in the first 8 hours postburn. Failure to continually assess this client's airway status could result in poor ventilation and oxygenation, in addition to an inability to intubate the client secondary to excessive edema formation in the neck.

NEW QUESTION: 9

Following her surgery, a 5-year-old child will return to the pediatric unit with a long-arm cast. She experienced a supracondylar fracture of the humerus near the elbow. Which nursing action is most essential during the first 24 hours after surgery and cast application?

- A. Mobilization of the child
- B. Discharge teaching
- C. Pain management
- D. Assessment of neurovascular status

Answer: D (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) Mobilization is important but not absolutely essential. (B) Discharge teaching should be initiated prior to surgery as well as during the postoperative period. (C) Assessment and management of pain are necessary and high in priority. (D) Neurovascular status of the extremity is of primary importance. The risk of circulatory impairment exists with any cast application. This type of fracture is common in children. A high incidence of neurovascular complications exists with fractures near the elbow.

NEW QUESTION: 10

A client calls the prenatal clinic to schedule an appointment. She states she has missed three menstrual periods and thinks she might be pregnant. During her first visit to the prenatal clinic, it is confirmed that she is pregnant. The registered nurse (RN) learns that her last menstrual period began on June 10. According to Naegele's rule, the estimated date of confinement is:

- A. March 17
- B. June 3
- C. August 30
- D. January 10

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

(A) Using Naegele's rule, count back 3 calendar months from the first day of the last menstrual period. The answer is March 10. Then add 7 days and 1 year, which would be March 17 of the following year. (B, C, D) This date is incorrect.

NEW QUESTION: 11

The nurse has been caring for a 16-year-old female who recently experienced date rape. After having had crisis intervention and been hospitalized for 2 weeks, the nurse knows that the client is effectively coping with the rape when she tells the nurse:

- A. "I know it was my fault that it happened, because I shouldn't have been out so late."
- B. "If I had not worn that sexy dress that night, he wouldn't have raped me."
- C. "I know my date just had so much passion he couldn't handle me saying 'no.' "
- D. "I know now that it was not my fault, but I want to continue counseling after my discharge."

Answer: ([SHOW ANSWER](#))

Explanation

(A) This response does not show any insight; the client falsely assumes that she is responsible for the rape. (B) The client continues to falsely assume responsibility for the rapist's behavior. (C) The client believes falsely that rape is an act of passion, rather than one of violence, control, and domination. (D) The client has insight into the rape; she does

not believe it was her fault and shows good judgment in deciding to continue with counseling after discharge.

NEW QUESTION: 12

A 47-year-old client has been admitted to the general surgery unit for bowel obstruction. The doctor has ordered that an NG tube be inserted to aid in bowel de-compression. When preparing to insert a NG tube, the nurse measures from the:

- A. Lower lip to the shoulder to the upper sternum
- B. Tip of the nose to the lower lip to the umbilicus
- C. End of the tube to the first measurement line on the tube
- D. Tip of the nose to the ear lobe to the xiphoid process or midepigastic area

Answer: D (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) This measurement is 50 cm (48-49 cm). Fifty centimeters is considered the length necessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (B) This measurement is 50 cm (47-48 cm). Fifty centimeters is considered the length necessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (C) This measurement gives an approximate indication of the length necessary for the distal end of the tube to be in place in the stomach, but it is not as accurate as actually measuring the client (nose-earxiphoid). (D) This is the correct measurement of 50 cm from the tip of the client's nose to the tip of the earlobe to the xiphoid process (called the NEX [nose-ear-xiphoid] measurement).

It is approximately equal to the distance necessary for the distal end of the tube to be located in the correct position in the stomach.

NEW QUESTION: 13

The nurse observes a client crying quietly. She has just experienced a spontaneous abortion at nine weeks' gestation. An appropriate response by the nurse would be:

- A. "It must be God's will and probably is for the best."
- B. "This must be a difficult time for you. Would you like to talk about it?"
- C. "I'm sure your other children will be a comfort for you."
- D. "Don't worry, you're still young. If I were you I'd just try again."

Answer: B (LEAVE A REPLY)

Explanation

(A) This response is nontherapeutic because it belittles the client's response and gives a meaningless rationalization. (B) This response acknowledges the client's feelings and demonstrates the therapeutic offering of self by the nurse. (C) This response is nontherapeutic because it does not focus on the client's feelings and offers false reassurance. (D) This response is nontherapeutic because it belittles the client's feelings and offers her advice.

NEW QUESTION: 14

The mother of a 7-year-old mental health center client reports that the client has refused to attend gymnastics for the past 2 weeks. Prior to that time, the child liked going to this class and was attending 3 times a week. In talking with the client, the nurse would:

- A.** Ask her why she doesn't like gymnastics anymore
- B.** Ask her to describe how things were at gymnastics before she started refusing to go
- C.** Tell her that it is OK to be afraid of this activity
- D.** Reassure her that things will get better once she begins the classes again

Answer: B (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) The child has not said that she dislikes gymnastics. (B) The nurse will be able to obtain information on what events occurred at gymnastics prior to her refusal to attend. The nurse will also gain information about the child's perception of the problem. (C) The child has not said she is afraid to go to gymnastics. (D) False reassurance is inappropriate.

NEW QUESTION: 15

In client teaching, the nurse should emphasize that fetal damage occurs more frequently with ingestion of drugs during:

- A.** First trimester
- B.** Second trimester
- C.** Third trimester
- D.** Every trimester

Answer: A (LEAVE A REPLY)

(A) Organogenesis occurs in the first trimester. Fetus is most susceptible to malformation during this period. (B) Organogenesis has occurred by the second trimester. (C) Fetal development is complete by this time. (D) The dangerous period for fetal damage is the first trimester, not the entire pregnancy.

NEW QUESTION: 16

A client has a chest tube placed in his left pleural space to re-expand his collapsed lung. In a closed-chest drainage system, the purpose of the water seal is to:

- A.** Prevent air from entering the pleural space
- B.** Prevent fluid from entering the pleural space
- C.** Provide a means to measure chest drainage
- D.** Provide an indicator of respiratory effort

Answer: A (LEAVE A REPLY)

Explanation

(A) A chest tube extends from the pleural space to a collection device. The tube is placed below the surface of the saline so that air cannot enter the pleural space. (B) Fluid may

enter the pleural space as a result of injury or disease. A chest tube may drain fluid from the pleural space, but the water seal is not involved in this. (C) Chest drainage should be measured, but the water seal is not involved in this. (D) Fluctuations in the tube in the water-sealed bottle will give an indication of respiratory effort, but that is not the purpose of the water seal.

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NEW QUESTION: 17

A 74-year-old female client is 3 days postoperative. She has an indwelling catheter and has been progressing well. While the nurse is in the room, the client states, "Oh dear, I feel like I have to urinate again!" Which of the following is the most appropriate initial nursing response?

- A. Assure her that this is most likely the result of bladder spasms.
- B. Check the collection bag and tubing to verify that the catheter is draining properly.
- C. Instruct her to do Kegel exercises to diminish the urge to void.
- D. Ask her if she has felt this way before.

Answer: (SHOW ANSWER)

(A) Although this may be an appropriate response, the initial response would be to assure the patency of the catheter. (B) The most frequent reason for an urge to void with an indwelling catheter is blocked tubing. This response would be the best initial response. (C) Kegel exercises while a retention catheter is in place would not help to prevent a voiding urge and could irritate the urethral sphincter. (D) Though the nurse would want to ascertain whether the client has felt the same urge to void before, the initial response should be to assure the patency of the catheter.

NEW QUESTION: 18

A 52-year-old female client is admitted to the hospital in acute renal failure. She has been on hemodialysis for the past 2 years. Stat arterial blood gases are drawn on the client yielding the following results: pH 7.30, PCO₂ 51 mm Hg, HCO₃⁻ 18 mEq/L, PaO₂ 84 mm Hg. The nurse would interpret these results as:

- A. Compensated metabolic alkalosis
- B. Respiratory acidosis
- C. Partially compensated metabolic alkalosis

D. Combined respiratory and metabolic acidosis

Answer: D (LEAVE A REPLY)

(A) Compensated metabolic alkalosis would be reflected by the following: pH within normal limit (7.35-7.45), $\text{PCO}_2 > 45$ mm Hg, $\text{HCO}_3 > 26$ mEq/L. (B) Respiratory acidosis would be reflected by the following: pH < 7.35 , $\text{PCO}_2 > 45$ mm Hg, HCO_3 within normal limits (22-26 mEq/L). (C) Partially compensated metabolic alkalosis would be reflected by the following: pH > 7.45 , $\text{PCO}_2 > 45$ mm Hg, $\text{HCO}_3 > 26$ mEq/L. (D) Combined respiratory and metabolic acidosis would be reflected by the following: pH < 7.35 , $\text{PCO}_2 > 45$ mm Hg, $\text{HCO}_3 < 22$ mEq/L.

NEW QUESTION: 19

The physician of an alcoholic client places him on a low-protein, high-carbohydrate diet. When choosing his menu, the client's best choice from the items below would be:

- A.** Liver and onions, macaroni and cheese, tea with sugar
- B.** Baked chicken, baked potato with bacon bits, milk
- C.** Waffles with butter and honey, orange juice
- D.** Cheese omelette with ham and mushrooms, milk

Answer: C (LEAVE A REPLY)

Explanation

(A, B, D) These foods are high in protein, which needs to be restricted. (C) Serum ammonia levels can be decreased by restricting dietary protein intake. Waffles, honey, and orange juice are high in carbohydrate and low or completely lacking in protein. Butter, a concentrated fat, will provide extra calories.

NEW QUESTION: 20

In healthcare settings, nurses must be familiar with primary, secondary, and tertiary levels of care. As a nurse in the community, which of the following interventions might be a primary prevention strategy?

- A.** Crisis intervention with an intoxicated teenager whose mother just committed suicide
- B.** Referring a client who has been on a detoxification unit to a rehabilitation center
- C.** Teaching fifth-grade children the harmful effects of substance abuse
- D.** Counseling a client with post-traumatic stress disorder

Answer: (SHOW ANSWER)

(A) The teenager is already coping ineffectively and requires early detection and treatment, which is secondary prevention. (B) The client must be sent to a rehabilitation unit, which requires tertiary prevention. (C) Reducing the incidence of disease through education supports primary prevention. (D) A client with identified symptoms of post-traumatic stress disorder requires intervention by treatment.

NEW QUESTION: 21

Succinylcholine chloride (Anectine) is ordered prior to electroconvulsive therapy treatment for depressed clients. The nurse explains that the purpose of the drug is to:

- A. Relax muscles
- B. Relieve anxiety
- C. Reduce secretions
- D. Act as an anesthetic

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) Succinylcholine chloride relaxes muscles and decreases the intensity of the seizure. (B) Succinylcholine chloride does not relieve anxiety. (C) Atropine is given to reduce secretions. (D) Thiamylal sodium (Surital) or other phenobarbital preparations are used as brief anesthetics.

NEW QUESTION: 22

The nurse documents a client's surgical incision as having red granulated tissue. This indicates that the wound is:

- A. Infected
- B. Not healing
- C. Necrotic
- D. Healing

Answer: D (LEAVE A REPLY)

Explanation

(A) The wound is not infected. An infected wound would contain pus, debris, and exudate. (B) The wound is healing properly. (C) A necrotic wound would appear black or brown. (D) The wound is healing properly and is filled with red granulated tissue and fragile capillaries.

NEW QUESTION: 23

Dietary planning is an essential part of the diabetic client's regimen. The American Diabetes Association recommends which of the following caloric guidelines for daily meal planning?

- A. 50% complex carbohydrate, 20%-25% protein, 20%-25% fat
- B. 45% complex carbohydrate, 25%-30% protein, 30%-35% fat
- C. 70% complex carbohydrate, 20%-30% protein, 10%-20% fat
- D. 60% complex carbohydrate, 12%-15% protein, 20%-25% fat

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The percentage of carbohydrates is too low to maintain blood sugar levels. The percent range of protein is too high and may cause extra workload on the kidney as it is metabolized. (B) The percentage of carbohydrates is too low to maintain blood sugar

levels. The percent range of protein is too high and may cause extra workload on the kidney. (C) The percentage of carbohydrates is too high; the percent range of protein is too high, and of fat, too low. (D) This combination provides enough carbohydrates to maintain blood glucose levels, enough protein to maintain body repair, and enough fat to ensure palatability.

NEW QUESTION: 24

A family by court order undergoes treatment by a family therapist for child abuse. The nurse, who is the child's case manager knows that treatment has been effective when:

- A.** The child is removed from the home and placed in foster care
- B.** The child's parents identify the ways in which he is different from the rest of the family
- C.** The child's father is arrested for child abuse
- D.** The child's parents can identify appropriate behaviors for children in his age group

Answer: [\(SHOW ANSWER\)](#)

Section: Questions Set G

Explanation:

(A) Removing an abused child from the home and placement in a foster home are not the desired outcome of treatment. (B) Children who are perceived as "different" from the rest of the family are more likely to be abused. (C) Although legal action may be taken against abusive parents, it is not an indicator of an effective treatment program. (D) Identification of age-appropriate behaviors is essential to the role of parents, because misunderstanding children's normal developmental needs often contributes to abuse or neglect.

NEW QUESTION: 25

A 66-year-old female client has smoked 2 packs of cigarettes per day for 20 years. Her arterial blood gases on room air are as follows: pH 7.35; PO₂ 70 mm Hg; PCO₂ 55 mm Hg; HCO₃ 32 mEq/L. These blood gases reflect:

- A.** Compensated metabolic acidosis
- B.** Compensated respiratory acidosis
- C.** Compensated respiratory alkalosis
- D.** Uncompensated respiratory acidosis

Answer: **B** [\(LEAVE A REPLY\)](#)

Explanation

(A) In compensated metabolic acidosis, the pH level is normal, the PCO₂ level is decreased, and the HCO₃ level is decreased. The client's primary alteration is an inability to remove excess acid via the kidneys.

The lungs compensate by hyperventilating and decreasing PCO₂. (B) In compensated respiratory acidosis, the pH level is normal, the PCO₂ level is elevated, and the HCO₃ level is elevated. The client's primary alteration is an inability to remove CO₂ from the lungs, so over time, the kidneys increase reabsorption of HCO₃ to buffer the CO₂. (C) In compensated respiratory alkalosis, the pH level is normal, the PCO₂ level is decreased,

and the HCO_3 level is decreased. The client's primary alteration is hyperventilation, which decreases PCO_2 . The client compensates by increasing the excretion of HCO_3 from the body. (D) In uncompensated respiratory acidosis, the pH level is decreased, the PCO_2 level is increased, and the HCO_3 level is normal. The client's primary alteration is an inability to remove CO_2 from the lungs. The kidneys have not compensated by increasing HCO_3 reabsorption.

NEW QUESTION: 26

Often children are monitored with pulse oximeter. The pulse oximeter measures the:

- A. O_2 content of the blood
- B. Oxygen saturation of arterial blood
- C. PO_2
- D. Affinity of hemoglobin for O_2

Answer: B (LEAVE A REPLY)

Explanation

(A) The O_2 content of whole blood is determined by the partial pressure of oxygen (PO_2) and the oxygen saturation. The pulse oximeter does not measure the PO_2 . (B) The pulse oximeter is a noninvasive method of measuring the arterial oxygen saturation. (C) The PO_2 is the amount of O_2 dissolved in plasma, which the pulse oximeter does not measure. (D) The affinity of hemoglobin for O_2 is the relationship between oxygen saturation and PO_2 and is not measured by the pulse oximeter.

NEW QUESTION: 27

A 12-year-old girl has been diagnosed with insulin-dependent diabetes mellitus. Which of these principles would best guide her nutritional management?

- A. Concentrated sweets are taken during increased activity.
- B. Food restriction is imposed to reduce weight.
- C. Caloric distribution should be calculated to fit activity patterns.
- D. Fat requirements are increased owing to the possibility of ketoacidosis.

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Concentrated sweets are eliminated from diet planning. Complex carbohydrates may be taken at the time of increased activity. (B) Food restriction is not used for diabetic control of growing children. Caloric restriction may be imposed for weight control if necessary. (C) Total caloric intake and proportions of basic nutrients should be consistent from day to day. Distribution of these calories should fit the activity pattern.

Extra food is needed for increased activity. A balance of food, exercise, and insulin should be maintained.

(D) Because of the increased risk of atherosclerosis, the fat percentage of the total caloric intake is reduced.

NEW QUESTION: 28

The physician of a client diagnosed with alcoholism orders neomycin 0.5 g q6h to prevent hepatic coma.

Neomycin decreases serum ammonia levels by:

- A. Decreasing nitrogen-forming bacteria in the intestines
- B. Acidifying colon contents by causing ammonia retention in the colon
- C. Decreasing the uptake of vitamin D, thereby drawing more water into the colon
- D. Irritating the bowel and promoting evacuation of stool

Answer: A (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) Neomycin interferes with protein synthesis in the bacterial cell, causing bacterial death. Neomycin reduces the growth of the ammonia-producing bacteria in the intestines and is used for the treatment of hepatic coma.

(B) This choice describes the action of lactulose, another drug commonly used to decrease systemic ammonia levels. (C) Neomycin's action does not decrease uptake of vitamin D to reduce serum ammonia levels. (D) Bowel irritation with diarrhea is more likely to occur with administration of lactulose rather than of neomycin.

Besides, diarrhea is a side effect of a drug, not the action of the drug.

NEW QUESTION: 29

A male client is scheduled for a liver biopsy. In preparing him for this test, the nurse should:

- A. Explain that he will be kept NPO for 24 hours before the exam
- B. Practice with him so he will be able to hold his breath for 1 minute
- C. Explain that he will be receiving a laxative to prevent a distended bowel from applying pressure on the liver
- D. Explain that his vital signs will be checked frequently after the test

Answer: D (LEAVE A REPLY)

(A) There is no NPO restriction prior to a liver biopsy. (B) The client would need to hold his breath for 5-10 seconds. (C) There is no pretest laxative given. (D) Following the test, the client is watched for hemorrhage and shock.

NEW QUESTION: 30

A premature infant needs supplemental O₂ therapy. A nursing intervention that reduces the risk of retrolental fibroplasia is to:

- A. Maintain O₂ at <40%
- B. Maintain O₂ at >40%
- C. Give moist O₂ at >40%
- D. Maintain on 100% O₂

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Retrolental fibroplasia is the result of prolonged exposure to high levels of O₂ in premature infants.

Complications are hemorrhage and retinal detachment. (B, C, D) O₂ concentration is too high.

NEW QUESTION: 31

A 5-year-old child cries continually in her bed. Her parents have been unsuccessful in assisting her in expressing her feelings. Which activity should the nurse provide the child to assist her in expressing her feelings?

A. Books with colorful pictures

B. Music

C. Riding toys

D. Puppets

Answer: ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) Books increase cognition, assist with fine motor skills, and augment language development. (B) Music provides auditory stimulation and large-muscle activity. (C) Riding toys provide large-muscle activity. (D) Puppets allow expression of feelings and fears that otherwise could not be directly communicated.

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NEW QUESTION: 32

The client has been in active labor for the last 12 hours. During the last 3 hours, labor has been augmented with oxytocin because of hypoactive uterine contractions. Her physician assesses her cervix as

95% effaced, 8 cm dilated, and the fetus is at 0 station. Her oral temperature is 100.2°F at this time. The physician orders that she be prepared for a cesarean delivery. In preparing the client for the cesarean delivery, which one of the following physician's orders should the RN question?

- A. Administer meperidine (Demerol) 100 mg IM 1 hour prior to the delivery.
- B. Discontinue the oxytocin infusion.
- C. Insert an indwelling Foley catheter prior to delivery.
- D. Prepare abdominal area from below the nipples to below the symphysis pubis area.

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Meperidine is a narcotic analgesic medication that crosses the placental barrier and reaches the fetus, causing respiratory depression in the fetus. A narcotic medication should never be included in the preoperative order for a cesarean delivery. (B) Oxytocin infusion would be discontinued if client is being prepared for a cesarean delivery because the medication would not be needed. (C) The bladder is always emptied prior to and during the surgical intervention to prevent the urinary bladder from accidentally being incised while the uterine incision is made. (D) The abdominal area is always prepared to rid the area of hair before the abdominal incision is made. Abdominal hair cannot be sterilized and could become a source for postoperative incisional infection.

NEW QUESTION: 33

A 55-year-old man is admitted to the hospital with complaints of fatigue, jaundice, anorexia, and clay-colored stools. His admitting diagnosis is "rule out hepatitis." Laboratory studies reveal elevated liver enzymes and bilirubin. In obtaining his health history, the nurse should assess his potential for exposure to hepatitis.

Which of the following represents a high-risk group for contracting this disease?

- A. Heterosexual males
- B. Oncology nurses
- C. American Indians
- D. Jehovah's Witnesses

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Homosexual males, not heterosexual males, are at high risk for contracting hepatitis. (B) Oncology nurses are employed in high-risk areas and perform invasive procedures that expose them to potential sources of infection. (C) The literature does not support the idea that any ethnic groups are at higher risk. (D) There is no evidence that any religious groups are at higher risk.

NEW QUESTION: 34

A seventh grader lost consciousness after being hit in the head with a basketball. In the emergency room his vital signs are stable, and he demonstrates no neurologic deficit. He will not be admitted to the hospital.

It is most important that you advise his mother to:

- A. Encourage him to drink plenty of fluids
- B. Expect him to have nausea with vomiting
- C. Keep him awake for the next 12 hours
- D. Wake him up every 1-2 hours during the night

Answer: D ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Fluid intake should be normal. Fluid intake may be restricted when there is a risk for increased ICP in a hospitalized client. (B) Nausea is possible, but vomiting without nausea is more likely with increased ICP.

Neither one should be expected, but the mother should know to notify the physician or hospital if they occur. (C) The child does not need to be kept awake. It is important that he can be aroused from sleep. (D) If the child cannot be awakened from sleep after head injury, it is an indication of serious increase in ICP.

The mother should call an ambulance right away.

NEW QUESTION: 35

A postoperative TURP client returns from the recovery room to the general surgery unit and is in stable condition. One hour later the nurse assesses him and finds him to be confused and disoriented. She recognizes that this is most likely caused by:

- A. Hypovolemic shock
- B. Hypokalemia
- C. Hypernatremia
- D. Hyponatremia

Answer: ([SHOW ANSWER](#))

Explanation

(A) Early signs of hypovolemic shock include hypotension, tachycardia, tachypnea, pallor, and diaphoresis.

(B) Early signs of potassium depletion include muscular weakness or paralysis, tetany, postural hypotension, weak pulse, shallow respirations, apathy, weak voice, and electrocardiographic changes. (C) Early signs of an elevated sodium level include dry oral mucous membranes, marked thirst, hypertension, tachycardia, oliguria or anuria, anxiety, and agitation. (D) This answer is correct. Important early clinical findings of a decreased sodium concentration include confusion and disorientation. Hyponatremia can occur after a TURP because absorption during surgery through the prostate veins can increase circulating blood volume and decrease sodium concentration.

NEW QUESTION: 36

To prevent thrombophlebitis in a client on complete bed rest, the nursing care plan should include:

- A. Dangle the client's legs over the edge of the bed every shift.

- B.** Massage the client's calves briskly every shift.
- C.** Keep the client's legs extended and discourage any movement.
- D.** Have the client tighten and relax leg muscles several times daily.

Answer: ([SHOW ANSWER](#))

(A) Dangling the client's legs over the edge of the bed will contribute to stasis and pooling of blood and increases the risk of thrombus formation. (B) Massaging the client's calves could result in dislodging an embolus. (C) Decreased movement will contribute to pooling of blood and increased risk of venous thrombosis. (D) Tightening and relaxing leg muscles increases circulation and decreases the risk of venous thrombosis.

NEW QUESTION: 37

A client is admitted to the hospital with diabetic ketoacidosis.

The emergency room nurse should anticipate the administration of:

- A.** Humulin N
- B.** Humulin R
- C.** Humulin U
- D.** Humulin L

Answer: **B** ([LEAVE A REPLY](#))

Explanation

(A) Intermediate-acting insulin is not indicated in an emergency. (B) Regular insulin is rapid acting and indicated in an emergency situation. (C) Long-acting insulin is not indicated in an emergency situation. (D) Intermediate-acting insulin is not indicated in an emergency situation.

NEW QUESTION: 38

Prior to his discharge from the hospital, a cardiac client is started on digoxin (Lanoxin) 25 mg po qd. The nurse initiates discharge teaching. Which of the following statements by the client would validate an understanding of his medication?

- A.** "I would notify my physician immediately if I experience nausea, vomiting, and double vision."
- B.** "I could stop taking this medication when I begin to feel better."
- C.** "I should only take the medication if my heart rate is greater than 100 bpm."
- D.** "I should always take this medication with an antacid."

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation:

(A) The first signs of digoxin toxicity include abdominal pain, anorexia, nausea, vomiting, and visual disturbances. The physician should be notified if any of these symptoms are experienced. (B) The positive inotropic effects of digoxin increase cardiac output and result in an enhanced activity tolerance. "Feeling better" indicates the drug is working and medication therapy must be continued. (C) Clients should be taught to take their pulse

prior to taking the digoxin. If their pulse rate becomes irregular, slows significantly, or is >100 bpm the physician should be notified. (D) Antacids decrease the effectiveness of digoxin.

NEW QUESTION: 39

A 3-year-old child was hospitalized for acute laryngotracheobronchitis. During her hospitalization, the child was placed under an oxygen mist tent. The nurse's frequent monitoring of the child's temperature frightened her parents. Which response by the nurse would be most appropriate?

- A. Monitoring the temperature prevents undue chilling.
- B. Rapid temperature elevations can occur in children.
- C. Checking the temperature will prevent febrile seizures.
- D. Taking the child's temperature can prevent airway obstruction.

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) The refrigerated cool mist tent creates a cool, moist environment. The child as well as bedding and clothing may become dampened. Monitoring the temperature of the child will ensure warmth and prevent chilling. (B) Only a low-grade fever is expected in laryngotracheobronchitis. (C) Febrile seizures are not expected with the low-grade fever. (D) Inflammation of the mucosal lining in the respiratory tract can cause airway obstruction. However, monitoring the child's temperature would not prevent airway obstruction.

NEW QUESTION: 40

The predominant purpose of the first Apgar scoring of a newborn is to:

- A. Determine gross abnormal motor function
- B. Obtain a baseline for comparison with the infant's future adaptation to the environment
- C. Evaluate the infant's vital functions
- D. Determine the extent of congenital malformations

Answer: ([SHOW ANSWER](#))

Explanation

(A) Apgar scores are not related to the infant's care, but to the infant's physical condition. (B) Apgar scores assess the current physical condition of the infant and are not related to future environmental adaptation. (C) The purpose of the Apgar system is to evaluate the physical condition of the newborn at birth and to determine if there is an immediate need for resuscitation. (D) Congenital malformations are not one of the areas assessed with Apgar scores.

NEW QUESTION: 41

Clinical manifestations seen in left-sided rather than in right-sided heart failure are:

- A. Elevated central venous pressure and peripheral edema
- B. Dyspnea and jaundice

- C. Hypotension and hepatomegaly
- D. Decreased peripheral perfusion and rales

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A, B, C) Clinical manifestations of right-sided heart failure are weakness, peripheral edema, jugular venous distention, hepatomegaly, jaundice, and elevated central venous pressure. (D) Clinical manifestations of left-sided heart failure are left ventricular dysfunction, decreased cardiac output, hypotension, and the backward failure as a result of increased left atrium and pulmonary artery pressures, pulmonary edema, and rales.

NEW QUESTION: 42

A male client receives 10 U of regular human insulin SC at 9:00 AM. The nurse would expect peak action from this injection to occur at:

- A. 9:30 AM
- B. 10:30 AM
- C. 12 noon
- D. 4:00 PM

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This is too early for peak action to occur. (B) This is too early for peak action to occur. (C) Regular insulin peak action occurs 2-4 hours after administration. (D) This is too late for peak action to occur.

NEW QUESTION: 43

The nurse notes hyperventilation in a client with a thermal injury. She recognizes that this may be a reaction to which of the following medications if applied in large amounts?

- A. Neosporin sulfate
- B. Mafenide acetate
- C. Silver sulfadiazine
- D. Povidone-iodine

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The side effects of neomycin sulfate include rash, urticaria, nephrotoxicity, and ototoxicity. (B) The side effects of mafenide acetate include bone marrow suppression, hemolytic anemia, eosinophilia, and metabolic acidosis. The hyperventilation is a compensatory response to the metabolic acidosis. (C) The side effects of silver sulfadiazine include rash, itching, leukopenia, and decreased renal function. (D) The primary side effect of povidone-iodine is decreased renal function.

NEW QUESTION: 44

The nurse assesses a postoperative mastectomy client and notes that breath sounds are diminished in both posterior bases. The nurse's action should be to:

- A. Encourage coughing and deep breathing each hour
- B. Obtain arterial blood gases
- C. Increase O₂ from 2-3 L/min
- D. Remove the postoperative dressing to check for bleeding

Answer: A (LEAVE A REPLY)

(A) Decreased or absent breath sounds are frequently indicators of postoperative atelectasis. (B) Arterial blood gases are not indicated because there is no other information indicating impending danger. (C) Increasing O₂ rate is not indicated without additional information. (D) Removing the dressing is not indicated without additional information.

NEW QUESTION: 45

An 11-year-old boy has received a partial-thickness burn to both legs. He presents to the emergency room approximately 15 minutes after the accident in excruciating pain with charred clothing to both legs. What is the first nursing action?

- A. Apply ice packs to both legs.
- B. Begin débridement by removing all charred clothing from wound.
- C. Apply Silvadene cream (silver sulfadiazine).
- D. Immerse both legs in cool water.

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Ice creates a dramatic temperature change in the tissue, which can cause further thermal injury. (B) Charred clothing should not be removed from wound first. This creates further tissue damage.

Débridement is not the first nursing action. (C) Applying silver sulfadiazine cream first insulates heat in injured tissue and increases potential for infection. (D) Emergency care of a thermal burn is immersing both legs in cool water. Cool water permits gradual temperature change and prevents further thermal damage.

NEW QUESTION: 46

On the first postpartal day, a client tells the nurse that she has been changing her perineal pads every 1/2 hour because they are saturated with bright red vaginal drainage. When palpating the uterus, the nurse assesses that it is somewhat soft, 1 fingerbreadth above the umbilicus, and midline. The nursing action to be taken is to:

- A. Gently massage the uterus until firm, express any clots, and note the amount and character of lochia
- B. Catheterize the client and reassess the uterus

- C. Begin IV fluids and administer oxytocic medication
- D. Administer analgesics as ordered to relieve discomfort

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Gentle massage and expression of clots will let the fundus return to a state of firmness, allowing the uterus to function as the "living ligature." (B) A distended bladder may promote uterine atony; however, after determining the bladder is distended, the nurse would have the client void. Catheterization is only done if normal bladder function has not returned. (C) Oxytocic medications are ordered and administered if the uterus does not remain contracted after gentle massage and determining if the bladder is empty. (D) The client is not complaining of discomfort or pain; therefore, analgesics are not necessary.

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NEW QUESTION: 47

When providing dietary teaching to an individual who has diabetes mellitus, type II, the nurse discusses the importance of consuming the recommended daily allowance of which of the following electrolytes?

- A. Potassium
- B. Magnesium
- C. Sodium
- D. HCO₃

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) Potassium intake that meets the recommended daily allowance is important, especially in clients who have a history of cardiac disease. (B) Low levels of magnesium can cause an increase in resistance to insulin and can lead to carbohydrate intolerance. (C) Sodium is an important electrolyte for all clients but has no direct effect on diabetes mellitus. (D) Bicarbonate plays an important role in acid-base balance. It is equally necessary for maintenance of all body functions.

NEW QUESTION: 48

A 58-year-old client on a general surgery unit is scheduled for transurethral resection of the prostate (TURP) in 2 hours. The nurse explains to the client that this procedure means:

- A.** Removal of the prostate tissue by way of a lower abdominal midline incision through the bladder and into the prostate gland
- B.** Removal of prostate tissue by a resectoscope that is inserted through the penile urethra
- C.** Removal of the prostate tissue by an open surgical approach through an incision between the ischial tuberosities, the scrotum, and the rectum
- D.** Removal of prostate tissue by an open surgical approach through a low horizontal incision, bypassing the bladder, to the prostate gland

Answer: B (LEAVE A REPLY)

(A) This describes a suprapubic (transvesical) prostatectomy procedure. (B) This is the correct description of a TURP procedure. (C) This describes a perineal prostatectomy procedure. (D) This describes a retropubic (extravesical) prostatectomy procedure.

NEW QUESTION: 49

A type I diabetic client is diagnosed with cellulitis in his right lower extremity. The nurse would expect which of the following to be present in relation to his blood sugar level?

- A.** A normal blood sugar level
- B.** A decreased blood sugar level
- C.** An increased blood sugar level
- D.** Fluctuating levels with a predawn increase

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Blood sugar levels increase when the body responds to stress and illness. (B) Blood sugar levels increase when the body responds to stress and illness. (C) Hyperglycemia occurs because glucose is produced as the body responds to the stress and illness of cellulitis. (D) Blood sugar levels remain elevated as long as the body responds to stress and illness.

NEW QUESTION: 50

A male client tells his nurse that he has had an ulcer in the past and is afraid it is "flaring up again." The nurse begins to ask him specific questions about his symptoms. The nurse knows that a symptom that might indicate a serious complication of an ulcer is:

- A.** Pain in the middle of the night
- B.** A bowel movement every 3-5 days
- C.** Melena
- D.** Episodes of nausea and vomiting

Answer: C (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) Clients with ulcers generally experience abdominal pain. It is common to have pain in the early morning hours with an ulcer. (B) Constipation is not a symptom associated with ulcers and would indicate a need to look at other factors. (C) Melena is blood in the stools. This could indicate a slow bleeding ulcer, which could result in significant amounts of blood loss over time. (D) Nausea and vomiting may be present as a result of the ulcer, especially if it is a gastric ulcer. This does not indicate an immediate life-threatening complication.

NEW QUESTION: 51

A client is now pregnant for the second time. Her first child weighed 4536 g at delivery. The client's glucose tolerance test shows elevated blood sugar levels. Because she only shows signs of diabetes when she is pregnant, she is classified as having:

- A.** Insulin-dependent diabetes
- B.** Type II diabetes mellitus
- C.** Type I diabetes mellitus
- D.** Gestational diabetes mellitus

Answer: ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) Insulin-dependent diabetes mellitus, also known as type I diabetes, usually appears before the age of 30 years with an abrupt onset of symptoms requiring insulin for management. It is not related to onset during pregnancy. (B) Non-insulin-dependent diabetes (type II diabetes) usually appears in older adults. It has a slow onset and progression of symptoms. (C) This type of diabetes is the same as insulin-dependent diabetes. (D) Gestational diabetes mellitus has its onset of symptoms during pregnancy and usually disappears after delivery. These symptoms are usually mild and not life threatening, although they are associated with increased fetal morbidity and other fetal complications.

NEW QUESTION: 52

To prevent transmission of bacterial meningitis, the nurse would instruct an infected baby's mother to:

- A.** Avoid touching the baby while in the room.
- B.** Stay outside of the baby's room.
- C.** Wear a gown and gloves and wash her hands before and after leaving the room.
- D.** Wear a mask while in the room.

Answer: **C** ([LEAVE A REPLY](#))

Explanation

(A) The mother should be allowed and encouraged to touch her baby. (B) With care, transmission can be prevented. There is no need for the mother to stay outside the room. (C) Everyone entering the baby's room should take appropriate measures to prevent

transmission of pathogens. (D) Wearing a mask will not protect against transmission of pathogens.

NEW QUESTION: 53

A client is being discharged from the hospital tomorrow following a colon resection with a left colostomy. The nurse knows that the client understands the discharge teaching about care of her colostomy when she says:

- A. "I know that I am not supposed to irrigate my colostomy."
- B. "My stool will be soft like paste."
- C. "My stoma should be red and slightly raised."
- D. "The skin around my stoma may become irritated from the enzymes in my stool."

Answer: (SHOW ANSWER)

(A) A left colostomy indicates an ascending colon resection. This type of colostomy can be irrigated. (B) The stool from an ascending colon resection should be formed. (C) The healthy stoma should be red and slightly raised. If it begins to turn dark or blue, the client should see the physician immediately. (D) The stool in the ascending colon does not usually have many enzymes in it. Stool from an ileostomy has more enzymes and is more irritating to the skin.

NEW QUESTION: 54

A client tells the nurse that he has been hearing voices that tell him to kill his girlfriend because she is a spy. He further states that he is having difficulty not obeying the voices because, if he does not, his house will be burned down. The highest priority nursing diagnosis for him at this time is:

- A. Sensory-perceptual alteration: auditory command hallucinations
- B. Alteration in thought processes: paranoid delusions
- C. Potential for violence directed at others
- D. Impaired verbal communication: loose associations

Answer: (SHOW ANSWER)

(A) Although the client is having command hallucinations, this is second in priority to real or potential violence, which can be a threat to life itself. (B) Although the client is experiencing delusions, this is also a lower priority than his potential or actual loss of control. (C) Whether real or potential, violence directed at self or others is always high priority. (D) There is no evidence of loosening of associations.

NEW QUESTION: 55

A 70-year-old client is almost finished receiving her second unit of packed red blood cells. The client, who weighs 80 lb, has started complaining of being short of breath and now has crackles in the bases of her lungs. After slowing or stopping the transfusion, the most appropriate initial nursing action would be to:

- A. Raise the client's head and place her feet in a dependent position

- B.** Notify the physician
- C.** Place the client on 2 liters of O₂ via nasal cannula
- D.** Administer furosemide (Lasix) 20 mg IV push

Answer: A (LEAVE A REPLY)

(A) Raising the client's head and placing her feet in a dependent position is an independent nursing action that can be taken to decrease venous return and to reduce pulmonary congestion. (B) Notifying the physician is an appropriate action that should be taken after the client is positioned to maximize her respiratory status. (C) Placing the client on O₂ may be done with a physician's order or according to an institution's standing orders; however, other actions should be taken first. (D) Furosemide 20 mg IV push is an appropriate medication for the client, but it must be ordered by her physician.

NEW QUESTION: 56

As a nurse in the emergency room, you receive an outside call from an elderly woman who states she has just been raped. She states, "I know I must come to the hospital, but what do I do next?" You advise her to call the police, then come to the hospital emergency room. What action by the nurse would indicate an understanding of the examination process once the victim enters the emergency room?

- A.** Inform the victim not to wash, change clothes, douche, brush teeth, or eat or drink anything.
- B.** Inform the victim to bring insurance information with her to the hospital so she can be properly cared for.
- C.** Phone a rape counselor to begin working with the victim as soon as she enters the hospital.
- D.** Do not leave the victim alone to collect her thoughts.

Answer: A (LEAVE A REPLY)

(A) Providing the victim with these instructions will aid in the determination of physical evidence of rape. Victims frequently feel "dirty" after rape, and their first instinct is to take care of personal hygiene before facing anyone. (B) This action is of lesser importance at this time. (C) Although this is a nursing measure appropriate in this situation, contacting a counselor can be done once the victim enters the hospital. Frequently victims call but do not follow up with the visit. (D) Once the victim enters the emergency room, it is important not to leave her alone.

NEW QUESTION: 57

A 52-year-old client's abdominal aortic aneurysm ruptured. She received rapid massive blood transfusions for bleeding. One potential complication of blood administration for which she is especially at risk is:

- A.** Air embolus
- B.** Circulatory overload
- C.** Hypocalcemia

D. Hypokalemia

Answer: C (LEAVE A REPLY)

Section: Questions Set C

Explanation:

(A) Air embolism is a potential complication of blood administration, but it is fairly rare and can be prevented by using good IV technique. (B) Circulatory overload is a potential complication of blood administration, but because this client is actively bleeding, she is not at high risk for overload. (C) Hypocalcemia is a potential complication of blood administration that occurs in situations where massive transfusion has occurred over a short period of time. It occurs because the citrate in stored blood binds with the client's calcium. Another potential complication for which this client is especially at risk is hypothermia, which can be prevented by using a blood warmer to administer the blood. (D) Hypokalemia is not a complication of blood administration.

NEW QUESTION: 58

A school-age child with asthma is ready for discharge from the hospital. His physician has written an order to continue the theophylline given in the hospital as an oral home medication. Immediately prior to discharge, he complains of nausea and becomes irritable. His vital signs were normal except for tachycardia. What first nursing actions would be essential in this situation?

- A.** Hold the child's discharge for 1 hour.
- B.** Notify the physician immediately.
- C.** Discharge the child as the physician ordered.
- D.** Administer an antiemetic as necessary.

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Holding the child's discharge alone does not address the client's problem. (B) Nausea, tachycardia, and irritability are all symptoms of theophylline toxicity. The physician should be notified immediately so that a serum theophylline level can be ordered. Theophylline dose should be withheld until the physician is notified. (C) The child must be evaluated for theophylline toxicity before any discharge. (D) Cause of the nausea should be investigated before the administration of an antiemetic.

NEW QUESTION: 59

Other drugs may be ordered to manage a client's ulcerative colitis. Which of the following medications, if ordered, would the nurse question?

- A.** Methylprednisolone sodium succinate (Solu-Medrol)
- B.** Loperamide (Imodium)
- C.** Psyllium
- D.** 6-Mercaptopurine

Answer: D (LEAVE A REPLY)

(A) Methylprednisolone sodium succinate is used for its anti-inflammatory effects. (B) Loperamide would be used to control diarrhea. (C) Psyllium may improve consistency of stools by providing bulk. (D) An immunosuppressant such as 6-mercaptopurine is used for chronic unrelenting Crohn's disease.

NEW QUESTION: 60

In planning daily care for a client with multiple sclerosis, the nurse would take into consideration that multiple sclerosis:

- A. Becomes progressively debilitating without remission
- B. Has unpredictable remissions and exacerbations
- C. Is rapidly fatal
- D. Responds quickly to antimicrobial therapy

Answer: B (LEAVE A REPLY)

(A) Multiple sclerosis eventually becomes debilitating, but it is characterized by remission of symptoms. (B) Remissions and exacerbations are unpredictable with multiple sclerosis. The client experiences progressive dysfunction after each exacerbation episode. (C) Multiple sclerosis is usually slowly progressive. (D) Multiple sclerosis is an autoimmune disease. Antimicrobial therapy has no effect on its course.

NEW QUESTION: 61

The nurse is teaching a mother care of her child's spica cast. The mother states that he complains of itching under the edge of the cast. One nonpharmacological technique the nurse might suggest would be:

- A. "Blowing air under the cast using a hair dryer on cool setting often relieves itching."
- B. "Slide a ruler under the cast and scratch the area."
- C. "Guide a towel under and through the cast and move it back and forth to relieve the itch."
- D. "Gently thump on cast to dislodge dried skin that causes the itching."

Answer: A (LEAVE A REPLY)

Section: Questions Set B

Explanation:

(A) Cool air will often relieve pruritus without damaging the cast or irritating the skin. (B) The nurse should never force anything under the cast, because the cast may become damaged and skin breakdown may occur.

(C) Forcing an object under the cast could lead to cast damage and skin breakdown. The object may become lodged under the cast necessitating cast removal. (D) This technique does not dislodge skin cells. It could damage the cast and cause skin breakdown.

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NEW QUESTION: 62

A client is scheduled for a magnetic resonance imaging (MRI) to locate a cerebral lesion. It is important for the nurse to find out if he has a(n):

- A.** Allergy to seafood
- B.** History of seizures
- C.** Movable metal implant
- D.** Pin or screw in any bone

Answer: C (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) Iodine is not used as a contrast medium for MRI. It is important to inquire about allergy to seafood if the client is to have an arteriogram or enhanced computer tomography. (B) MRI is safe if seizures are under control. It is more important to inquire about movable metal implants. (C) Clients with movable metal implants such as shrapnel or aneurysm clips or clients with permanent pacemakers or implanted pumps can be traumatized during an MRI. (D) Nonmovable metal prostheses or hardware will not cause trauma during an MRI.

NEW QUESTION: 63

What is the most effective method to identify early breast cancer lumps?

- A.** Mammograms every 3 years
- B.** Yearly checkups performed by physician
- C.** Ultrasounds every 3 years
- D.** Monthly breast self-examination

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Mammograms are less effective than breast self-examination for the diagnosis of abnormalities in younger women, who have denser breast tissue. They are more effective for women older than 40. (B) Up to 15% of early-stage breast cancers are detected by physical examination; however, 95% are detected by women doing breast self-examination. (C) Ultrasound is used primarily to determine the location of cysts and to distinguish cysts from solid masses. (D) Monthly breast self-examination has been shown

to be the most effective method for early detection of breast cancer. Approximately 95% of lumps are detected by women themselves.

NEW QUESTION: 64

Which of the following medications requires close observation for bronchospasm in the client with chronic obstructive pulmonary disease or asthma?

- A. Verapamil (Isoptin)
- B. Amrinone (Inocor)
- C. Epinephrine (Adrenalin)
- D. Propranolol (Inderal)

Answer: (SHOW ANSWER)

(A) Verapamil has the respiratory side effect of nasal or chest congestion, dyspnea, shortness of breath (SOB), and wheezing. (B) Amrinone has the effect of increased contractility and dilation of the vascular smooth muscle. It has no noted respiratory side effects. (C) Epinephrine has the effect of bronchodilation through stimulation. (D) Propranolol, esmolol, and labetalol are all - blocking agents, which can increase airway resistance and cause bronchospasms.

NEW QUESTION: 65

A 52-year-old client who underwent an exploratory laparotomy for a bowel obstruction begins to complain of hunger on the third postoperative day. His nasogastric (NG) tube was removed this morning, and he has an IV of D5W with 0.45% normal saline running at 125 mL/hr. He asks when he can get rid of his IV and start eating. The nurse recognizes that he will be able to begin taking oral fluids and nourishment when:

- A. It is determined that he has no signs of wound infection
- B. He is able to eat a full meal without evidence of nausea or vomiting
- C. The nurse can detect bowel sounds in all four quadrants
- D. His blood pressure returns to its preoperative baseline level or greater

Answer: C (LEAVE A REPLY)

Explanation

(A) The absence of wound infection is related to his surgical wound and not to postoperative GI functioning and return of peristalsis. (B) Routine postoperative protocol involves detection of bowel sounds and return of peristalsis before introduction of clear liquids, followed by progression of full liquids and a regular diet versus a full regular meal first. (C) Routine postoperative protocol for bowel obstruction is to assess for the return of bowel sounds within 72 hours after major surgery, because that is when bowel sounds normally return. If unable to detect bowel sounds, the surgeon should be notified immediately and have the client remain NPO.

(D) Routine postoperative protocol for bowel obstruction and other major surgeries involves frequent monitoring of vital signs in the immediate postoperative period (in recovery room) and then every 4 hours, or more frequently if the client is unstable, on the

nursing unit. This includes assessing for signs of hypovolemic shock. Vital signs usually stabilize within the first 24 hours postoperatively.

NEW QUESTION: 66

A client is receiving peritoneal dialysis. He has been taught to warm the dialyzing fluid prior to instilling it because:

- A. Warmed solution helps keep the body temperature maintained within a normal range during instillation
- B. Warmed solution helps dilate the peritoneal blood vessels
- C. Warmed solution decreases the risk of peritoneal infection
- D. Warmed solution promotes a relaxed abdominal muscle

Answer: B ([LEAVE A REPLY](#))

(A) Instilling a cool solution does not significantly lower the body temperature during peritoneal dialysis. (B) Warmed solution does help dilate the peritoneal blood vessels, facilitating the exchange of fluids. (C) Warming the dialysate does not decrease the risk of peritoneal infection. Sterile technique decreases this risk. (D) Relaxing the abdominal muscles does not facilitate peritoneal dialysis.

NEW QUESTION: 67

Nursing assessment of early evidence of septic shock in children at risk includes:

- A. Fever, tachycardia, and tachypnea
- B. Respiratory distress, cold skin, and pale extremities
- C. Elevated blood pressure, hyperventilation, and thready pulses
- D. Normal pulses, hypotension, and oliguria

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation:

(A) Fever, tachycardia, and tachypnea are the classic early signs of septic shock in children. (B) Respiratory distress, cold skin, and pale extremities are later signs of septic shock. (C) Elevated blood pressure, hyperventilation, and thready pulses are later signs of septic shock. (D) Normal pulses, hypotension, and oliguria are not early signs of septic shock.

NEW QUESTION: 68

Which type of insulin can be administered by a continuous IV drip?

- A. Humulin N
- B. NPH insulin
- C. Regular insulin
- D. Lente insulin

Answer: ([SHOW ANSWER](#))

Explanation

(A) Humulin N cannot be administered IV. (B) NPH insulin cannot be administered IV. (C) Regular insulin is the only insulin that can be administered IV. (D) Lente insulin cannot be administered IV.

NEW QUESTION: 69

The physician decides to prescribe both a short-acting insulin and an intermediate-acting insulin for a newly diagnosed 8-year-old diabetic client. An example of a short-acting insulin is:

- A. Novolin Regular
- B. Humulin NPH
- C. Lente Beef
- D. Protamine zinc insulin

Answer: A (LEAVE A REPLY)

(A)

Novolin is a short-acting insulin. (B, C) NPH and Lente are intermediate-acting insulins.

(D)

Protamine zinc insulin is a long-acting insulin preparation.

NEW QUESTION: 70

Hematotympanum and otorrhea are associated with which of the following head injuries?

- A. Basilar skull fracture
- B. Subdural hematoma
- C. Epidural hematoma
- D. Frontal lobe fracture

Answer: A (LEAVE A REPLY)

(A) Basilar skull fractures are fractures of the base of the skull. Blood behind the eardrum or blood or cerebrospinal fluid (CSF) leaking from the ear are indicative of a dural laceration. Basilar skull fractures are the only type with these symptoms. (B, C, D) These do not typically cause dural lacerations and CSF leakage.

NEW QUESTION: 71

A 4-year-old child has Down syndrome. The community health nurse has coordinated a special preschool program. The nurse's primary goal is to:

- A. Provide respite care for the mother
- B. Facilitate optimal development
- C. Provide a demanding and challenging educational program
- D. Prepare child to enter mainstream education

Answer: B (LEAVE A REPLY)

Explanation

(A) Respite care for the family may be needed, but it is not the primary goal of a preschool program. (B) Facilitation of optimal growth and development is essential for every child. (C)

A demanding and challenging educational program may predispose the child to failure. Children with retardation should begin with simple and challenging educational programs. (D) Mental retardation associated with Down syndrome may not permit mainstream education. A preschool program's primary goal is not preparation for mainstream education but continuation of optimal development.

NEW QUESTION: 72

When interviewing parents who are suspected of child abuse, the nurse would use which of the following interview techniques?

- A.** Be direct, honest, and attentive.
- B.** Approach them in the emergency room as soon as you suspect abuse to "clear the air" right away.
- C.** Ask the parents what they could have done differently to prevent this from happening to the child.
- D.** After the interview, call child protective services.

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

- (A) The nurse must be honest, direct, professional, and attentive in her interview to gain the parent's trust.
- (B) The nurse should approach the parents in private, away from the child. (C) Asking them to relive and evaluate the situation may be looked at as placing blame on the parents for the child's "accident." At this point, the parents may get defensive and stop communicating. (D) Although you may call child protective services, the nurse should inform the parents of their responsibility to do this and explain the process to them.

NEW QUESTION: 73

When assessing fetal heart rate status during labor, the monitor displays late decelerations with tachycardia and decreasing variability. What action should the nurse take?

- A.** Continue monitoring because this is a normal occurrence.
- B.** Turn client on right side.
- C.** Decrease IV fluids.
- D.** Report to physician or midwife.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

- (A) This is not a normal occurrence. Late decelerations need prompt intervention for immediate infant recovery. (B) To increase O₂ perfusion to the unborn infant, the mother should be placed on her left side.
- (C) IV fluids should be increased, not decreased. (D) Immediate action is warranted, such as reporting findings, turning mother on left side, administering O₂, discontinuing oxytocin

(Pitocin), assessing maternal blood pressure and the labor process, preparing for immediate cesarean delivery, and explaining plan of action to client.

NEW QUESTION: 74

A male client is started on IV anticoagulant therapy with heparin. Which of the following laboratory studies will be ordered to monitor the therapeutic effects of heparin?

- A.** Partial thromboplastin time
- B.** Hemoglobin
- C.** Red blood cell (RBC) count
- D.** Prothrombin time

Answer: A ([LEAVE A REPLY](#))

(A) Partial thromboplastin time is used to monitor the effects of heparin, and dosage is adjusted depending on test results. It is a screening test used to detect deficiencies in all plasma clotting factors except factors VII and XIII and platelets. (B) Hemoglobin is the main component of RBCs. Its main function is to carry O₂ from the lungs to the body tissues and to transport CO₂ back to the lungs. (C) RBC count is the determination of the number of RBCs found in each cubic millimeter of whole blood. (D) PT is used to monitor the effects of oral anticoagulants, e.g., coumarin type anticoagulants.

NEW QUESTION: 75

A client is having a vertical partial laryngectomy, and the nurse is planning his postoperative care. A priority postoperative nursing diagnosis for a client having a vertical partial laryngectomy would be:

- A.** Activity intolerance
- B.** Ineffective airway clearance
- C.** High risk for infection
- D.** Altered oral mucous membrane

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) The laryngectomy client should be able to gradually increase activities without difficulty. (B) The laryngectomy client may have copious amounts of secretions and require suctioning for the first 24-48 hours.

The cannula will require cleaning even after the first 24 hours because mucus collects in it.

(C) The client does have a potential for infection, but it is not a more important nursing priority than the ineffective airway clearance.

(D) This problem is not a more important nursing priority than ineffective airway clearance. The client's mouth may become dry, but good oral care should take care of the dryness.

NEW QUESTION: 76

The nurse begins morning assessment on a male client and notices that she is unable to palpate either of his dorsalis pedis pulses in his feet. What is the first nursing action after assessing this finding?

- A. Palpate these pulses again in 15 minutes.
- B. Use a Doppler to determine presence and strength of these pulses.
- C. Document the finding that the pulses are not palpable.
- D. Call the physician and notify the physician of this finding.

Answer: B (LEAVE A REPLY)

(A) Palpating these pulses again in 15 minutes may only result in the same findings. (B) Any time during an assessment that the nurse is unable to palpate pulses, the nurse should then obtain a Doppler and assess for presence or absence of the pulse and pulse strength, if a pulse is present. (C) Pulses may be present and assessed through use of a Doppler. Absence of palpable pulses does not indicate absence of blood flow unless pulses cannot be located with a Doppler. (D) The nurse would only call the physician after determining that the pulses are absent by both palpation and Doppler.

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NEW QUESTION: 77

A client is to be discharged from the hospital and is to continue taking warfarin 2.5 mg po bid. Which of the following should be included in her discharge teaching concerning the warfarin therapy?

- A. "If you forget to take your morning dose, double the night time dose."
- B. "You should take aspirin instead of acetaminophen (Tylenol) for headaches."
- C. "Carry a medications alert card with you at all times."
- D. "You should use a straight-edge razor when shaving your arms and legs."

Answer: (SHOW ANSWER)

Section: Questions Set G

Explanation:

(A) Warfarin must always be taken exactly as directed. Clients should be instructed never to skip or double up on their dosage. (B) Aspirin decreases platelet aggregation, which would potentiate the effects of the coumadin. (C) Healthcare providers need to be aware of persons on warfarin therapy prior to the initiation of any diagnostic tests and/or surgery to

help prevent bleeding complications. (D) An electric razor should be used to prevent accidental cutting, which can lead to bleeding.

NEW QUESTION: 78

In assessing cardiovascular clients with progression of aortic stenosis, the nurse should be aware that there is typically:

- A.** Decreased pulmonary blood flow and cyanosis
- B.** Increased pressure in the pulmonary veins and pulmonary edema
- C.** Systemic venous engorgement
- D.** Increased left ventricular systolic pressures and hypertrophy

Answer: D (LEAVE A REPLY)

Explanation

(A) These signs are seen in pulmonic stenosis or in response to pulmonary congestion and edema and mitral stenosis. (B) These signs are seen primarily in mitral stenosis or as a late sign in aortic stenosis after left ventricular failure. (C) These signs are seen primarily in right-sided heart valve dysfunction. (D) Left ventricular hypertrophy occurs to increase muscle mass and overcome the stenosis; left ventricular pressures increase as left ventricular volume increases owing to insufficient emptying.

NEW QUESTION: 79

The nurse is preparing a 6-year-old child for an IV insertion. Which one of the following statements by the nurse is appropriate when preparing a child for a potentially painful procedure?

- A.** "Some say this feels like a pinch or a bug bite. You tell me what it feels like."
- B.** "This is going to hurt a lot; close your eyes and hold my hand."
- C.** "This is a terrible procedure, so don't look."
- D.** "This will hurt only a little; try to be a big boy."

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Educating the child about the pain may lessen anxiety. The child should be prepared for a potentially painful procedure but avoid suggesting pain. The nurse should allow the child his own sensory perception and evaluation of the procedure. (B) The nurse should avoid absolute descriptive statements and allow the child his own perception of the procedure. (C) The nurse should avoid evaluative statements or descriptions and give the child control in describing his reactions. (D) False statements regarding a painful procedure will cause a loss of trust between the child and the nurse.

NEW QUESTION: 80

In assisting preconceptual clients, the nurse should teach that the corpus luteum secretes progesterone, which thickens the endometrial lining in which of the phases of the menstrual cycle?

- A. Menstrual phase
- B. Proliferative phase
- C. Secretory phase
- D. Ischemic phase

Answer: (SHOW ANSWER)

(A) Menses occurs during the menstrual phase, during which levels of both estrogen and progesterone are decreased. (B) The ovarian hormone responsible for the proliferative phase, during which the uterine endometrium enlarges, is estrogen. (C) The ovarian hormone responsible for the secretory phase is progesterone, which is secreted by the corpus luteum and causes marked swelling in the uterine endometrium. (D) The corpus luteum begins to degenerate in the ischemic phase, causing a fall in both estrogen and progesterone.

NEW QUESTION: 81

A male client is experiencing auditory hallucinations. His nurse enters the room and he tells her that his mother is talking to him, and he will take his medicine after she leaves. The nurse looks around the room and sees that she and the client are the only ones in the room. The nurse's most therapeutic response will be:

- A. "I don't see your mother in the room. Let's talk about how you're feeling."
- B. "OK, I'll come back later when you're feeling more like taking your medicine."
- C. "She may be here, but I can't see her."
- D. "Why don't you finish talking to her, and I'll wait."

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This response uses the principle of reality orientation by the nurse telling the client that he or she does not see anything, but it does recognize his feelings. (B) This response does not make it clear that the nurse does not see anyone else in the room, and the nurse leaves the client alone to continue hallucinating. (C) This response leaves room for doubt; the nurse is further confusing the client by this statement. (D) This response reinforces the hallucination and implies that the nurse sees his mother, too.

NEW QUESTION: 82

When assessing a female child for Turner's syndrome, the nurse observes for which of the following symptoms?

- A. Tall stature
- B. Amenorrhea
- C. Secondary sex characteristics

D. Gynecomastia

Answer: [\(SHOW ANSWER\)](#)

Section: Questions Set G

Explanation:

(A) This syndrome is caused by absence of one of the X chromosomes. These children are short in stature. (B) Amenorrhea is a symptom of Turner's syndrome, which appears at puberty. (C) Sexual infantilism is characteristic of this syndrome. (D) Gynecomastia is a symptom in Klinefelter's syndrome.

NEW QUESTION: 83

A child is to receive atropine 0.15 mg (1/400 g) as part of his preoperative medication. A vial containing atropine 0.4 mg (1/150 g)/mL is on hand. How much atropine should be given?

A. 0.06 mL

B. 0.38 mL

C. 2.7 mL

D. Information given insufficient to determine the amount of atropine to be administered

Answer: [B \(LEAVE A REPLY\)](#)

Explanation/Reference:

Explanation:

(A, C) Information was incorrectly placed in the formula, resulting in an incorrect answer.

(B) The answer is correct.

$$0.4 \text{ mg} = 1 \text{ mL}; 0.15 \text{ mg } x = \text{mL}$$

$$0.4 x = 0.15$$

$$x = 0.15/0.4$$

$$x = 0.375 \text{ or } 0.38 \text{ mL}$$

(D) Sufficient information is provided to determine the amount of atropine to administer.

The amount of atropine available and the amount of atropine ordered is required to determine the amount of atropine to be given.

NEW QUESTION: 84

The nurse has been caring for a 16-year-old female who recently experienced date rape. After having had crisis intervention and been hospitalized for 2 weeks, the nurse knows that the client is effectively coping with the rape when she tells the nurse:

A. "I know it was my fault that it happened, because I shouldn't have been out so late."

B. "If I had not worn that sexy dress that night, he wouldn't have raped me."

C. "I know my date just had so much passion he couldn't handle me saying 'no.' "

D. "I know now that it was not my fault, but I want to continue counseling after my discharge."

Answer: [D \(LEAVE A REPLY\)](#)

(A) This response does not show any insight; the client falsely assumes that she is responsible for the rape. (B) The client continues to falsely assume responsibility for the rapist's behavior. (C) The client believes falsely that rape is an act of passion, rather than one of violence, control, and domination. (D) The client has insight into the rape; she does not believe it was her fault and shows good judgment in deciding to continue with counseling after discharge.

NEW QUESTION: 85

A client hospitalized with a medical diagnosis of adjustment disorder versus personality disorder states,

"Nobody cares about the clients." The nurse's most effective response would be:

- A. "How can you say that I don't care? We just met."
- B. "What makes you think the nurses don't care?"
- C. "You will feel differently about us in a few days."
- D. "You seem angry. Tell me more about how you feel."

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This statement is a defensive response that places the nurse in a vulnerable countertransference position, and at the same time, fails to challenge the client's "splitting" behavior. (B) This statement is a defensive response by the nurse. In addition, this type of nontherapeutic statement requests that the client explain the reasons for her behavior, a difficult task for an individual with limited insight. (C) This statement is a nontherapeutic response that both ignores the intensity of the client's emotions and the dynamics underlying "splitting" behavior. (D) By simultaneously acknowledging the client's emotional intensity and gently challenging her "splitting" behavior, the nurse addresses the client's current distortions and prepares for further interventions with angry or ambivalent feelings.

NEW QUESTION: 86

A physician's order reads: Administer KCl 10% oral solution 1.5 mL. The KCl bottle reads 20 mEq/15 mL.

What dosage should the nurse administer to the infant?

- A. 1 mEq
- B. 1.13 mEq
- C. 2 mEq
- D. Not enough information to calculate

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) $1.33 \text{ mEq} = 1 \text{ mL}$, then $1.5 \text{ mL} \times 1.99$, or 2 mEq. (D) Information is adequate for calculation.

NEW QUESTION: 87

A 16-month-old infant is being prepared for tetralogy of Fallot repair. In the nursing assessment, which lab value should elicit further assessment and requires notification of physician?

- A. pH 7.39
- B. White blood cell (WBC) count 10,000 WBCs/mm³
- C. Hematocrit 60%
- D. Bleeding time of 4 minutes

Answer: C ([LEAVE A REPLY](#))

(A) Normal pH of arterial blood gases for an infant is 7.35-7.45. (B) Normal white blood cell count in an infant is 6,000-17,500 WBCs/mm³. (C) Normal hematocrit in infant is 28%-42%. A 60% hematocrit may indicate polycythemia, a common complication of cyanotic heart disease. (D) Normal bleeding time is 2-7 minutes.

NEW QUESTION: 88

A husband and wife and their two children, age 9 and age 5, are requesting family therapy. Which of the following strategies is most therapeutic for the nurse to use during the initial interaction with a family?

- A. Always allow the most vocal person to state the problem first.
- B. Encourage the mother to speak for the children.
- C. Interpret immediately what seems to be going on within the family.
- D. Allow family members to assume the seats as they choose.

Answer: ([SHOW ANSWER](#))

Explanation

(A) One will always hear what the most vocal person has to say. It is best to start with the quietest family member to encourage that person to express emotions. (B) All family members are encouraged to speak for themselves. (C) In the initial family assessment, only data collection occurs; interpretations are made later. (D) Allowing family members to choose their own seats will assist the nurse in assessing the family system and in determining who feels closer to whom.

NEW QUESTION: 89

A client is being admitted to the labor and delivery unit. She has had previous admissions for "false labor." Which clinical manifestation would be most indicative of true labor?

- A. Increased bloody show
- B. Progressive dilatation and effacement of the cervix
- C. Uterine contractions
- D. Decreased discomfort with ambulation

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) Bloody show is considered a sign of imminent labor, which usually begins in 24-48 hours. An increase in bloody show is an indication that the cervix is changing. (B) Contractions of true labor produce progressive cervical effacement and dilatation. (C) Contractions of false labor may mimic those of true labor. However, the contractions of false labor do not produce progressive effacement and dilatation of the cervix. (D) In true labor, the discomfort is not relieved by ambulation; walking may intensify the discomfort.

NEW QUESTION: 90

A 19-year-old male client arrived via ambulance to the emergency room following a motorcycle accident. He is comatose. His face has evidence of dried blood. On assessment, the nurse notes an obvious injury to his left eye. The preferred positioning for a client with an obvious eye injury is:

- A. Any position in which the client is comfortable
- B. Reclining to control bleeding
- C. Side-lying, either left or right
- D. Sitting with head support

Answer: D ([LEAVE A REPLY](#))

NEW QUESTION: 91

One of the most dramatic and serious complications associated with bacterial meningitis is Waterhouse- Friderichsen syndrome, which is:

- A. Peripheral circulatory collapse
- B. Syndrome of inappropriate antidiuretic hormone
- C. Cerebral edema resulting in hydrocephalus
- D. Auditory nerve damage resulting in permanent hearing loss

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set A

Explanation/Reference:

Explanation:

(A) Waterhouse-Friderichsen syndrome is peripheral circulatory collapse, which may result in extensive and diffuse intravascular coagulation and thrombocytopenia resulting in death. (B) Syndrome of inappropriate antidiuretic hormone is a complication of meningitis, but it is not Waterhouse-Friderichsen syndrome. (C) Cerebral edema resulting in hydrocephalus is a complication of meningitis, but it is not Waterhouse- Friderichsen syndrome. (D) Auditory nerve damage resulting in permanent hearing loss is a complication of meningitis, but it is not Waterhouse-Friderichsen syndrome.

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NEW QUESTION: 92

A newborn infant is exhibiting signs of respiratory distress. Which of the following would the nurse recognize as the earliest clinical sign of respiratory distress?

- A. Cyanosis
- B. Increased respirations
- C. Sternal and subcostal retractions
- D. Decreased respirations

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Cyanosis is a late clinical sign of respiratory distress. (B) Rapid respirations are normal in a newborn.

(C) The newborn has to exert an extra effort for ventilation, which is accomplished by using the accessory muscles of ventilation. The diaphragm and abdominal muscles are immature and weak in the newborn. (D) Decreased respirations are a late clinical sign. In the newborn, decreased respirations precede respiratory failure.

NEW QUESTION: 93

A pregnant client is at the clinic for a third trimester prenatal visit. During this examination, it has been determined that her fetus is in a vertex presentation with the occiput located in her right anterior quadrant.

On her chart this would be noted as:

- A. Right occipitoposterior
- B. Right occipitoanterior
- C. Right sacroanterior
- D. LOA

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The fetus in the right occipitoposterior position would be presenting with the occiput in the maternal right posterior quadrant. (B) Fetal position is defined by the location of the fetal presenting part in the four quadrants of the maternal pelvis. The right occipitoanterior is a fetus presenting with the occiput in mother's right anterior quadrant. (C) The fetus in right sacroanterior position would be presenting a sacrum, not an occiput. (D) The fetus in left occipitoanterior position would be presenting with the occiput in the mother's left anterior quadrant.

NEW QUESTION: 94

The nurse is interviewing a client with a diagnosis of possible abdominal aortic aneurysm. Which of the following statements will be reflected in the client's chief complaint?

- A. "I've been having a dull pain at the upper left shoulder."
- B. "My legs have been numb for three months."
- C. "I've only been urinating three times a day lately."
- D. "I don't remember anything in particular, I just haven't felt well."

Answer: D ([LEAVE A REPLY](#))

Explanation

(A, B, C) These complaints are not specific signs and symptoms associated with abdominal aortic aneurysm. If symptoms are present, the aneurysm is expanding or rupture is imminent. (D) Many clients may experience no symptoms. The only symptom may be a pulsation noted in the abdomen in the reclining position.

NEW QUESTION: 95

A child with celiac disease is being discharged from the hospital. The mother demonstrates knowledge of nutritional needs of her child when she is able to state the foods which are included in a:

- A. Lactose-restricted diet
- B. Gluten-restricted diet
- C. Phenylalanine-restricted diet
- D. Fat-restricted diet

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) A lactose-restricted diet is prescribed for children with lactose intolerance or diarrhea. (B) A gluten-restricted diet is the diet for children with celiac disease. (C) A phenylalanine-restricted diet is prescribed for children with phenylketonuria. (D) A fat-restricted diet is prescribed for children with disorders of the liver, gallbladder, or pancreas.

NEW QUESTION: 96

A pregnant client experiences spontaneous rupture of membranes. The first nursing action is to:

- A. Assess the client's respirations
- B. Notify the physician
- C. Auscultate fetal heart rate
- D. Transfer to delivery suite

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Immediately following membrane rupture, the fetus is at risk for complications, not necessarily the mother. (B) The physician is notified after the nurse completes an assessment of the mother's and fetus's conditions. (C) Rupture of membranes facilitates fetal descent. A potential complication is cord prolapse, which is assessed by auscultating fetal heart rate. (D) Rupture of membranes does not necessarily indicate readiness to deliver.

NEW QUESTION: 97

The physician prescribes amitriptyline (Elavil) for a client. What does the patient need to know about this medication?

- A.** Prolonged use of this medication will result in extrapyramidal side effects.
- B.** When the medication is effective, he will experience no anxiety.
- C.** The medication should relieve his symptoms of depression.
- D.** Blood must be drawn weekly to test for toxicity.

Answer: [\(SHOW ANSWER\)](#)

(A) Phenothiazines cause extrapyramidal symptoms. (B) No amount of medication can relieve all anxiety in all cases. (C) The purpose of amitriptyline is to relieve the symptoms of depression because it is an antidepressant. It increases the action of norepinephrine and serotonin on nerve cells. (D) Periodic blood tests are done when lithium is prescribed.

NEW QUESTION: 98

A 16-year-old client with a diagnosis of oppositional defiant disorder is threatening violence toward another child. In managing a potentially violent client, the nurse:

- A.** Must use the least restrictive measure possible to control the behavior
- B.** Should put the client in seclusion until he promises to behave appropriately
- C.** Should apply full restraints until the behavior is under control
- D.** Should allow other clients to observe the acting out so that they can learn from the experience

Answer: **A** [\(LEAVE A REPLY\)](#)

(A) This answer is correct. Least restrictive measures should always be attempted before a client is placed in seclusion or restraints. The nurse should first try a calm verbal approach, suggest a quiet room, or request that the client take "time-out" before placing the client in seclusion, giving medication as necessary, or restraining. (B) This answer is incorrect. A calm verbal approach or requesting that a client go to his room should be attempted before restraining. (C) This answer is incorrect. Restraints should be applied only after all other measures fail to control the behavior. (D) This answer is incorrect. Other clients should be removed from the area. It is often very anxiety producing for other clients to see a peer out of control. It could also lead to mass acting-out behaviors.

NEW QUESTION: 99

The nurse who is caring for a client with pneumonia assesses that the client has become increasingly irritable and restless. The nurse realizes that this is a result of:

- A. Prolonged bed rest
- B. The client's maintaining a semi-Fowler position
- C. Cerebral hypoxia
- D. IV fluids of 2.5-3 liters in 24 hours

Answer: C ([LEAVE A REPLY](#))

Section: Questions Set D

Explanation:

(A) Maintaining bed rest helps to decrease the O₂ needs of the tissues, which decreases dyspnea and workload on the respiratory system. (B) The semi-Fowler or high-Fowler position is necessary to aid in lessening pressure on the diaphragm from the abdominal organs, which facilitates comfort and easier breathing patterns. (C) Cerebral hypoxia causes the client with pneumonia to be increasingly irritable and restless and results from the client not obtaining enough O₂ to meet metabolic needs. (D) Proper hydration facilitates liquefaction of mucus trapped in the bronchioles and alveoli and enhances expectoration. Unless contraindicated, a reasonable amount of IV fluids to be administered is at least 2.5-3 liters in a 24-hour period.

NEW QUESTION: 100

Which stage of labor lasts from delivery of the baby to delivery of the placenta?

- A. Second
- B. Third
- C. Fourth
- D. Fifth

Answer: ([SHOW ANSWER](#))

(A) This stage is from complete dilatation of the cervix to delivery of the fetus. (B) This is the correct stage for the definition. (C) This stage lasts for about 2 hours after the delivery of the placenta. (D) There is no fifth stage of labor.

NEW QUESTION: 101

The nurse is admitting a client with folic acid deficiency anemia. Which of the following questions is most important for the nurse to ask the client?

- A. "Do you take aspirin on a regular basis?"
- B. "Do you drink alcohol on a regular basis?"
- C. "Do you eat red meat?"
- D. "Have your stools been normal?"

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Aspirin does not affect folic acid absorption. (B) Folic acid deficiency is strongly associated with alcohol abuse. (C) Because folic acid is a coenzyme for single carbon transfer purines, calves liver or other purines are the meat sources. (D) Folic acid does not affect stool character.

NEW QUESTION: 102

The nurse documents a client's surgical incision as having red granulated tissue. This indicates that the wound is:

- A.** Infected
- B.** Not healing
- C.** Necrotic
- D.** Healing

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The wound is not infected. An infected wound would contain pus, debris, and exudate. (B) The wound is healing properly. (C) A necrotic wound would appear black or brown. (D) The wound is healing properly and is filled with red granulated tissue and fragile capillaries.

NEW QUESTION: 103

Medication is administered to a client who has been placed in restraints after a sudden violent episode, and his EPSs subside. Restraints can be removed when:

- A.** The physician orders it
- B.** A therapeutic alliance has been established, and violent behavior subsides
- C.** The violent behavior subsides, and the client agrees to behave
- D.** The nurse deems that removal of restraints is necessary

Answer: B (LEAVE A REPLY)

(A) The physician may order release of restraints, but prior to that, the client must meet criteria for release. (B) While the client is still restrained, but after violent behavior has subsided, a therapeutic bridge is built. This alliance encourages dialogue between nurse and client, allowing the client to determine causative factors, feelings prior to loss of control, and adaptive alternatives to violence. (C) If the client only "agrees to behave" after violent behavior subsides, he has developed no insight into cause and effect of violence or his response to stress. (D) Removal of restraints occurs only when the client meets the criteria for release, not just because the nurse says it is necessary.

NEW QUESTION: 104

In assisting preconceptual clients, the nurse should teach that the corpus luteum secretes progesterone, which thickens the endometrial lining in which of the phases of the menstrual cycle?

- A.** Menstrual phase

- B. Proliferative phase
- C. Secretory phase
- D. Ischemic phase

Answer: ([SHOW ANSWER](#))

Section: Questions Set B

Explanation

Explanation:

(A) Menses occurs during the menstrual phase, during which levels of both estrogen and progesterone are decreased. (B) The ovarian hormone responsible for the proliferative phase, during which the uterine endometrium enlarges, is estrogen. (C) The ovarian hormone responsible for the secretory phase is progesterone, which is secreted by the corpus luteum and causes marked swelling in the uterine endometrium. (D) The corpus luteum begins to degenerate in the ischemic phase, causing a fall in both estrogen and progesterone.

NEW QUESTION: 105

An 8-year-old child comes to the physician's office complaining of swelling and pain in the knees. His mother says, "The swelling occurred for no reason, and it keeps getting worse." The initial diagnosis is Lyme disease.

When talking to the mother and child, questions related to which of the following would be important to include in the initial history?

- A. A decreased urinary output and flank pain
- B. A fever of over 103F occurring over the last 2-3 weeks
- C. Rashes covering the palms of the hands and the soles of the feet
- D. Headaches, malaise, or sore throat

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) Urinary tract symptoms are not commonly associated with Lyme disease. (B) A fever of 103F is not characteristic of Lyme disease. (C) The rash that is associated with Lyme disease does not appear on the palms of the hands and the soles of the feet. (D) Classic symptoms of Lyme disease include headache, malaise, fatigue, anorexia, stiff neck, generalized lymphadenopathy, splenomegaly, conjunctivitis, sore throat, abdominal pain, and cough.

NEW QUESTION: 106

A client is taught to eat foods high in potassium. Which food choices would indicate that this teaching has been successful?

- A. Pork chop, baked acorn squash, brussel sprouts
- B. Chicken breast, rice, and green beans
- C. Roast beef, baked potato, and diced carrots
- D. Tuna casserole, noodles, and spinach

Answer: A (LEAVE A REPLY)

Explanation

(A) Both acorn squash and brussels sprouts are potassium-rich foods. (B) None of these foods is considered potassium rich. (C) Only the baked potato is a potassium-rich food. (D) Spinach is the only potassium-rich food in this option.

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NEW QUESTION: 107

The nurse discovers that a 78-year-old client who received hydralazine (Apresoline) 20 mg 45 minutes ago has a blood pressure of 70/40 mm Hg. The client has been on this dose of the medication for 3 years. Which of the following data is most likely significant in relation to the cause of the low blood pressure?

- A. Pedal pulses 11 (weak)
- B. Twenty-four-hour intake 1000 mL/day for past 2 days
- C. Serum potassium 3.3
- D. Pulse rate 150 bpm

Answer: B (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A, D) Decreased pulse volume and increased pulse rate are signs of an acute hypotensive episode. (B) Inadequate fluid volume when taking vasodilators can result in a drop in blood pressure when vasodilation starts to physiologically occur as an action of the drug. (C) A potassium level of 3.3 would not be associated with a significant drop in blood pressure.

NEW QUESTION: 108

A 45-year-old male client was admitted to a chemical dependency treatment center following legal problems related to alcohol abuse. He states, "I know that alcohol is a problem for some people, but I can stop whenever I want to. I'm never sick or miss work, and no one can complain about me." During the initial assessment, the best response by the nurse would be:

- A. "The fact is you are an alcoholic or you wouldn't be here."

B. "I understand it took strength to admit yourself to the unit, and I will do my part to help you to stay alcohol- free."

C. "If you can stop drinking when you want to, why don't you stop?"

D. "It's good that you can stop drinking when you want to."

Answer: ([SHOW ANSWER](#))

(A) Direct confrontation initially is nontherapeutic and may result in the client becoming frustrated and wanting to leave. (B) A positive, supportive attitude builds trust, and identifying positive strength raises self-esteem. Offering help allows the client to feel that he is not alone in dealing with problems. (C) Asking the client why or to give an explanation for his behavior puts him in a position of having to justify his behavior to the nurse. (D) Giving approval or placing a value on feelings or a behavior may limit the client's freedom to behave in a way that may displease another. This response may lead to seeking praise instead of progress.

NEW QUESTION: 109

The primary reason that an increase in heart rate (100 bpm) detrimental to the client with a myocardial infarction (MI) is that:

A. Stroke volume and blood pressure will drop proportionately

B. Systolic ejection time will decrease, thereby decreasing cardiac output

C. Decreased contractile strength will occur due to decreased filling time

D. Decreased coronary artery perfusion due to decreased diastolic filling time will occur, which will increase ischemic damage to the myocardium

Answer: **D** ([LEAVE A REPLY](#))

Explanation

(A) Decreased stroke volume and blood pressure will occur secondary to decreased diastolic filling. (B) Tachycardia primarily decreases diastole; systolic time changes very little. (C) Contractility decreases owing to the decreased filling time and decreased time for fiber lengthening. (D) Decreased O₂ supply due to decreased time for filling of the coronary arteries increases ischemia and infarct size. Tachycardia primarily robs the heart of diastolic time, which is the primary time for coronary artery filling.

NEW QUESTION: 110

Following a gastric resection, which of the following actions would the nurse reinforce with the client in order to alleviate the distress from dumping syndrome?

A. Eating three large meals a day

B. Drinking small amounts of liquids with meals

C. Taking a long walk after meals

D. Eating a low-carbohydrate diet

Answer: ([SHOW ANSWER](#))

Section: Questions Set B

Explanation:

(A) Six small meals are recommended. (B) Liquids after meals increase the time food empties from the stomach. (C) Lying down after meals is recommended to prevent gravity from producing dumping. (D) A low- carbohydrate diet will prevent a hypertonic bolus, which causes dumping.

NEW QUESTION: 111

A client returns for her 6-month prenatal checkup and has gained 10 lb in 2 months. The results of her physical examination are normal. How does the nurse interpret the effectiveness of the instruction about diet and weight control?

- A.** She is compliant with her diet as previously taught.
- B.** She needs further instruction and reinforcement.
- C.** She needs to increase her caloric intake.
- D.** She needs to be placed on a restrictive diet immediately.

Answer: B (LEAVE A REPLY)

(A) She is probably not compliant with her diet and exercise program. Recommended weight gain during second and third trimesters is approximately 12 lb. (B) Because of her excessive weight gain of 10 lb in 2 months, she needs re-evaluation of her eating habits and reinforcement of proper dietary habits for pregnancy. A 2200-calorie diet is recommended for most pregnant women with a weight gain of 27-30 lb over the 9-month period. With rapid and excessive weightgain, PIH should also be suspected. (C) She does not need to increase her caloric intake, but she does need to re-evaluate dietary habits. Ten pounds in 2 months is excessive weight gain during pregnancy, and health teaching is warranted. (D) Restrictive dieting is not recommended during pregnancy.

NEW QUESTION: 112

To prevent fungal infections of the mouth and throat, the nurse should teach clients on inhaled steroids to:

- A.** Rinse the plastic holder that aerosolizes the drug with hydrogen peroxide every other day
- B.** Rinse the mouth and gargle with warm water after each use of the inhaler
- C.** Take antacids immediately before inhalation to neutralize mucous membranes and prevent infection
- D.** Rinse the mouth before each use to eliminate colonization of bacteria

Answer: B (LEAVE A REPLY)

Explanation

(A) It is sufficient to rinse the plastic holders with warm water at least once per day. (B) It is important to rinse the mouth after each use to minimize the risk of fungal infections by reducing the droplets of the glucocorticoid left in the oral cavity. (C) Antacids act by neutralizing or reducing gastric acid, thus decreasing the pH of the stomach. "Neutralizing" the oral mucosa prior to inhalation of a steroid inhaler does not minimize the risk of fungal

infections. (D) Rinsing prior to the use of the glucocorticoid will not eliminate the droplets left on the oral mucous membranes following the use of the inhaler.

NEW QUESTION: 113

A 68-year-old man was recently diagnosed with endstage renal disease. He has not yet begun dialysis but is experiencing severe anemia with associated symptoms of dyspnea on exertion and chest pain. Which statement best describes the management of anemia in renal failure?

- A.** Hematocrit levels usually remain slightly below normal in clients with renal failure.
- B.** Transfusion is often begun as early as possible to prevent complications of anemia such as dyspnea and angina.
- C.** Anemia in renal failure is frequently caused by low serum iron and ferritin and corrected by oral iron and ferritin replacement therapy.
- D.** The renal secretion of erythropoiesis is decreased. The bone marrow requires erythropoietin to mature red blood cells.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Clients in renal failure typically have very low hematocrits, often in the range of 16-22%. (B) Transfusion is avoided unless the client exhibits acute symptoms such as dyspnea, chest pain, tachycardia, and extreme fatigue. When the client is given a transfusion, the bone marrow adjusts by producing less red blood cells. (C) Anemia in renal failure is caused primarily by decreased erythropoietin.

Low serum iron and ferritin may aggravate the anemia and require treatment. (D) Decreased secretion of erythropoietin by the kidney is the primary cause of anemia. The bone marrow requires this hormone to mature red blood cells. Treatment is with replacement therapy.

NEW QUESTION: 114

A female client at 37 weeks' gestation has just undergone a nonstress test. The results were two fetal movements with a corresponding increase in fetal heart rate (FHR) of 15 bpm lasting 15 seconds within a 20-minute period. Her results would be classified as:

- A.** Reactive; needs follow-up contraction stress test
- B.** Reactive; no contraction stress test required
- C.** Non-reactive; needs follow-up contraction stress test
- D.** Non-reactive; no contraction stress test required

Answer: **B** ([LEAVE A REPLY](#))

(A)

A contraction stress test is unnecessary following a reactive (normal) nonstress test. (B) The results are considered reactive, indicating that the fetus is not showing distress. Therefore, a contraction stress test, which is a more in-depth test for fetal distress, is

unnecessary. (C) A nonreactive test would show fewer than two fetal movements or a failure of the FHR to increase at least 15 bpm with the movements in a 20-minute period.

(D)

A contraction stress test should follow a nonreactive nonstress test to validate fetal distress.

NEW QUESTION: 115

A 5-year-old has just had a tonsillectomy and adenoidectomy. Which of these nursing measures should be included in the postoperative care?

- A.** Encourage the child to cough up blood if present.
- B.** Give warm clear liquids when fully alert.
- C.** Have child gargle and do toothbrushing to remove old blood.
- D.** Observe for evidence of bleeding.

Answer: D (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) The nurse should discourage the child from coughing, clearing the throat, or putting objects in his mouth.

These may induce bleeding. (B) Cool, clear liquids may be given when child is fully alert.

Warm liquids may dislodge a blood clot. The nurse should avoid red- or brown-colored liquids to distinguish fresh or old blood from ingested liquid should the child vomit. (C)

Gargles and vigorous toothbrushing could initiate bleeding. (D) Postoperative hemorrhage, though unusual, may occur. The nurse should observe for bleeding by looking directly into the throat and for vomiting of bright red blood, continuous swallowing, and changes in vital signs.

NEW QUESTION: 116

During the active phase of rheumatic fever, the nurse teaches parents of a child with acute rheumatic fever to assist in minimizing joint pain and promoting healing by:

- A.** Putting all joints through full range-of-motion twice daily
- B.** Massaging the joints briskly with lotion or liniment after bath
- C.** Immobilizing the joints in functional position using splints, rolls, and pillows
- D.** Applying warm water bottle or heating pads over involved joints

Answer: C (LEAVE A REPLY)

Explanation

(A) Any movement of the joint causes severe pain. (B) Touching or moving the joint causes severe pain. (C) Immobilization in a functional position allows the joint to rest and heal. (D)

Pressure from the warm water bottle or pads can cause severe pain or burning of the skin.

NEW QUESTION: 117

In planning daily care for a client with multiple sclerosis, the nurse would take into consideration that multiple sclerosis:

- A. Becomes progressively debilitating without remission
- B. Has unpredictable remissions and exacerbations
- C. Is rapidly fatal
- D. Responds quickly to antimicrobial therapy

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation:

(A) Multiple sclerosis eventually becomes debilitating, but it is characterized by remission of symptoms. (B) Remissions and exacerbations are unpredictable with multiple sclerosis. The client experiences progressive dysfunction after each exacerbation episode. (C) Multiple sclerosis is usually slowly progressive. (D) Multiple sclerosis is an autoimmune disease. Antimicrobial therapy has no effect on its course.

NEW QUESTION: 118

A 19-year-old male client arrived via ambulance to the emergency room following a motorcycle accident. He is comatose. His face has evidence of dried blood. On assessment, the nurse notes an obvious injury to his left eye. The preferred positioning for a client with an obvious eye injury is:

- A. Reclining to control bleeding
- B. Any position in which the client is comfortable
- C. Side-lying, either left or right
- D. Sitting with head support

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) A reclining position can cause a penetrating object to advance further into the eye. (B) Prevention of further injury is the priority, not comfort. (C) A side-lying position may increase intraocular and intracranial pressure if an accompanying head injury is suspected. (D) A sitting position with the head supported will prevent further injury while allowing injury care to take place.

NEW QUESTION: 119

A client has been taking lithium 300 mg po bid for the past two weeks. This morning her lithium level was 1 mEq/L. The nurse should:

- A. Notify the physician immediately
- B. Hold the morning lithium dose and continue to observe the client
- C. Administer the morning lithium dose as scheduled
- D. Obtain an order for benztropine (Cogentin)

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) There is no need to phone the physician because the lithium level is within therapeutic range and because there are no indications of toxicity present. (B) There is no reason to withhold the lithium because the blood level is within therapeutic range. Also, it is necessary to give the medication as scheduled to maintain adequate blood levels. (C) The lab results indicate that the client's lithium level is within therapeutic range (0.2-1.4 mEq/L), so the medication should be given as ordered. (D) Benztropine is an antiparkinsonism drug frequently given to counteract extrapyramidal symptoms associated with the administration of antipsychotic drugs (not lithium).

NEW QUESTION: 120

Decreased pulmonary blood flow, right-to-left shunting, and deoxygenated blood reaching the systemic circulation are characteristic of:

- A. Tetralogy of Fallot
- B. Ventricular septal defect
- C. Patent ductus arteriosus
- D. Transposition of the great arteries

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Tetralogy of Fallot is the most common cyanotic heart defect, which includes a VSD, pulmonary stenosis, an overriding aorta, and ventricular hypertrophy. The blood flow is obstructed because the pulmonary stenosis decreases the pulmonary blood flow and shunts blood through the VSD, creating a right-to-left shunt that allows deoxygenated blood to reach the systemic circulation. (B) A VSD alone creates a left-to-right shunt. The pressure in the left ventricle is greater than that of the right; therefore, the blood will shunt from the left ventricle to the right ventricle, increasing the blood flow to the lungs. No deoxygenated blood will reach the systemic circulation. (C) In patent ductus arteriosus, the pressure in the aorta is greater than in the pulmonary artery, creating a left-to-right shunt. Oxygenated blood from the aorta flows into the unoxygenated blood of the pulmonary artery. (D) Transposition of the great arteries results in two separate and parallel circulatory systems. The only mixing or shunting of blood is based on the presence of associated lesions.

NEW QUESTION: 121

A psychotic client who believes that he is God and rules all the universe is experiencing which type of delusion?

- A. Somatic
- B. Grandiose
- C. Persecutory
- D. Nihilistic

Answer: B (LEAVE A REPLY)

Section: Questions Set A

Explanation:

(A) These delusions are related to the belief that an individual has an incurable illness. (B) These delusions are related to feelings of self-importance and uniqueness. (C) These delusions are related to feelings of being conspired against. (D) These delusions are related to denial of self-existence.

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NEW QUESTION: 122

A client with severe PIH receiving MgSO₄ is placed in a quiet, darkened room. The nurse bases this action on the following understanding:

- A.** The client is restless.
- B.** The elevated blood pressure causes photophobia.
- C.** Noise or bright lights may precipitate a convulsion.
- D.** External stimuli are annoying to the client with PIH.

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The client may be anxious and hyperresponsive to stimuli but not necessarily restless. (B) This is not a physiological response to an elevated blood pressure in PIH. (C) The nurse must know the nursing measures that decrease the potential for convulsions. A quiet, darkened room decreases stimuli and promotes rest. (D) External stimuli might induce a convulsion but are not annoying to the client with PIH.

NEW QUESTION: 123

A client is resting comfortably after delivering her first child. When assessing her pulse rate, the nurse would recognize the following finding to be typical:

- A.** Thready pulse
- B.** Irregular pulse
- C.** Tachycardia
- D.** Bradycardia

Answer: (SHOW ANSWER)

Explanation

(A) A thready pulse is indicative of hypotension and excessive blood loss and is often rapid. (B) Pulse irregularities or dysrhythmias do not occur in the normal postpartal woman. (C) Tachycardia occurs less frequently than bradycardia and is related to increased blood loss or prolonged difficult labor and/or birth. (D) Puerperal bradycardia with rates of 50-70 bpm commonly occurs during the first 6-10 days of the postpartal period. It may be related to decreased cardiac strain, decreased blood volume, contraction of the uterus, and increased stroke volume.

NEW QUESTION: 124

A client presents to the psychiatric unit crying hysterically. She is diagnosed with severe anxiety disorder. The first nursing action is to:

- A. Demand that she relax
- B. Ask what is the problem
- C. Stand or sit next to her
- D. Give her something to do

Answer: ([SHOW ANSWER](#))

(A) This nursing action is too controlling and authoritative. It could increase the client's anxiety level. (B) In her anxiety state, the client cannot rationally identify a problem. (C) This nursing action conveys a message of caring and security. (D) Giving the client a task would increase her anxiety. This would be a late nursing action.

NEW QUESTION: 125

The nurse would be sure to instruct a client on the signs and symptoms of an eye infection and hemorrhage. These signs and symptoms would include:

- A. Blurred vision and dizziness
- B. Eye pain and itching
- C. Feeling of eye pressure and headache
- D. Eye discharge and hemoptysis

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Although blurred vision may occur, dizziness would not be associated with an infection or hemorrhage.

(B) Eye pain is a symptom of hemorrhage within the eye, and itching is associated with infection. (C) Nausea and headache would not be usual symptoms of eye hemorrhage or infection. (D) Some eye discharge might be anticipated if an infection is present; hemoptysis would not.

NEW QUESTION: 126

A 16-month-old infant is being prepared for tetralogy of Fallot repair. In the nursing assessment, which lab value should elicit further assessment and requires notification of physician?

- A. pH 7.39
- B. White blood cell (WBC) count 10,000 WBCs/mm³
- C. Hematocrit 60%
- D. Bleeding time of 4 minutes

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) Normal pH of arterial blood gases for an infant is 7.35-7.45. (B) Normal white blood cell count in an infant is 6,000-17,500 WBCs/mm³. (C) Normal hematocrit in infant is 28%-42%. A 60% hematocrit may indicate polycythemia, a common complication of cyanotic heart disease. (D) Normal bleeding time is 2-7 minutes.

NEW QUESTION: 127

On assessment, the nurse learns that a chronic paranoid schizophrenic has been taking "the blue pill" (haloperidol) in the morning and evening, and "the white pill" (benztropine) right before bedtime. The nurse might suggest to the client that she try:

- A. Doubling the daily dose of benztropine
- B. Decreasing the haloperidol dosage for a few days
- C. Taking the benztropine in the morning
- D. Taking her medication with food or milk

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Suggesting that a client increase a medication dosage is an inappropriate (and illegal) nursing action.

This action requires a physician's order. (B) To suggest that a client decrease a medication dosage is an inappropriate (and illegal) nursing action. This action requires a physician's order. (C) This response is an appropriate independent nursing action. Because motorrestlessness can also be a side effect of cogentin, the nurse may suggest that the client try taking the drug early in the day rather than at bedtime. (D) Certain medications can cause gastric irritation and may be taken with food or milk to prevent this side effect.

NEW QUESTION: 128

A primipara is assessed on arrival to the postpartum unit. The nurse finds her uterus to be boggy. The nurse's first action should be to:

- A. Call the physician
- B. Assess her vital signs
- C. Give the prescribed oxytocic drug
- D. Massage her fundus

Answer: (SHOW ANSWER)

Section: Questions Set E

Explanation:

(A) The nurse should first implement independent and dependent measures to achieve uterine tone before calling the physician. (B) Assessment of vital signs will not help to restore uterine atony, which is the priority need. (C) Giving a prescribed oxytocic drug would be necessary if the uterus did not maintain tone with massage. (D) Fundal massage generally restores uterine tone within a few moments and should be attempted first.

NEW QUESTION: 129

The physician prescribes a medical regimen of isoniazid, rifampin, and vitamin B6 for a tuberculosis client.

The nurse instructs the client that B6 is given because it:

- A. Increases activity of isoniazid
- B. Increases activity of rifampin
- C. Improves nutritional status
- D. Reduces peripheral neuropathy

Answer: D (LEAVE A REPLY)

Explanation

(A) Vitamin B6 does not enhance the activity of isoniazid. (B) Vitamin B6 does not enhance the activity of rifampin. (C) A vitamin alone does not improve nutritional status. (D) Isoniazid leads to Vitamin B6 deficiency, which is manifested as peripheral neuropathy.

NEW QUESTION: 130

A diagnosis of hepatitis C is confirmed by a male client's physician. The nurse should be knowledgeable of the differences between hepatitis A, B, and C.

Which of the following are characteristics of hepatitis C?

- A. The potential for chronic liver disease is minimal.
- B. The onset of symptoms is abrupt.
- C. The incubation period is 2-26 weeks.
- D. There is an effective vaccine for hepatitis B, but not for hepatitis C.

Answer: C (LEAVE A REPLY)

Explanation

(A) Hepatitis C and B may result in chronic liver disease. Hepatitis A has a low potential for chronic liver disease. (B) Hepatitis C and B have insidious onsets. Hepatitis A has an abrupt onset. (C) Incubation periods are as follows: hepatitis C is 2-26 weeks, hepatitis B is 6-20 weeks, and hepatitis A is 2-6 weeks. (D) Only hepatitis B has an effective vaccine.

NEW QUESTION: 131

During the active phase of rheumatic fever, the nurse teaches parents of a child with acute rheumatic fever to assist in minimizing joint pain and promoting healing by:

- A. Putting all joints through full range-of-motion twice daily
- B. Massaging the joints briskly with lotion or liniment after bath
- C. Immobilizing the joints in functional position using splints, rolls, and pillows
- D. Applying warm water bottle or heating pads over involved joints

Answer: C ([LEAVE A REPLY](#))

(A) Any movement of the joint causes severe pain. (B) Touching or moving the joint causes severe pain. (C) Immobilization in a functional position allows the joint to rest and heal. (D) Pressure from the warm water bottle or pads can cause severe pain or burning of the skin.

NEW QUESTION: 132

A client delivered a stillborn male at term. An appropriate action of the nurse would be to:

- A. State, "You have an angel in heaven."
- B. Discourage the parents from seeing the baby.
- C. Provide an opportunity for the parents to see and hold the baby for an undetermined amount of time.
- D. Reassure the parents that they can have other children.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) This is not a supportive statement. There are also no data to indicate the family's religious beliefs. (B) Seeing their baby assists the parents in the grieving process. This gives them the opportunity to say "good- bye." (C) Parents need time to get to know their baby. (D) This is not a comforting statement when a baby has died. There are also no guarantees that the couple will be able to have another child.

NEW QUESTION: 133

A client is having a pneumonectomy done today, and the nurse is planning her postoperative care. Nursing interventions for a postoperative left pneumonectomy would include:

- A. Monitoring the chest tubes
- B. Positioning the client on the right side
- C. Positioning the client in semi-Fowler position with a pillow under the shoulder and back
- D. Monitoring the right lung for an increase in rales

Answer: ([SHOW ANSWER](#))

Explanation

(A) Chest tubes are usually not necessary in a pneumonectomy because there is no lung to re-expand on the operative side. (B) The pneumonectomy client should be positioned on the back or operated side because the sutured bronchial stump may open, allowing fluid to drain into the unoperated side and drown the client. (C) The client should not have a pillow under the shoulder and back because of the subscapular incision. (D) Rales are commonly

heard over the base of the remaining lung, but an increase could indicate circulatory overload and therefore should be closely monitored.

NEW QUESTION: 134

A client is a victim of domestic violence. She is now receiving assistance at a shelter for battered women. She tells the nurse about the cycle of violence that she has been experiencing in her relationship with her husband of 5 years. In the "tension-building phase," the nurse might expect the client to describe which of the following?

- A. Promises of gifts that her husband made to her
- B. Acute battering of the client, characterized by his volatile discharge of tension
- C. Minor battering incidents, such as the throwing of food or dishes at her
- D. A period of tenderness between the couple

Answer: (SHOW ANSWER)

(A) This description is characteristic of the "honeymoon" or "respite" phase. (B) This description is characteristic of the "battering" phase. (C) This description is characteristic of the "tension- building" phase prior to the volatile discharge of tension found in the battering phase. (D) This description is characteristic of the "honeymoon" or "respite" phase.

NEW QUESTION: 135

In planning daily care for a client with multiple sclerosis, the nurse would take into consideration that multiple sclerosis:

- A. Becomes progressively debilitating without remission
- B. Has unpredictable remissions and exacerbations
- C. Is rapidly fatal
- D. Responds quickly to antimicrobial therapy

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Multiple sclerosis eventually becomes debilitating, but it is characterized by remission of symptoms. (B) Remissions and exacerbations are unpredictable with multiple sclerosis. The client experiences progressive dysfunction after each exacerbation episode. (C) Multiple sclerosis is usually slowly progressive. (D) Multiple sclerosis is an autoimmune disease. Antimicrobial therapy has no effect on its course.

NEW QUESTION: 136

Seven days ago, a 45-year-old female client had an ileostomy. She is self-sufficient and well otherwise.

Which of the following long-term objectives would be unrealistic?

- A. She should be able to control evacuation of her bowels.
- B. She should be able to return to a regular diet.
- C. She should be able to resume sexual activity.

D. She should be able to manage her own care.

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Because of the location of an ileostomy, the client will not be able to control the evacuation of her bowels. The ileostomy will drain liquid stool continuously. (B) The client should be able to return to a normal, well-balanced diet. She should avoid foods that cause diarrhea or excessive gas production, and she should eat small meals. (C) The client should be able to resume sexual activity. She will be able to wear a pouch. (D) The client has no other health or mental problems and should be able to manage her own ileostomy.

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NEW QUESTION: 137

A 56-year-old psychiatric inpatient has had recurring episodes of depression and chronic low self-esteem. She feels that her family does not want her around, experiences a sense of helplessness, and has a negative view of herself. To assist the client in focusing on her strengths and positive traits, a strategy used by the nurse would be to:

- A. Tell the client to attend all structured activities on the unit
- B. Encourage or direct client to attend activities that offer simple methods to attain success
- C. Increase the client's self-esteem by asking that she make all decisions regarding attendance in group activities
- D. Not allow any dependent behaviors by the client because she must learn independence and will have to ask for any assistance from staff

Answer: B (LEAVE A REPLY)

Explanation

(A) The nurse should encourage activities gradually, as client's energy level and tolerance for shared activities improve. (B) Activities that focus on strengths and accomplishments, with uncomplicated tasks, minimize failure and increase self-worth. (C) Asking a client to set a goal to make all decisions about attending group activities is unrealistic, and such decisions are not always under the client's control; this sets up the client for further failure and possibly decreased self-worth. (D) Encouragement toward independence does promote increased feelings of selfworth; however, clients may need assistance with decision making and problem solving for various situations and on an individual basis.

NEW QUESTION: 138

Nursing care of the infant prior to surgical closure of a meningomyelocele would include:

- A. Cover sac with dry sterile dressing
- B. Cover sac with saline-soaked sterile dressing
- C. Do not apply dressing; keep sac open to air
- D. Aspirate any fluid from sac

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) A dry, sterile dressing would adhere to the sac, causing tissue damage. (B) A saline-soaked sterile dressing protects the sac from contamination by air and prevents drying. (C) A sac open to air causes drying and potential for contamination. (D) This intervention is not an independent nursing action.

NEW QUESTION: 139

The predominant purpose of the first Apgar scoring of a newborn is to:

- A. Determine gross abnormal motor function
- B. Obtain a baseline for comparison with the infant's future adaptation to the environment
- C. Evaluate the infant's vital functions
- D. Determine the extent of congenital malformations

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Apgar scores are not related to the infant's care, but to the infant's physical condition. (B) Apgar scores assess the current physical condition of the infant and are not related to future environmental adaptation. (C) The purpose of the Apgar system is to evaluate the physical condition of the newborn at birth and to determine if there is an immediate need for resuscitation. (D) Congenital malformations are not one of the areas assessed with Apgar scores.

NEW QUESTION: 140

A client has been uncomfortable in crowds all her life. After the birth of her child, she has been housebound unless her husband can accompany her to the grocery store and for medical appointments. His schedule will not allow for this, and he has insisted that she must be more independent. Her anxiety has increased to the point of panic. The client has been diagnosed with agoraphobia. Which statement is true about this disorder?

- A. The behavior is not considered disabling.
- B. More men suffer from agoraphobia than women.
- C. The fears are persistent, and avoidance is used as the coping mechanism.
- D. Agoraphobia moves into remission when treated with chlorpromazine.

Answer: C (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) Agoraphobia is the most pervasive and serious phobic disorder. (B) Women compose 70%-85% of agoraphobia sufferers. (C) Agoraphobia is an acute disorder that immobilizes the sufferer with extreme anxiety.

(D) Chlorpromazine is not a drug used to treat phobias.

NEW QUESTION: 141

A 5-year-old child was recently diagnosed as having acute lymphoid leukemia. She is hospitalized for additional tests and to begin a course of chemotherapy designed to induce a remission. She is scheduled to have a bone marrow aspiration tomorrow. She has had a bone marrow test previously and is apprehensive about having another. Which of the following interventions will be most effective in relieving her anxiety?

A. Explain what will take place and what she will see, feel, and hear.

B. Remind her that she has had this procedure before and that it is nothing to be afraid of.

C. Tell her not to worry about it, that it will be over soon and she can join her friends in the playroom.

D. Give her a big hug and tell her that she is a big girl now and that she will do just fine.

Answer: A (LEAVE A REPLY)

Section: Questions Set D

Explanation

Explanation:

(A) Even though the child has had the procedure before, she will probably need additional explanations and emotional support. (B) The fact that the child has had the procedure before and possibly found it painful or uncomfortable may increase, not relieve, her stress. (C) This intervention does nothing to reassure the child and may well prevent her from expressing her feelings. (D) This does not prepare the child for the test and burdens her with the expectation that she act bigger and braver than she is.

NEW QUESTION: 142

Proper positioning for the child who is in Bryant's traction is:

A. Both hips flexed at a 90-degree angle with the knees extended and the buttocks elevated off the bed

B. Both legs extended, and the hips are not flexed

C. The affected leg extended with slight hip flexion

D. Both hips and knees maintained at a 90-degree flexion angle, and the back flat on the bed

Answer: A (LEAVE A REPLY)

(A) The child's weight supplies the countertraction for Bryant's traction; the buttocks are slightly elevated off the bed, and the hips are flexed at a 90-degree angle. Both legs are

suspended by skin traction. (B) The child in Buck's extension traction maintains the legs extended and parallel to the bed. (C) The child in Russell traction maintains hip flexion of the affected leg at the prescribed angle with the leg extended. (D) The child in "90-90" traction maintains both hips and knees at a 90-degree flexion angle and the back is flat on the bed.

NEW QUESTION: 143

In healthcare settings, nurses must be familiar with primary, secondary, and tertiary levels of care. As a nurse in the community, which of the following interventions might be a primary prevention strategy?

- A.** Crisis intervention with an intoxicated teenager whose mother just committed suicide
- B.** Referring a client who has been on a detoxification unit to a rehabilitation center
- C.** Teaching fifth-grade children the harmful effects of substance abuse
- D.** Counseling a client with post-traumatic stress disorder

Answer: C (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) The teenager is already coping ineffectively and requires early detection and treatment, which is secondary prevention. (B) The client must be sent to a rehabilitation unit, which requires tertiary prevention. (C) Reducing the incidence of disease through education supports primary prevention. (D) A client with identified symptoms of post-traumatic stress disorder requires intervention by treatment.

NEW QUESTION: 144

A mother frantically calls the emergency room (ER) asking what to do about her 3-year-old girl who was found eating pills out of a bottle in the medicine cabinet. The ER nurse tells the mother to:

- A.** Give the child 15 mL of syrup of ipecac.
- B.** Give the child 10 mL of syrup of ipecac with a sip of water.
- C.** Give the child 1 cup of water to induce vomiting.
- D.** Bring the child to the ER immediately.

Answer: D (LEAVE A REPLY)

Explanation

(A) Before giving any emetic, the substance ingested must be known. (B) At least 8 oz of water should be administered along with ipecac syrup to increase volume in the stomach and facilitate vomiting. (C) Water alone will not induce vomiting. An emetic is necessary to facilitate vomiting. (D) Vomiting should never be induced in an unconscious client because of the risk of aspiration.

NEW QUESTION: 145

Which of the following nursing orders should be included in the plan of care for a client with hepatitis C?

- A.** The nurse should use universal precautions when obtaining blood samples.
- B.** Total bed rest should be maintained until the client is asymptomatic.
- C.** The client should be instructed to maintain a low semi-Fowler position when eating meals.
- D.** The nurse should administer an alcohol backrub at bedtime.

Answer: A (LEAVE A REPLY)

Explanation

(A) The source of infection with hepatitis C is contaminated blood products. (B) Modified bed rest should be maintained while the client is symptomatic. Routine activities can be slowly resumed once the client is asymptomatic. (C) Nausea and vomiting occur frequently with hepatitis C. A high Fowler position may decrease the tendency to vomit. (D) The buildup of bilirubin in the client's skin may cause pruritus. Alcohol is a drying agent.

NEW QUESTION: 146

After the RN is finished the initial assessment of a newborn baby and after the initial bonding between the newborn and the mother has taken place in the delivery room, the RN will bring the newborn to the well-baby nursery. Before the newborn is taken from the delivery room and brought to the well-baby nursery, the RN makes sure that which of the following interventions was completed?

- A.** The physician verifies the exact time of birth.
- B.** The nurse counts the instruments and sponges with the scrub nurse.
- C.** The nurse instills prophylactic ointment in the conjunctival sacs of the newborn's eyes.
- D.** The nurse makes sure the mother and her newborn have been tagged with identical bands.

Answer: D (LEAVE A REPLY)

(A) The delivery room personnel are responsible for verifying time of birth. (B) The scrub and circulating nurses count sponges and instruments. (C) This intervention is done in the nursery. (D) Tagging the mother and infant with identical bands is of utmost importance. The mother wears one band, and the newborn wears two. Identical numbers on the three bands provide identification for the newborn and the birth mother. Every time the newborn is brought to the mother after delivery, those bands are checked to be sure that the numbers are identical.

NEW QUESTION: 147

A 48-hour-old male infant is ordered to have phototherapy. When his mother questions the nurse about its purpose, the nurse explains that phototherapy:

- A.** Prevents the development of ophthalmia neonatorum
- B.** Assists the baby's clotting mechanism
- C.** Breaks down bilirubin in the skin into substances that can be excreted in stool or urine

D. Increases levels of unconjugated bilirubin, thereby preventing kernicterus (brain damage)

Answer: C ([LEAVE A REPLY](#))

(A) The instillation of erythromycin ophthalmic preparation, not phototherapy, prevents ophthalmia neonatorum. (B) The administration of vitamin K (AquaMEPHYTON) assists the infant's clotting mechanism. (C) Excessive bilirubin accumulates when the infant's liver cannot handle the increased load caused by the breakdown of red blood cells postnatally. This excessive bilirubin seeps out of the blood and into the tissues, staining them yellow. Phototherapy accelerates the removal of bilirubin from the skin by breaking it down into substances that can be excreted in stool or urine. (D) Phototherapy decreases levels of unconjugated bilirubin, thereby preventing kernicterus.

NEW QUESTION: 148

The physician is preparing to induce labor on a 40-week multigravida. The nurse should anticipate the administration of:

- A.** Oxytocin (Pitocin)
- B.** Progesterone
- C.** Vasopressin (Pitressin)
- D.** Ergonovine maleate

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Oxytocin is a hormone secreted by the neurohypophysis during suckling and parturition that produces strong uterine contractions. (B) Progesterone has a quiescence effect on the uterus. (C) Vasopressin is an antidiuretic hormone that promotes water reabsorption by the renal tubules. (D) Ergonovine produces dystocia as a result of sustained uterine contractions.

NEW QUESTION: 149

Parents of a child with rheumatic fever express concern that she will always be arthritic. The nurse discusses their concerns and tells them the joint pain usually:

- A.** Subsides in <3 weeks
- B.** Is relieved by aspirin
- C.** Is responsive to ibuprofen (Motrin)
- D.** Subsides in 3-6 days

Answer: A ([LEAVE A REPLY](#))

(A)

Joints usually remain inflamed and tender until the disease runs its course in <3 weeks.

(B)

This response does not answer the question of whether she will always be arthritic. (C)

This response does not answer the question asked. (D) The disease takes <3 weeks to run its course.

NEW QUESTION: 150

A family by court order undergoes treatment by a family therapist for child abuse. The nurse, who is the child's case manager knows that treatment has been effective when:

- A.** The child is removed from the home and placed in foster care
- B.** The child's parents identify the ways in which he is different from the rest of the family
- C.** The child's father is arrested for child abuse
- D.** The child's parents can identify appropriate behaviors for children in his age group

Answer: D ([LEAVE A REPLY](#))

(A) Removing an abused child from the home and placement in a foster home are not the desired outcome of treatment. (B) Children who are perceived as "different" from the rest of the family are more likely to be abused. (C) Although legal action may be taken against abusive parents, it is not an indicator of an effective treatment program. (D) Identification of age-appropriate behaviors is essential to the role of parents, because misunderstanding children's normal developmental needs often contributes to abuse or neglect.

NEW QUESTION: 151

A 3-year-old child has had symptoms of influenza including fever, productive cough, nausea, vomiting, and sore throat for the past several days. In caring for a young child with symptoms of influenza, the mother must be cautioned about:

- A.** Giving aspirin and bismuth subsalicylate (Pepto-Bismol) to treat the symptoms
- B.** Giving clear liquids too soon
- C.** Allowing the child to come in contact with other children for 3 days
- D.** The possibility of pneumonia as a complication

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Aspirin should never be given to children with influenza because of the possibility of causing Reye's syndrome. Pepto- Bismol is also classified as a salicylate and should be avoided. (B) Depending on the severity of symptoms, the child may be receiving IV therapy or clear liquids. (C) The disease has a 1-3 day incubation period and affected children are most infectious 24 hours before and after the onset of symptoms. (D) Although viral pneumonia can be a complication of influenza, this would not be an initial priority.

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NEW QUESTION: 152

Following a fracture of the left femur, a client develops symptoms of osteomyelitis. During the acute phase of osteomyelitis, nursing care is directed toward:

- A. Moving or turning the client's left leg carefully to minimize pain and discomfort
- B. Allowing the client out of bed only in a wheelchair or gurney to minimize weight bearing on the left leg
- C. Providing the client with a high-protein, high-fiber diet to promote healing
- D. Instituting physical therapy to ensure restoration of optimal functioning of the leg

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) Any movement of his affected limb will cause discomfort to the child. (B) No weight bearing will be allowed until healing is well underway to avoid pathological fractures. (C) The child will be anorexic and may experience vomiting. Diet should be simple and high caloric until appetite returns and symptoms subside. (D) Physical therapy is instituted only after infection subsides.

NEW QUESTION: 153

A 20-year-old client presents to the obstetrics-gynecology clinic for the first time. She tells the nurse that she is pregnant and wants to start prenatal care. After collecting some initial assessment data, the nurse measures her fundal height to be at the level of the umbilicus. The nurse estimates the fetal gestational age to be approximately:

- A. 10 weeks
- B. 16 weeks
- C. 20 weeks
- D. 30 weeks

Answer: C (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) At 10 weeks, the fundus is located slightly above the symphysis pubis. (B) At 16 weeks, the fundus is halfway between the symphysis pubis and the umbilicus. (C) At 20 weeks, the fundus is located approximately at the umbilicus. (D) At 30 weeks, the fundal height is about 30 cm, or 10 cm above the umbilicus.

NEW QUESTION: 154

A young boy tells the nurse, "I don't like my Dad to kiss or hug my Mom. I love my Mom and want to marry her." The nurse recognizes this stage of growth and development as:

- A. Electra complex

- B. Oedipus complex
- C. Superego
- D. Ego

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The Electra complex is the erotic attachment of the female child to the father. (B) The Oedipus complex is characterized by jealousy toward the parent of the same sex and erotic attachment to the parent of the opposite sex. (C) The superego as described by Freud is the part of personality that is associated with internalized parental and societal control. (D) The ego as described by Freud is the part of personality that is associated with reality assessment.

NEW QUESTION: 155

A client develops an intestinal obstruction postoperatively. A nasogastric tube is attached to low, intermittent suction with orders to "Irrigate NG tube with sterile saline q1h and prn." The rationale for using sterile saline, as opposed to using sterile water to irrigate the NG tube is:

- A. Water will deplete electrolytes resulting in metabolic acidosis.
- B. Saline will reduce the risk of severe, colicky abdominal pain during NG irrigation.
- C. Water is not isotonic and will increase restlessness and insomnia in the immediate postoperative period.
- D. Saline will increase peristalsis in the bowel.

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Water is a hypotonic solution and will deplete electrolytes and cause metabolic acidosis when used for nasogastric irrigation. (B) Irrigating with saline does not cause abdominal discomfort. Severe, colicky abdominal pain is a symptom of intestinal obstruction. (C) Irrigating with water will not cause restlessness or insomnia in the postoperative client. Restlessness and insomnia can be emotional complications of surgery. (D) A nasogastric tube placed in the stomach is used to decompress the bowel. Irrigating with saline ensures a patent, well-functioning tube. Irrigating with saline will not increase peristalsis.

NEW QUESTION: 156

A first-trimester primigravida is diagnosed with anemia.

The nurse should suspect that this anemia is a result of:

- A. Mother's increased blood volume
- B. Mother's decreased blood volume
- C. Fetal blood volume increase
- D. Increase in iron absorption

Answer: A (LEAVE A REPLY)

Explanation

(A) Maternal blood volume increases at the end of the first trimester leading to a dilutional anemia. (B) Maternal blood volume increases. (C) Fetal blood volume is minimal in the first trimester. (D) Increased iron absorption would facilitate the manufacturing of erythrocytes and decrease anemia.

NEW QUESTION: 157

A client is being discharged with albuterol (Proventil) and beclomethasone dipropionate (Vanceril) to be administered via inhalation three times a day and at bedtime. Client teaching regarding the sequential order in which the drugs should be administered includes:

- A. Glucocorticoid followed by the bronchodilator
- B. Bronchodilator followed by the glucocorticoid
- C. Alternate successive administrations
- D. According to the client's preference

Answer: B (LEAVE A REPLY)

Section: Questions Set B

Explanation:

(A) The client would not receive therapeutic effects of the glucocorticoid when it is inhaled through constricted airways. (B) Bronchodilating the airways first allows for the glucocorticoid to be inhaled through open airways and increases the penetration of the steroid for maximum effectiveness of the drug. (C) Inaccurate use of the inhalers will lead to decreased effectiveness of the treatment. (D) Client teaching regarding the use and effects of inhalers will promote client understanding and compliance.

NEW QUESTION: 158

A client has been in labor 10 hours and is becoming very tired. She has dilated to 7 cm and is at 0 station with the fetus in a right occipitoposterior position. She is complaining of severe backache with each contraction. One comfort measure the nurse can employ is to:

- A. Place her in knee-chest position during the contraction
- B. Use effleurage during the contraction
- C. Apply strong sacral pressure during the contraction
- D. Have her push with each contraction

Answer: C (LEAVE A REPLY)

(A) This measure is inappropriate. The knee-chest position is employed to take pressure off the cord. (B) Effleurage is a comfort measure but not the one that will contribute most to the relief of backache caused by a posterior position. (C) Sacral pressure will counteract the pressure created by the position of the fetal head. (D) The client is not completely dilated. Pushing is contraindicated until the second stage of labor.

NEW QUESTION: 159

A 26-year-old client is in a treatment center for aprazolam (Xanax) abuse and continues to manifest moderate levels of anxiety 3 weeks into the rehabilitation program, often requesting medication for "his nerves." Included in the client's plan of care is to identify alternate methods of coping with stress and anxiety other than use of medication. After intervening with assistance in stress reduction techniques, identifying feelings and past coping, the nurse evaluates the outcome as being met if:

- A.** Client promises that he will not abuse aprazolam after discharge
- B.** Client demonstrates use of exercise or physical activity to handle nervous energy following conflicts of everyday life
- C.** Client is able to verbalize effects of substance abuse on the body
- D.** Client has remained substance free during hospitalization and is discharged

Answer: B (LEAVE A REPLY)

Explanation

(A) This client response does not address stress reduction techniques. Verbal response focuses only on the problem. (B) Exercise or physical activity is a common strategy or coping technique used to reduce stress and anxiety. (C) Verbalizing effects of substance abuse on the body may help with insight and break through denial, but it is not a strategy to reduce anxiety. (D) Remaining substance-free does indicate motivation to change lifestyle of substance abuse or dependence, and it is not a stress reduction strategy in itself.

NEW QUESTION: 160

A 56-year-old client is admitted to the psychiatric unit in a state of total despair. She feels hopeless and worthless, has a flat affect and very sad appearance, and is unable to feel pleasure from anything. Her husband has been assisting her at home with the housework and cooking; however, she has not been eating much, lies around or sits in a chair most of the day, and is becoming confused and thinks her family does not want her around anymore. In assessing the client, the nurse determines that her behavior is consistent with:

- A.** Transient depression
- B.** Mild depression
- C.** Moderate depression
- D.** Severe depression

Answer: D (LEAVE A REPLY)

(A) Transient depression manifests as sadness or the "blues" as seen with everyday disappointments and is not necessarily dysfunctional. (B) Mild depression manifests as symptoms seen with grief response, such as denial, sadness, withdrawal, somatic symptoms, and frequent or continuous thoughts of the loss. (C) Moderate depression manifests as feelings of sadness, negativism; low self-esteem; rumination about life's failures; decreased interest in grooming and eating; and possibly sleep disturbances. These symptoms are consistent with dysthymia. (D) Severe depression manifests as

feelings of total despair, hopelessness, emptiness, inability to feel pleasure; possibly extreme psychomotor retardation; inattention to hygiene; delusional thinking; confusion; self-blame; and suicidal thoughts. These symptoms are consistent with major depression.

NEW QUESTION: 161

A 6-year-old child returned to the surgical floor 20 hours ago after an appendectomy for a gangrenous appendix. His mother tells the nurse that he is becoming more restless and is anxious. Assessment findings indicate that the child has atelectasis. Appropriate nursing actions would include:

- A.** Allowing the child to remain in the position of comfort, preferably semi-or high-Fowler position
- B.** Administering analgesics as ordered
- C.** Having the child turn, cough, and deep breathe every 1-2 hours
- D.** Remaining with the child and keeping as calm and quiet as possible

Answer: C (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) Allowing the client to remain in the position of comfort will not resolve the atelectasis. This position, if left unchanged, over time may actually increase the atelectasis. (B) Analgesics will not resolve the atelectasis and may contribute to it if proper nursing actions are not taken to help resolve the atelectasis. (C) Having the client turn, cough, and deep breathe every 1-2 hours will aid in resolving the atelectasis. Surgery clients are at risk for postoperative respiratory complications because pulmonary function is reduced as a result of anesthesia and surgery. (D) Remaining with the client and keeping him calm and quiet will not affect the client's anxiety, restlessness, or help to resolve the atelectasis. The cause (atelectasis) needs to be treated, not the symptoms (anxiety and restlessness).

NEW QUESTION: 162

A client with a head injury asks why he cannot have something for his headache. The nurse's response is based on the understanding that analgesics could:

- A.** Counteract the effects of antibiotics
- B.** Elevate the blood pressure
- C.** Mask symptoms of increasing intracranial pressure
- D.** Stimulate the central nervous system

Answer: C (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) Analgesic medication does not counteract the effects of antibiotics. (B) Analgesic medication may lower blood pressure elevated due to anxiety. (C) Analgesic medication, especially CNS depressants, is not given if there is danger of increasing ICP, because

neurological changes may not be apparent. Also, further depression of the CNS is contraindicated. (D) Analgesics do not stimulate the CNS.

NEW QUESTION: 163

A mother came to the pediatric clinic with her 17- month-old child. The mother would like to begin toilet training. What should the nurse teach her about implementing toilet training?

- A.** Take two or three favorite toys with the child.
- B.** Have a child-sized toilet seat or training potty on hand.
- C.** Explain to the child she is going to "void" and "defecate."
- D.** Show disapproval if she does not void or defecate.

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) Giving her toys will distract her and interfere with toilet training because of inappropriate reinforcement.

(B) A child-sized toilet seat or training potty gives a child a feeling of security. (C) She should use words that are age appropriate for the child. (D) Children should be praised for cooperative behavior and/or successful evacuation.

NEW QUESTION: 164

The nurse would need to monitor the serum glucose levels of a client receiving which of the following medications, owing to its effects on glycogenolysis and insulin release?

- A.** Norepinephrine (Levophed)
- B.** Dobutamine (Dobutrex)
- C.** Propranolol (Inderal)
- D.** Epinephrine (Adrenalin)

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) Norepinephrine's side effects are primarily related to safe, effective care environment and include decreased peripheral perfusion and bradycardia. (B) Dobutamine's side effects include increased heart rate and blood pressure, ventricular ectopy, nausea, and headache. (C) Propranolol's side effects include elevated blood urea nitrogen, serum transaminase, alkaline phosphatase, and lactic dehydrogenase. (D) Epinephrine increases serum glucose levels by increasing glycogenolysis and inhibiting insulin release. Prolonged use can elevate serum lactate levels, leading to metabolic acidosis, increased urinary catecholamines, false elevation of blood urea nitrogen, and decreased coagulation time.

NEW QUESTION: 165

In evaluating the laboratory results of a client with severe pressure ulcers, the nurse finds that her albumin level is low. A decrease in serum albumin would contribute to the formation of pressure ulcers because:

- A.** The proteins needed for tissue repair are diminished.

- B.** The iron stores needed for tissue repair are inadequate.
- C.** A decreased serum albumin level indicates kidney disease.
- D.** A decreased serum albumin causes fluid movement into the blood vessels, causing dehydration.

Answer: A (LEAVE A REPLY)

(A)

Serum albumin levels indicate the adequacy of protein stores available for tissue repair.

(B)

Serum albumin does not measure iron stores. (C) Serum albumin levels do not measure kidney function. (D) A decreased serum albumin level would cause fluid movement out of blood vessels, not into them.

NEW QUESTION: 166

A young child has been placed in a spica cast. The chief concern of the nurse during the first few hours is:

- A.** Prevention of neurovascular complications
- B.** Prevention of loss of muscle tone
- C.** Immobilization of the affected limb
- D.** Using heated fans to dry the cast

Answer: A (LEAVE A REPLY)

Explanation

(A) Because the extremity may continue to swell and the cast could constrict circulation, the nurse should elevate the limb and observe for capillary refill, warmth, mobility of toes and circulation. (B) Although muscle tone may diminish over time in the affected limb, this is not the immediate concern. (C) The limb has been immobilized already by the cast, and therefore immobilization is not a concern. (D) Heated fans and dryers are discouraged because the outside cast will dry quickly, yet the area beneath the cast remains wet and could cause burns.

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NEW QUESTION: 167

A client delivered a term infant 1 hour ago. Her uterus on assessment is boggy and is U +1 in contrast to the previous assessment of U _2. The immediate nursing response is to:

- A. Administer methergine IM
- B. Remove the retained placental fragments
- C. Assist the client to the bathroom and provide cues to stimulate urination
- D. Massage the fundus until firm

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Methergine is given following placental delivery to promote uterine contractions and prevent hemorrhage. Methergine may be administered in this clinical situation, but fundal massage would be the first response. (B) Removal of retained placental fragments is done by the physician and is not the first response. (C) If the fundus rises and is deviated, particularly to the right, the nurse should suspect bladder distention secondary to bladder and urethral trauma associated with birth and decreased bladder tone following delivery. Therefore, women have a diminished sensation to void. (D) A boggy fundus rises and is indicative of blood pooling, predisposing the woman to clot formation. Massage the uterus until firm. Too vigorous massage will result in atonia. Clots may be expelled by a kneading motion of the uterus by the nurse.

NEW QUESTION: 168

A client is going to have a pneumonectomy in the morning. She had a previous negative surgical experience, is talking rapidly, and has an increased pulse and respiratory rate. Nursing interventions for this client should include:

- A. Providing opportunities to ask questions and talk about concerns
- B. Providing distractors such as reading or watching television
- C. Telling her that she should not be so nervous and assuring her that everything will be OK
- D. Reminding her that this surgery is not as extensive as her past surgery was

Answer: A (LEAVE A REPLY)

(A) This intervention will help to clarify any misunderstandings about the surgery and give the client an opportunity to verbalize concerns about the surgery. (B) Distractors will not alleviate the preoperative anxiety that the client is experiencing. This response actually denies the client's anxiety. (C) This intervention is false assurance and denies that anxiety is a normal response to the threat of surgery. (D) Psychological responses are not directly related to the extent of the surgery, because they are influenced by the client's past experiences.

NEW QUESTION: 169

A child receiving chemotherapeutic drugs experiences a loss of appetite directly related to the therapy. Which of the following strategies should be most effective in encouraging the child to eat?

- A.** Provide a well-balanced diet at usual times, and restrict dessert if the child fails to eat well.
- B.** Schedule procedures immediately after eating so that the child will not be tired or in pain at mealtime.
- C.** Offer the child a diet with a wider variety of foods and with more seasoning than her usual diet.
- D.** Offer the child smaller meals more frequently than usual, and include as many of her favorite foods as possible.

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) Because the child's appetite is capricious at best, regular servings may be overwhelming. Praise the child for what is eaten. (B) The child will soon learn that procedures follow meals and may play with food rather than eat it to avoid or delay the procedure. (C) Young children usually do not like highly seasoned foods and may need the security of usual foods. Such a change may actually increase anorexia. (D) Small servings appear more achievable to the child, and the inclusion of favorite foods can add a sense of security.

NEW QUESTION: 170

The pediatrician has diagnosed tinea capitis in an 8- year-old girl and has placed her on oral griseofulvin.

The nurse should emphasize which of these instructions to the mother and/or child?

- A.** Administer oral griseofulvin on an empty stomach for best results.
- B.** Discontinue drug therapy if food tastes funny.
- C.** May discontinue medication when the child experiences symptomatic relief.
- D.** Observe for headaches, dizziness, and anorexia.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Giving the drug with or after meals may allay gastrointestinal discomfort. Giving the drug with a fatty meal (ice cream or milk) increases absorption rate. (B) Griseofulvin may alter taste sensations and thereby decrease the appetite. Monitoring of food intake is important, and inadequate nutrient intake should be reported to the physician. (C) The child may experience symptomatic relief after 48-96 hours of therapy. It is important to stress continuing the drug therapy to prevent relapse (usually about 6 weeks). (D) The incidence of side effects is low; however, headaches are common. Nausea, vomiting, diarrhea, and anorexia may occur. Dizziness, although uncommon, should be reported to the physician.

NEW QUESTION: 171

A gravida 2 para 1 client delivered a full-term newborn 12 hours ago. The nurse finds her uterus to be boggy, high, and deviated to the right. The most appropriate nursing action is to:

- A. Notify the physician
- B. Place the client on a pad count
- C. Massage the uterus and re-evaluate in 30 minutes
- D. Have the client void and then re-evaluate the fundus

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) The nurse should initiate actions to remove the most frequent cause of uterine displacement, which involves emptying the bladder. Notifying the physician is an inappropriate nursing action. (B) The pad count gives an estimate of blood loss, which is likely to increase with a boggy uterus; but this action does not remove the most frequent cause of uterine displacement, which is a full bladder. (C) Massage may firm the uterus temporarily, but if a full bladder is not emptied, the uterus will remain displaced and is likely to relax again.

(D) The most common cause of uterine displacement is a full bladder.

NEW QUESTION: 172

Except for initial explosiveness on admission, a client diagnosed with schizophrenia stays in her room. She continues to believe other people are out to get her. A nursing intervention basic to improving withdrawn behavior is:

- A. Assigning her to occupational therapy
- B. Having her sit with the nurses while they chart
- C. Helping her to make friends
- D. Facilitating communication

Answer: ([SHOW ANSWER](#))

(A) The nurse does not make this assignment. (B) One-to-one observation is not appropriate. It does not focus on the client or encourage communication. (C) The client is too suspicious to accomplish this goal. (D) The withdrawn individual must learn to communicate on a one-to-one level before moving on to more threatening situations.

NEW QUESTION: 173

A 47-year-old male client is admitted for colon surgery. Intravenous antibiotics are begun 2 hours prior to surgery. He has no known infection. The rationale for giving antibiotics prior to surgery is to:

- A. Provide cathartic action within the colon
- B. Reduce the risk of wound infection from anaerobic bacteria
- C. Relieve the client's concern regarding possible infection
- D. Reduce the risk of intraoperative fever

Answer: B ([LEAVE A REPLY](#))

(A) Cathartic drugs promote evacuation of intestinal contents. (B) The client undergoing intestinal surgery is at increased risk for infection from large numbers of anaerobic bacteria that inhabit the intestines. Administering antibiotics prophylactically can reduce the client's risk for infection. (C) Antibiotics are indicated in the treatment of infections and have no effect on emotions. (D) Antipyretics are useful in the treatment of elevated temperatures. Antibiotics would have an effect on infection, which causes temperature elevation, but would not directly affect such an elevation.

NEW QUESTION: 174

A 38-year-old female client with a history of chronic schizophrenia, paranoid type, is currently an outpatient at the local mental health and mental retardation clinic. The client comes in once a week for medication evaluation and/or refills. She self-administers haloperidol 5 mg twice a day and benztropine 1 mg once a day. During a recent clinic visit, she says to the nurse, "I can't stay still at night. I toss and turn and can't fall asleep." The nurse suspects that she may be experiencing:

- A. Akathisia
- B. Akinesia
- C. Dystonia
- D. Opisthotonos

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Akathisia, or motor restlessness, is a reversible EPS frequently associated with the administration of antipsychotic drugs such as haloperidol. (B) Akinesia, or muscular or motor retardation, is an example of reversible EPS frequently associated with the administration of major tranquilizers such as haloperidol. (C) Acute dystonic reactions, bizarre and severe muscle contractions usually of the tongue, face, neck or extraocular muscles, are examples of EPS. (D) Opisthotonos, a severe type of whole-body dystonic reaction in which the head and heels are bent backward while the body is bowed forward, is an example of EPS.

NEW QUESTION: 175

A 2-year-old boy is in the hospital outpatient department for observation after falling out of his crib and hitting his head. The nurse calls the physician to report:

- A. Evidence of perineal irritation
- B. Pulse fell from 102 to 96
- C. Pulse increased from 96 to 102
- D. Temperature rose to 102_F rectally

Answer: D (LEAVE A REPLY)

(A) Perineal irritation needs to be addressed, but it is probably not necessary to call the physician. (B) This fall in pulse rate remains within normal limits and is probably

insignificant. It is important to monitor for continued change. (C) This rise in pulse rate is probably not significant, but it is important to monitor for continued change. (D) This temperature is above normal limits and needs medical investigation. It may or may not be related to the head injury.

NEW QUESTION: 176

A 49-year-old obese woman has been admitted to the general surgery unit with choledocholithiasis. As the nurse is admitting her to the unit, she states, "The doctor said I have stones that need to be removed; where are they?" The nurse knows that the best explanation for this is to tell her that:

- A.** There are stones present in her gallbladder
- B.** There are stones present in her kidneys
- C.** There are stones present in her common bile duct
- D.** There are no stones, but her gallbladder is irritated and caused her nausea, vomiting, and pain

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A)Cholelithiasis is the correct term used to describe the presence of stones in the gallbladder. (B) Nephrolithiasis, or renal calculi, is the correct term used to describe the presence of stones in the kidney. (C) Choledocholithiasis is the correct term used to describe the presence of stones in the common bile duct.

(D)Cholecystitis is the correct term used to describe inflammation of the gallbladder and can be associated with cystic duct obstructions from impacted stones.

NEW QUESTION: 177

After an infant is delivered by cesarean delivery and placed on the warmer, the RN dries and assesses the infant. At 1 and 5 minutes after birth, the RN does the Apgar scoring of the infant. The RN knows that because this infant was delivered by cesarean section, he is at increased risk for having which one of the following:

- A.** Cold stress
- B.** Cyanosis
- C.** Respiratory distress syndrome
- D.** Seizures

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) The infant is placed on the warmer and dried after birth. Cold stress occurs when the infant is not dried and kept warm. (B) The fact that this infant was born by cesarean delivery does not place him at a greater risk for cyanosis than an infant delivered vaginally. Cyanosis occurs when infants cannot oxygenate their blood after the umbilical cord is severed. (C) Infants born by cesarean delivery are at a higher risk for developing

respiratory distress syndrome because these infants do not pass through the pelvis, where the chest is compressed and fluid is able to escape from the lungs. (D) Cesarean-delivered infants are not at greater risk for seizures than infants delivered vaginally.

NEW QUESTION: 178

A 26-year-old client is in a treatment center for aprazolam (Xanax) abuse and continues to manifest moderate levels of anxiety 3 weeks into the rehabilitation program, often requesting medication for "his nerves." Included in the client's plan of care is to identify alternate methods of coping with stress and anxiety other than use of medication. After intervening with assistance in stress reduction techniques, identifying feelings and past coping, the nurse evaluates the outcome as being met if:

- A.** Client promises that he will not abuse aprazolam after discharge
- B.** Client demonstrates use of exercise or physical activity to handle nervous energy following conflicts of everyday life
- C.** Client is able to verbalize effects of substance abuse on the body
- D.** Client has remained substance free during hospitalization and is discharged

Answer: B (LEAVE A REPLY)

(A) This client response does not address stress reduction techniques. Verbal response focuses only on the problem. (B) Exercise or physical activity is a common strategy or coping technique used to reduce stress and anxiety. (C) Verbalizing effects of substance abuse on the body may help with insight and break through denial, but it is not a strategy to reduce anxiety. (D) Remaining substance-free does indicate motivation to change lifestyle of substance abuse or dependence, and it is not a stress reduction strategy in itself.

NEW QUESTION: 179

In caring at home for a child who just ingested a caustic alkali, the nurse would immediately tell the mother to:

- A.** Give vinegar, lemon juice, or orange juice
- B.** Phone the doctor
- C.** Take the child to the emergency room
- D.** Induce vomiting

Answer: A (LEAVE A REPLY)

Explanation

(A) The immediate action is to neutralize the action of the chemical before further damage takes place. (B) This action should be done after neutralizing the chemical. (C) This action should be done after neutralizing the chemical. (D) Never induce vomiting with a strong alkali or acid. Additional damage will be done when the child vomits the chemical.

NEW QUESTION: 180

A client is now pregnant for the second time. Her first child weighed 4536 g at delivery. The client's glucose tolerance test shows elevated blood sugar levels. Because she only shows signs of diabetes when she is pregnant, she is classified as having:

- A. Insulin-dependent diabetes
- B. Type II diabetes mellitus
- C. Type I diabetes mellitus
- D. Gestational diabetes mellitus

Answer: D (LEAVE A REPLY)

(A) Insulin-dependent diabetes mellitus, also known as type I diabetes, usually appears before the age of 30 years with an abrupt onset of symptoms requiring insulin for management. It is not related to onset during pregnancy. (B) Non-insulin-dependent diabetes (type II diabetes) usually appears in older adults. It has a slow onset and progression of symptoms. (C) This type of diabetes is the same as insulin-dependent diabetes. (D) Gestational diabetes mellitus has its onset of symptoms during pregnancy and usually disappears after delivery. These symptoms are usually mild and not life threatening, although they are associated with increased fetal morbidity and other fetal complications.

NEW QUESTION: 181

One week ago, a 21-year-old client with a diagnosis of bipolar disorder was started on lithium 300 mg po qid. A lithium level is ordered. The client's level is 1.3 mEq/L. The nurse recognizes that this level is considered to be:

- A. Within therapeutic range
- B. Below therapeutic range
- C. Above therapeutic range
- D. At a level of toxic poisoning

Answer: A (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) This answer is correct. The therapeutic range is 1.0-1.5 mEq/L in the acute phase. Maintenance control levels are 0.6-1.2 mEq/L. (B, C) This answer is incorrect. A level of 1.3 mEq/L is within therapeutic range. (D) This answer is incorrect. Toxic poisoning is usually at the 2.0 level or higher.

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NEW QUESTION: 182

A client has just received an epidural block. She is laboring on her right side. The nurse notes that her blood pressure has dropped from 132/68 to 78/42 mm Hg. The nurse's first action would be to:

- A. Call the physician immediately and give dopamine IM
- B. Turn her on her left side and recheck her blood pressure in 5 minutes
- C. Administer oxytocin (Pitocin) immediately and increase the rate of IV fluids
- D. Increase the rate of IV fluids and start O2 by mask

Answer: D (LEAVE A REPLY)

(A) Nursing measures to support fetal oxygenation and promote maternal blood pressure would precede calling the physician. (B) Systolic pressures below 100 mm Hg or a reduction in the systolic pressure of >30% necessitate treatment. Assessing the blood pressure in 5 minutes may allow for further fetal and/or maternal compromise. Turning the client on her left side will promote uteroplacental perfusion and is appropriate. (C) Oxytocin (Pitocin) increases the strength of uterine contractions and may cause maternal hypotension; thus it is an inappropriate drug for use in this clinical situation. IV fluids would be increased to expand the circulating blood volume and promote increased blood pressure. (D) Turning the mother to her left lateral side promotes uteroplacental perfusion. IV fluids are administered to increase the circulating blood volume, and O2 is administered to promote fetal oxygenation and decrease the nausea accompanying the hypotension.

NEW QUESTION: 183

Three hours postoperatively, a 27-year-old client complains of right leg pain after knee reduction. The first action by the nurse will be to:

- A. Assess vital signs
- B. Elevate the extremity
- C. Perform a lower extremity neurovascular check
- D. Remind the client that he has a client-controlled analgesic pump, and reinstruct him on its use

Answer: C (LEAVE A REPLY)

Explanation

(A) Vital signs may be altered if there is acute pain or complications related to bleeding or swelling, but they should not be assessed before checking the affected extremity. (B) The extremity will be elevated if ordered by the doctor. (C) Assessment of the postoperative area is important to determine if bleeding, swelling, or decreased circulation is occurring. (D) Reinforcement of teaching on use of the client-controlled analgesic pump is important, but not the first action.

NEW QUESTION: 184

An 83-year-old client has been hospitalized following a fall in his home. He has developed a possible fecal impaction. Which of the following assessment findings would be most indicative of a fecal impaction?

- A. Boardlike, rigid abdomen
- B. Loss of the urge to defecate
- C. Liquid stool
- D. Abdominal pain

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) A boardlike, rigid abdomen would point to a perforated bowel, not a fecal impaction. (B) When a client is fecally impacted, a common symptom is the urge to defecate but the inability to do so. (C) When an impaction is present, only liquid stool will be able to pass around the impacted site. (D) Abdominal pain without distention is not a sign of a fecal impaction.

NEW QUESTION: 185

A mother brings her 3-year-old child who is unconscious but breathing to the ER with an apparent drug overdose. The mother found an empty bottle of aspirin next to her child in the bathroom. Which nursing action is the most appropriate?

- A. Put in a nasogastric tube and lavage the child's stomach.
- B. Monitor muscular status.
- C. Teach mother poison prevention techniques.
- D. Place child on respiratory assistance.

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) The immediate treatment for drug overdose is removal of the drug from the stomach by either forced emesis or gastric lavage. The child's unconscious state prohibits forced emesis. (B) Toxic amounts of salicylates directly affect the respiratory system, which could lead to respiratory failure. (C) The mother's anxiety is probably so high that preventive guidance will be ineffective. (D) Respiratory assistance is not needed if the child's respiratory function is unaltered.

NEW QUESTION: 186

Pregnant women with diabetes often have problems related to the effectiveness of insulin in controlling their glucose levels during their second half of pregnancy. The nurse teaches the client that this is due to:

- A. Decreased glomerular filtration and increased tubular absorption
- B. Decreased estrogen levels
- C. Decreased progesterone levels

D. Increased human placental lactogen levels

Answer: (SHOW ANSWER)

(A) There is a rise in glomerular filtration rate in the kidneys in conjunction with decreased tubular glucose reabsorption, resulting in glycosuria. (B) Insulin is inhibited by increased levels of estrogen. (C) Insulin is inhibited by increased levels of progesterone. (D) Human placental lactogen levels increase later in pregnancy. This hormonal antagonist reduces insulin's effectiveness, stimulates lipolysis, and increases the circulation of free fatty acids.

NEW QUESTION: 187

A chronic alcoholic client's condition deteriorates, and he begins to exhibit signs of hepatic coma. Which of the following is an early sign of impending hepatic coma?

- A. Hiccups**
- B. Anorexia**
- C. Mental confusion**
- D. Feter hepaticus**

Answer: (SHOW ANSWER)

(A) Hiccups are not a sign of impending hepatic coma. (B) Anorexia is not a sign of impending hepatic coma. (C) One of the earliest symptoms of hepatic coma is mental confusion. Asterixis, a flapping tremor of the hand, may also be seen. (D) This sign is associated with the later stages of hepatic coma. Feter hepaticus, a characteristic odor on the breath that smells like acetone, may sometimes be noted when the liver fails.

NEW QUESTION: 188

A male client receives 10 U of regular human insulin SC at 9:00 AM. The nurse would expect peak action from this injection to occur at:

- A. 9:30 AM**
- B. 10:30 AM**
- C. 12 noon**
- D. 4:00 PM**

Answer: C (LEAVE A REPLY)

(A)

This is too early for peak action to occur. (B) This is too early for peak action to occur.

(C)

Regular insulin peak action occurs 2-4 hours after administration. (D) This is too late for peak action to occur.

NEW QUESTION: 189

A client is having a pneumonectomy done today, and the nurse is planning her postoperative care. Nursing interventions for a postoperative left pneumonectomy would include:

- A. Monitoring the chest tubes**

- B.** Positioning the client on the right side
- C.** Positioning the client in semi-Fowler position with a pillow under the shoulder and back
- D.** Monitoring the right lung for an increase in rales

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Chest tubes are usually not necessary in a pneumonectomy because there is no lung to re-expand on the operative side. (B) The pneumonectomy client should be positioned on the back or operated side because the sutured bronchial stump may open, allowing fluid to drain into the unoperated side and drown the client. (C) The client should not have a pillow under the shoulder and back because of the subscapular incision. (D) Rales are commonly heard over the base of the remaining lung, but an increase could indicate circulatory overload and therefore should be closely monitored.

NEW QUESTION: 190

A 3-year-old child has had symptoms of influenza including fever, productive cough, nausea, vomiting, and sore throat for the past several days. In caring for a young child with symptoms of influenza, the mother must be cautioned about:

- A.** Giving aspirin and bismuth subsalicylate (Pepto-Bismol) to treat the symptoms
- B.** Giving clear liquids too soon
- C.** Allowing the child to come in contact with other children for 3 days
- D.** The possibility of pneumonia as a complication

Answer: A (LEAVE A REPLY)

(A) Aspirin should never be given to children with influenza because of the possibility of causing Reye's syndrome. Pepto-Bismol is also classified as a salicylate and should be avoided. (B) Depending on the severity of symptoms, the child may be receiving IV therapy or clear liquids. (C) The disease has a 1-3 day incubation period and affected children are most infectious 24 hours before and after the onset of symptoms. (D) Although viral pneumonia can be a complication of influenza, this would not be an initial priority.

NEW QUESTION: 191

Chorioamnionitis is a maternal infection that is usually associated with:

- A.** Prolonged rupture of membranes
- B.** Postterm deliveries
- C.** Maternal pyelonephritis
- D.** Maternal dehydration

Answer: A (LEAVE A REPLY)

(A) Chorioamnionitis is an inflammation of the chorion and amnion that is generally associated with premature or prolonged rupture of membranes. (B) Postterm deliveries have not been shown to increase the risk of chorioamnionitis unless there has been prolonged rupture of membranes. (C) Pyelonephritis is a kidney infection that develops in

20%-40% of untreated maternal UTIs. (D) Maternal dehydration, though of great concern, is not related to chorioamnionitis.

NEW QUESTION: 192

In the client with a diagnosis of coronary artery disease, the nurse would anticipate the complication of bradycardia with occlusion of which coronary artery?

- A.** Right coronary artery
- B.** Left main coronary artery
- C.** Circumflex coronary artery
- D.** Left anterior descending coronary artery

Answer: [\(SHOW ANSWER\)](#)

Explanation

(A) Sinus bradycardia and atrioventricular (AV) heart block are usually a result of right coronary artery occlusion. The right coronary artery perfuses the sinoatrial and AV nodes in most individuals. (B) Occlusion of the left main coronary artery causes bundle branch blocks and premature ventricular contractions. (C) Occlusion of the circumflex artery does not cause bradycardia. (D) Sinus tachycardia occurs primarily with left anterior descending coronary artery occlusion because this form of occlusion impairs left ventricular function.

NEW QUESTION: 193

A client has been instructed in how to take her nitroglycerin tablets. The nurse giving her instructions knows the client understands the information when she tells her:

- A.** "I should contact my physician if I have headaches after I take this medicine."
- B.** "I should keep the tablets in the refrigerator."
- C.** "I should call the doctor if three doses of the medicine do not relieve my pain."
- D.** "I should take these with water but not with milk."

Answer: [C \(LEAVE A REPLY\)](#)

Section: Questions Set E

Explanation:

(A) Headaches may occur after taking nitroglycerin because of vasodilation. (B) The tablets do not need to be refrigerated. The client should carry them with her. (C) The client should contact the physician if repeated doses of nitroglycerin do not relieve the discomfort. (D) Nitroglycerin tablets should be dissolved under the tongue, not swallowed.

NEW QUESTION: 194

A 74-year-old female client is 3 days postoperative. She has an indwelling catheter and has been progressing well. While the nurse is in the room, the client states, "Oh dear, I feel like I have to urinate again!" Which of the following is the most appropriate initial nursing response?

- A.** Assure her that this is most likely the result of bladder spasms.
- B.** Check the collection bag and tubing to verify that the catheter is draining properly.

C. Instruct her to do Kegel exercises to diminish the urge to void.

D. Ask her if she has felt this way before.

Answer: [\(SHOW ANSWER\)](#)

Section: Questions Set B

Explanation:

(A) Although this may be an appropriate response, the initial response would be to assure the patency of the catheter. (B) The most frequent reason for an urge to void with an indwelling catheter is blocked tubing. This response would be the best initial response. (C) Kegel exercises while a retention catheter is in place would not help to prevent a voiding urge and could irritate the urethral sphincter. (D) Though the nurse would want to ascertain whether the client has felt the same urge to void before, the initial response should be to assure the patency of the catheter.

NEW QUESTION: 195

The nurse recognizes that a client with the diagnosis of cholecystitis and cholelithiasis would expect to have stools that are:

A. Clay or gray colored

B. Watery and loose

C. Bright-red streaked

D. Black

Answer: **A** [\(LEAVE A REPLY\)](#)

Explanation

(A) Clients who have obstruction in the biliary tract so that bile is not released into the duodenum experience a change in stools from brown to gray or clay colored. (B) This type of stool can occur with other GI problems, such as bacterial or viral infections, and other disease problems, and is not a common finding with biliary obstructions such as cholecystitis and cholelithiasis. (C) This type of stool is usually associated with a GI or bowel problem, such as lower GI bleeding, rather than with biliary obstructions. (D) This type of stool is usually associated with a GI or bowel problem, such as upper GI bleeding, rather than with biliary obstructions.

NEW QUESTION: 196

The primary reason for sending a burn client home with a pressure garment, such as a Jobst garment, is that the garment:

A. Decreases hypertrophic scar formation

B. Assists with ambulation

C. Covers burn scars and decreases the psychological impact during recovery

D. Increases venous return and cardiac output by normalizing fluid status

Answer: [\(SHOW ANSWER\)](#)

Explanation

(A) Tubular support, such as that received with a Jobst garment, applies tension of 10-20 mm Hg. This amount of uniform pressure is necessary to prevent or reduce hypertrophic scarring. Clients typically wear a pressure garment for 6-12 months during the recovery phase of their care. (B) Pressure garments have no ambulatory assistive properties. (C) Pressure garments can worsen the psychological impact of burn injury, especially if worn on the face. (D) Pressure garments do not normalize fluid status.

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NEW QUESTION: 197

A 12-year-old girl has been diagnosed with insulindependent diabetes mellitus. Which of these principles would best guide her nutritional management?

- A.** Concentrated sweets are taken during increased activity.
- B.** Food restriction is imposed to reduce weight.
- C.** Caloric distribution should be calculated to fit activity patterns.
- D.** Fat requirements are increased owing to the possibility of ketoacidosis.

Answer: (SHOW ANSWER)

(A) Concentrated sweets are eliminated from diet planning. Complex carbohydrates may be taken at the time of increased activity. (B) Food restriction is not used for diabetic control of growing children. Caloric restriction may be imposed for weight control if necessary. (C) Total caloric intake and proportions of basic nutrients should be consistent from day to day. Distribution of these calories should fit the activity pattern. Extra food is needed for increased activity. A balance of food, exercise, and insulin should be maintained. (D) Because of the increased risk of atherosclerosis, the fat percentage of the total caloric intake is reduced.

NEW QUESTION: 198

A husband asks if he can visit with his wife on her ECT treatment days and what to expect after the initial treatment. The nurse's best response is:

- A.** "You'll have to get permission from the physician to visit. Clients are pretty sick after the first treatment."
- B.** "Visitors are not allowed. We will telephone you to inform you of her progress."
- C.** "There's really no need to stay with her. She's going to sleep for several hours after the treatment."

D. "Yes, you may visit. She may experience temporary drowsiness, confusion, or memory loss after each treatment."

Answer: D ([LEAVE A REPLY](#))

Section: Questions Set F

Explanation:

(A) It is within the nurse's realm of practice to grant visiting privileges according to hospital policy. ECT treatments do not make clients sick. (B) Visitors are allowed and encouraged, particularly family members. (C) Clients are usually awake within 1 hour posttreatment. Drowsiness wanes as the anesthetic wears off. (D) A family member is encouraged to stay with the client after return to the unit. The nurse has used an opportunity to do family teaching and allay fears by explaining temporary side effects of the treatment.

NEW QUESTION: 199

A client is being discharged and will continue enteral feedings at home. Which of the following statements by a family member indicates the need for further teaching?

A. "If he develops diarrhea lasting for more than 2-3 days, I will contact the doctor or nurse."

B. "I should anticipate that he will gain about 1 lb/day now that he is on continuous feedings."

C. "It is important to keep the head of his bed elevated or sit him in the chair during feedings."

D. "I should use prepared or open formula within 24 hours and store unused portions in the refrigerator."

Answer: (SHOW ANSWER)

Section: Questions Set B

Explanation:

(A) Diarrhea is a complication of tube feedings that can lead to dehydration. Diarrhea may be the result of hypertonic formulas that can draw fluid into the bowel. Other causes of diarrhea may be bacterial contamination, fecal impaction, medications, and low albumin. (B) A consistent weight gain of more than 0.22 kg/day (1 □ 2lb/day) over several days should be reported promptly. The client should be evaluated for fluid volume excess. (C) Elevating the client's head prevents reflux and thus formula from entering the airway. (D) Bacteria proliferate rapidly in enteral formulas and can cause gastroenteritis and even sepsis.

NEW QUESTION: 200

A 65-year-old client who has a new colostomy is preparing for discharge from the hospital. As part of the instructions on colostomy care, the nurse explains to the client that to regulate the bowel, colostomy irrigation should be performed at the same time each day. The best time is:

A. After meals

- B. Before meals
- C. Every 2 hours
- D. At bedtime

Answer: A (LEAVE A REPLY)

(A) Bowel movements should be regulated at a specific time each day to prevent "accidents." Irrigating after meals takes advantage of the gastrocolic reflex and time of increased peristalsis, so better results may be produced. After meals is the normal time that peristalsis begins in most persons and evacuation of feces occurs. (B) Irrigating before meals may cause poor results because of decreased gastrocolic reflex and decreased peristalsis. (C) Irrigating a colostomy every 2 hours may produce hyperactivity of the bowel, leading to irritation and diarrhea. This would not aid in regulation of the bowel. (D) If irrigation of a colostomy were done at bedtime, there is greater chance of having an "accident" during sleep. This would not be an advantageous practice of bowel regulation.

NEW QUESTION: 201

A female client has a chest tube placed. It is accidentally pulled out of the intrapleural space when she is ambulating. The first action the nurse should take is to:

- A. Instruct the client to cough deeply to re-expand her lung
- B. Put on sterile gloves and replace the tube
- C. Apply a petrolatum dressing over the site
- D. Auscultate the lung to determine if she needs the tube replaced

Answer: C (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) This action is inappropriate. Coughing will not re-expand the lung and could result in further harm. (B) This action is a medical procedure, not a nursing procedure. (C) An occlusive dressing will prevent further air leak until the physician institutes further treatment. (D) The decision to reinsert the tube is a medical decision, not a nursing one.

NEW QUESTION: 202

A 42-year-old client with bipolar disorder has been hospitalized on the inpatient psychiatric unit. She is dancing around, talking incessantly, and singing. Much of the time the client is anorexic and eats very little from her tray before she is up and about again. The nurse's intervention would be to:

- A. Confront the client with the fact that she will have to eat more from her tray to sustain her
- B. Try to get the client to focus on her eating by offering a detailed discussion on the importance of nutrition
- C. Let her have snacks and drinks anytime that she wants them because she will not eat at regular meal times

D. Not expect the client to sit down for complete meals; monitor intake, offering snacks and juice frequently

Answer: D (LEAVE A REPLY)

Explanation

(A) The manic client's mood may easily change from euphoric to irritable. The nurse should avoid confrontation and let the client know what she can do, rather than what she cannot. (B) Although helpful to refocus or redirect the manic client to discuss only one topic at a time, distractibility is very high and it's best to avoid long discussions. (C) Manic clients have a tendency to manipulate persons in their environment. Staff should monitor intake, including at mealtime and snacks, and be consistent in their approach to meeting nutritional needs. (D) Manic clients may not sit and eat complete meals, but they can carry foods and liquids from regular meals with them. Staff can monitor and give high-caloric and high-energy snacks and liquids.

NEW QUESTION: 203

A client is being discharged with albuterol (Proventil) and beclomethasone dipropionate (Vanceril) to be administered via inhalation three times a day and at bedtime. Client teaching regarding the sequential order in which the drugs should be administered includes:

- A.** Glucocorticoid followed by the bronchodilator
- B.** Bronchodilator followed by the glucocorticoid
- C.** Alternate successive administrations
- D.** According to the client's preference

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The client would not receive therapeutic effects of the glucocorticoid when it is inhaled through constricted airways. (B) Bronchodilating the airways first allows for the glucocorticoid to be inhaled through open airways and increases the penetration of the steroid for maximum effectiveness of the drug. (C) Inac- Inaccurate use of the inhalers will lead to decreased effectiveness of the treatment. (D) Client teaching regarding the use and effects of inhalers will promote client understanding and compliance.

NEW QUESTION: 204

A nurse is performing a vaginal exam on a client in active labor. An important landmark to assess during labor and delivery are the ischial spines because:

- A.** Ischial spines are the narrowest diameter of the pelvis
- B.** Ischial spines are the widest diameter of the pelvis
- C.** They represent the inlet of birth canal
- D.** They measure pelvic floor

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The fetal descent, or station, is determined by the relationship of the presenting part to the spine. (B) Ischial spines are the narrowest measurement. (C) Ischial spines measure the pelvic outlet. (D) Pelvic floor measurement is not related to fetal descent.

NEW QUESTION: 205

A client in active labor asks the nurse for coaching with her breathing during contractions. The client has attended Lamaze birth preparation classes. Which of the following is the best response by the nurse?

- A. "Keep breathing with your abdominal muscles as long as you can."
- B. "Make sure you take a deep cleansing breath as the contractions start, focus on an object, and breathe about 16-20 times a minute with shallow chest breaths."
- C. "Find a comfortable position before you start a contraction. Once the contraction has started, take slow breaths using your abdominal muscles."
- D. "If a woman in labor listens to her body and takes rapid, deep breaths, she will be able to deal with her contractions quite well."

Answer: B (LEAVE A REPLY)

(A) Lamaze childbirth preparation teaches the use of chest, not abdominal, breathing. (B) In Lamaze preparation, every patterned breath is preceded by a cleansing breath; as labor progresses, shallow, paced breathing is found to be effective. (C) It is important to assume a comfortable position in labor, but the Lamazeprepared laboring woman is taught to breathe with her chest, not abdominal, muscles. (D) When deep chest breathing patterns are used in Lamaze preparation, they are slowly paced at a rate of 6-9 breaths/min.

NEW QUESTION: 206

A client is to be discharged from the hospital and is to continue taking warfarin 2.5 mg po bid. Which of the following should be included in her discharge teaching concerning the warfarin therapy?

- A. "If you forget to take your morning dose, double the night time dose."
- B. "You should take aspirin instead of acetaminophen (Tylenol) for headaches."
- C. "Carry a medications alert card with you at all times."
- D. "You should use a straight-edge razor when shaving your arms and legs."

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Warfarin must always be taken exactly as directed. Clients should be instructed never to skip or double up on their dosage. (B) Aspirin decreases platelet aggregation, which would potentiate the effects of the coumadin. (C) Healthcare providers need to be aware of persons on warfarin therapy prior to the initiation of any diagnostic tests and/or surgery to

help prevent bleeding complications. (D) An electric razor should be used to prevent accidental cutting, which can lead to bleeding.

NEW QUESTION: 207

The nurse is teaching a mother care of her child's spica cast. The mother states that he complains of itching under the edge of the cast. One nonpharmacological technique the nurse might suggest would be:

- A. "Blowing air under the cast using a hair dryer on cool setting often relieves itching."
- B. "Slide a ruler under the cast and scratch the area."
- C. "Guide a towel under and through the cast and move it back and forth to relieve the itch."
- D. "Gently thump on cast to dislodge dried skin that causes the itching."

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Cool air will often relieve pruritus without damaging the cast or irritating the skin. (B) The nurse should never force anything under the cast, because the cast may become damaged and skin breakdown may occur.

(C) Forcing an object under the cast could lead to cast damage and skin breakdown. The object may become lodged under the cast necessitating cast removal. (D) This technique does not dislodge skin cells. It could damage the cast and cause skin breakdown.

NEW QUESTION: 208

A six-month-old infant has been admitted to the emergency room with febrile seizures. In the teaching of the parents, the nurse states that:

- A. Sustained temperature elevation over 103F is generally related to febrile seizures
- B. Febrile seizures do not usually recur
- C. There is little risk of neurological deficit and mental retardation as sequelae to febrile seizures
- D. Febrile seizures are associated with diseases of the central nervous system

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) The temperature elevation related to febrile seizures generally exceeds 101F, and seizures occur during the temperature rise rather than after a prolonged elevation. (B) Febrile seizures may recur and are more likely to do so when the first seizure occurs in the 1st year of life. (C) There is little risk of neurological deficit, mental retardation, or altered behavior secondary to febrile seizures. (D) Febrile seizures are associated with disease of the central nervous system.

NEW QUESTION: 209

While the nurse is taking a male client's blood pressure, he makes flirtatious remarks to her. The nurse will handle this effectively if she:

- A. Politely tells the client, "Keep your hands off "

- B. Ignores the remarks and hopes he will not try it again
- C. Confronts the remarks but attempts not to reject the client
- D. Leaves the room in order to compose herself

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) This response does not recognize normal feelings of attraction and rejects the client. (B) By ignoring the situation, the nurse has not set limits to discourage other remarks or perhaps more sexually aggressive behavior. (C) By confronting the remarks, she can recognize that his feelings of attraction may be normal but are not appropriate within the context of their nurse-client relationship. (D) Leaving the room does not deal with setting limits for future interactions.

NEW QUESTION: 210

An 18-month-old child has been playing in the garage. His mother brings him to a nurse's home complaining of his mouth being sore. His lips and mouth are soapy and white, with small ulcerated areas beginning to form. The child begins to vomit. His pulse is rapid and weak. The nurse suspects that the child has:

- A. Inhaled gasoline fumes
- B. Ingested a caustic alkali
- C. Eaten construction chalk
- D. Lead poisoning

Answer: B (LEAVE A REPLY)

(A, C, D) These agents would not cause ulcerations on mouth and lips. (B) Strong alkali or acids will cause burns and ulcerations on the mucous membranes.

NEW QUESTION: 211

A successful executive left her job and became a housewife after her marriage to a plastic surgeon. She started doing volunteer work for a charity organization. She developed pain in her legs that advanced to the point of paralysis. Her physicians can find no organic basis for the paralysis. The client's behavior can be described as:

- A. Housework phobia
- B. Malingering
- C. Conversion reaction
- D. Agoraphobia

Answer: C (LEAVE A REPLY)

(A) A typical phobia does not result in physical symptoms (i.e., paralysis). (B) Malingering is pretending to be ill. This person has a true paralysis. (C) A conversion reaction is a physical expression of an emotional conflict. It has no organic basis. (D) Agoraphobia is fear of public places.

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NEW QUESTION: 212

A young boy tells the nurse, "I don't like my Dad to kiss or hug my Mom. I love my Mom and want to marry her." The nurse recognizes this stage of growth and development as:

- A.** Electra complex
- B.** Oedipus complex
- C.** Superego
- D.** Ego

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

(A) The Electra complex is the erotic attachment of the female child to the father. (B) The Oedipus complex is characterized by jealousy toward the parent of the same sex and erotic attachment to the parent of the opposite sex. (C) The superego as described by Freud is the part of personality that is associated with internalized parental and societal control. (D) The ego as described by Freud is the part of personality that is associated with reality assessment.

NEW QUESTION: 213

In teaching the client about proper umbilical cord care, the nurse recommends that:

- A.** Petrolatum be placed around the cord after the sponge bath
- B.** A belly binder be applied to prevent umbilical hernia
- C.** The area be cleansed at diaper changes with alcohol and inspected for redness or drainage
- D.** The cord clamp be left on until the cord stump separates

Answer: (SHOW ANSWER)

Explanation

(A) Petrolatum does not allow the cord to dry and will encourage infection. (B) Belly binders do not facilitate drying of the cord and will encourage abdominal relaxation. (C) Frequent applications of alcohol will facilitate drying and discourage infection. (D) The cord clamp can be removed in 24 hours. Leaving it on is cumbersome and could pull on the cord unnecessarily.

NEW QUESTION: 214

A client is placed on lithium therapy for her manicdepressive illness. When monitoring the client, the nurse assesses the laboratory blood values. Toxicity may occur with lithium therapy when the blood level is above:

- A. 1.0 mEq/L
- B. 2.2 mEq/L
- C. 0.03 mEq/L
- D. 1.5 mEq/L

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) This value is a low blood level. (B) This value is a toxic blood level. (C) This value is a low blood level.

(D) This value is the level at which most clients are maintained, and toxicity may occur if the level increases.

The client should be monitored closely for symptoms, because some clients become toxic even at this level.

NEW QUESTION: 215

A female client at 37 weeks' gestation has just undergone a nonstress test. The results were two fetal movements with a corresponding increase in fetal heart rate (FHR) of 15 bpm lasting 15 seconds within a 20-minute period. Her results would be classified as:

- A. Non-reactive; no contraction stress test required
- B. Reactive; no contraction stress test required
- C. Reactive; needs follow-up contraction stress test
- D. Non-reactive; needs follow-up contraction stress test

Answer: B ([LEAVE A REPLY](#))

NEW QUESTION: 216

After the RN is finished the initial assessment of a newborn baby and after the initial bonding between the newborn and the mother has taken place in the delivery room, the RN will bring the newborn to the well-baby nursery. Before the newborn is taken from the delivery room and brought to the well-baby nursery, the RN makes sure that which of the following interventions was completed?

- A. The physician verifies the exact time of birth.
- B. The nurse counts the instruments and sponges with the scrub nurse.
- C. The nurse instills prophylactic ointment in the conjunctival sacs of the newborn's eyes.
- D. The nurse makes sure the mother and her newborn have been tagged with identical bands.

Answer: D ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

(A) The delivery room personnel are responsible for verifying time of birth. (B) The scrub and circulating nurses count sponges and instruments. (C) This intervention is done in the nursery. (D) Tagging the mother and infant with identical bands is of utmost importance.

The mother wears one band, and the newborn wears two.

Identical numbers on the three bands provide identification for the newborn and the birth mother. Every time the newborn is brought to the mother after delivery, those bands are checked to be sure that the numbers are identical.

NEW QUESTION: 217

Diagnostic assessment findings for an infant with possible coarctation of the aorta would include:

A. A third heart sound

B. A diastolic murmur

C. Pulse pressure difference between the upper extremities

D. Diminished or absent femoral pulses

Answer: D (LEAVE A REPLY)

(A) S1 and S2 in an infant with coarctation of the aorta are usually normal. S3 and S4 do not exist with this diagnosis. (B) Either no murmur will be heard or a systolic murmur from an associated cardiac defect will be heard along the left upper sternal border. A diastolic murmur is not associated with coarctation of the aorta. (C) Pulse pressure differences of >20 mm Hg exist between the upper extremities and the lower extremities. It is important to evaluate the upper and lower extremities with the appropriate- sized cuffs. (D) Femoral and pedal pulses will be diminished or absent in infants with coarctation of the aorta.

NEW QUESTION: 218

Plans for the care of a client with an ulcer caused by emotional problems need to take into consideration that:

A. His priority needs are limited to medical management

B. There is no real psychological basis for his illness

C. The disorder is a threat to his physical well-being

D. He is unable to participate in planning his care

Answer: C (LEAVE A REPLY)

(A)

There may be a medical emergency that takes top priority; however, the basis of the problem is emotional. (B) The problem is a physical manifestation of an emotional conflict.

(C)

The bleeding ulcer can be life threatening. (D) For lifestyle change to occur, the client must participate in the planning of his care so that he is committed to changes that will have positive results.

NEW QUESTION: 219

Which of the following physician's orders would the nurse question on a client with chronic arterial insufficiency?

- A. Neurovascular checks every 2 hours
- B. Elevate legs on pillows
- C. Arteriogram in the morning
- D. No smoking

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Neurovascular checks are a routine part of assessment with clients having this diagnosis. (B) Elevation of the legs is contraindicated because it reduces blood flow to areas already compromised. (C) Arteriogram is a routine diagnostic order. (D) Smoking is highly correlated with this disorder.

NEW QUESTION: 220

Stat serum electrolytes ordered for a client in acute renal failure revealed a serum potassium level of 6.4.

The physician is immediately notified and orders 50 mL of dextrose and 10 U of regular insulin IV push.

The nurse administering these drugs knows the Rationale for this therapy is to:

- A. Remove the potassium from the body by renin exchange
- B. Protect the myocardium from the effects of hypokalemia
- C. Promote rapid protein catabolism
- D. Drive potassium from the serum back into the cells

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Sodium polystyrene sulfonate (Kayexalate), a cation exchange resin, exchanges sodium ions for potassium ions in the large intestine reducing the serum potassium. (B) Calcium is administered to protect the myocardium from the adverse effects of hyperkalemia. Serum levels reflect hyperkalemia. (C) Rapid catabolism releases potassium from the body tissue into the bloodstream. Infection and hyperthermia increase the process of catabolism. (D) The administration of dextrose and regular insulin IV forces potassium back into the cells decreasing the potassium in the serum.

NEW QUESTION: 221

When providing dietary teaching to an individual who has diabetes mellitus, type II, the nurse discusses the importance of consuming the recommended daily allowance of which of the following electrolytes?

- A. Potassium

- B. Magnesium
- C. Sodium
- D. HCO₃

Answer: B (LEAVE A REPLY)

(A) Potassium intake that meets the recommended daily allowance is important, especially in clients who have a history of cardiac disease. (B) Low levels of magnesium can cause an increase in resistance to insulin and can lead to carbohydrate intolerance. (C) Sodium is an important electrolyte for all clients but has no direct effect on diabetes mellitus. (D) Bicarbonate plays an important role in acid-base balance. It is equally necessary for maintenance of all body functions.

NEW QUESTION: 222

The nurse is preparing a 6-year-old child for an IV insertion. Which one of the following statements by the nurse is appropriate when preparing a child for a potentially painful procedure?

- A. "Some say this feels like a pinch or a bug bite. You tell me what it feels like."
- B. "This is going to hurt a lot; close your eyes and hold my hand."
- C. "This is a terrible procedure, so don't look."
- D. "This will hurt only a little; try to be a big boy."

Answer: A (LEAVE A REPLY)

Section: Questions Set B

Explanation:

(A) Educating the child about the pain may lessen anxiety. The child should be prepared for a potentially painful procedure but avoid suggesting pain. The nurse should allow the child his own sensory perception and evaluation of the procedure. (B) The nurse should avoid absolute descriptive statements and allow the child his own perception of the procedure. (C) The nurse should avoid evaluative statements or descriptions and give the child control in describing his reactions. (D) False statements regarding a painful procedure will cause a loss of trust between the child and the nurse.

NEW QUESTION: 223

The nurse is trying to help a mother understand what is happening with her son who has recently been diagnosed with paranoid schizophrenia. At present, he is experiencing hallucinations and delusions of persecution and suffers from poor hygiene. The nurse can best help her understand her son's condition by which of the following statements?

- A. "Sometimes these symptoms are caused by an overstimulation of a chemical called dopamine in the brain."
- B. "Has anyone in your family ever had schizophrenia?"
- C. "If your son has a twin, he probably will eventually develop schizophrenia, too."
- D. "Some of his symptoms may be a result of his lack of a strong mother-child bonding relationship."

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) The most plausible theory to date is that dopamine causes an overstimulation in the brain, which results in the psychotic symptoms. (B) This statement will only create anxiety in the mother, and the genetic theory is only one of the etiological factors. (C) This statement will cause the mother much alarm, and nothing was mentioned about any other child. (D) The motherchild relationship is one of the previous theories examined, but it is not one to be emphasized, thereby causing a lot of anxiety for the mother.

NEW QUESTION: 224

A 28-year-old client comes to the clinic for her first prenatal examination. In relating her obstetrical history, she tells the nurse that she has been pregnant twice before. She had a "miscarriage" with the first pregnancy after 6 weeks. With the second pregnancy, she delivered twin girls at 31 weeks' gestation. One of the twins was stillborn and the other twin died at 4 days of age. Using a five-digit system, the nurse records her as being:

A. 2-0-2-1-0

B. 2-2-2-1-2

C. 3-0-1-1-0

D. 2-1-1-0-0

Answer: C (LEAVE A REPLY)

(A) The first digit represents the total number of pregnancies. This client has been pregnant 3 times including this pregnancy. The twin pregnancy counts as only one pregnancy, and because she delivered prior to 37 weeks' gestation, the third digit is recorded as 1. (B) The first digit represents the total number of pregnancies. This client has been pregnant 3 times including this pregnancy. The second digit represents the total number of fullterm deliveries; she has lost two pregnancies before 37 weeks' gestation. At present, she has no living children, so the fifth digit is noted as 0. (C) The client is pregnant for the third time, and the first digit reflects the total number of pregnancies. She has had no full-term deliveries, because she delivered prior to 37 gestational weeks, so the second digit is recorded as 0. The third digit represents the number of preterm deliveries, and a twin pregnancy counts as only one delivery. She lost an earlier pregnancy prior to 20 gestational weeks, and the fourth digit reflects spontaneous or elective abortions. Lastly, the fifth digit indicates the number of children currently living, and she has no living children. (D) She is pregnant for the third time, and the first digit reflects the total number of pregnancies. In the previous two pregnancies, she delivered prior to 37 gestational weeks, thus having no full-term deliveries, which is indicated by the second digit. The fourth digit represents the total number of abortions, spontaneous or elective, and she reported a spontaneous abortion with her first pregnancy.

NEW QUESTION: 225

A client's behavior is annoying other clients on the unit. He is meddling with their belongings and dominating the group. The best approach by the nurse is to:

- A. Seclude him in his room.
- B. Set limits on his behavior.
- C. Have his medication increased.
- D. Ignore him and tell the other clients that these behaviors are due to his illness and that they should understand.

Answer: ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) This action by the nurse would be punitive. (B) Consistent limit setting will help the client to know what is acceptable behavior. (C) This action is not within the nurse's scope of practice. (D) This could be dangerous to the client and to others and violates other clients' rights.

NEW QUESTION: 226

At 16 weeks' gestation, a pregnant client is admitted to the maternity unit to have a McDonald procedure (cerclage) done. She tells the RN who is admitting her to the unit that her physician had explained what this procedure was, but that she did not understand. The RN explains to the client that the purpose for this procedure is to:

- A. Reinforce an incompetent cervix
- B. Repair the amniotic sac
- C. Evaluate cephalopelvic disproportion
- D. Dilate the cervix

Answer: ([SHOW ANSWER](#))

Explanation

(A) The treatment most commonly uses the Shirodkar-Barter procedure (McDonald procedure) or cerclage to enforce the weakened cervix by encircling it with a suture at the level of the internal os. (B) There is no known procedure that is used to repair the amniotic sac. (C) Cephalopelvic disproportion is evaluated later in pregnancy. It is not related to this procedure. (D) No procedure is done to dilate the cervix at 16 weeks' gestation unless the pregnancy is to be terminated.

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NEW QUESTION: 227

A physician's order reads: Administer furosemide oral solution 0.5 mL stat. The furosemide bottle dosage is 10 mg/mL. What dosage of furosemide should the nurse give to this infant?

- A. 5 mg
- B. 0.5 mg
- C. 0.05 mg
- D. 20 mg

Answer: A (LEAVE A REPLY)

Section: Questions Set C

Explanation:

(A) 1 mg = 0.1 mL, then 0.5 mL x = 55 mg. (B) This answer is a miscalculation. (C) This answer is a miscalculation. (D) This answer is a miscalculation.

NEW QUESTION: 228

An 11-month-old infant is admitted with a possible diagnosis of pyloric stenosis. Which of the following best describes the characteristic clinical manifestations of pyloric stenosis?

- A. Pain, especially when eating
- B. Poor appetite and sucking reflex
- C. Increased frequency and quantity of stools
- D. Palpable olive-shaped mass in the epigastrium just right of the umbilical cord

Answer: D (LEAVE A REPLY)

(A) There is no evidence of pain in infants with pyloric stenosis whether eating or not. (B) There are both good appetite and feeding habits in these children. (C) Because of regurgitation, there is usually decreased frequency and quantity of stools and also signs of dehydration and weight loss. (D) Along with upper abdominal distention, there is a characteristic palpable olive-shaped mass located to the right of the umbilicus.

NEW QUESTION: 229

The primary reason for sending a burn client home with a pressure garment, such as a Jobst garment, is that the garment:

- A. Decreases hypertrophic scar formation
- B. Assists with ambulation
- C. Covers burn scars and decreases the psychological impact during recovery
- D. Increases venous return and cardiac output by normalizing fluid status

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Tubular support, such as that received with a Jobst garment, applies tension of 10-20 mm Hg. This amount of uniform pressure is necessary to prevent or reduce hypertrophic scarring. Clients typically wear a pressure garment for 6-12 months during the recovery phase of their care. (B) Pressure garments have no ambulatory assistive properties. (C) Pressure garments can worsen the psychological impact of burn injury, especially if worn on the face. (D) Pressure garments do not normalize fluid status.

NEW QUESTION: 230

A child is admitted to the emergency room with her mother. Her mother states that she has been exposed to chickenpox. During the assessment, the nurse would note a characteristic rash:

- A.** That is covered with vesicular scabs all in the macular stage
- B.** That appears profusely on the trunk and sparsely on the extremities
- C.** That first appears on the neck and spreads downward
- D.** That appears especially on the cheeks, which gives a "slapped-cheek" appearance

Answer: [\(SHOW ANSWER\)](#)

Explanation/Reference:

Explanation:

(A) A rash with vesicular scabs in all stages (macule, papule, vesicle, and crusts). (B) A rash that appears profusely on the trunk and sparsely on the extremities. (C) A rash that first appears on the neck and spreads downward is characteristic of rubeola and rubella. (D) A rash, especially on the cheeks, that gives a "slapped-cheek" appearance is characteristic of roseola.

NEW QUESTION: 231

A couple is experiencing difficulties conceiving a baby. The nurse explains basal body temperature (BBT) by instructing the female client to take her temperature:

- A.** Orally in the morning and at bedtime
- B.** Only one time during the day as long as it is always at the same time of day
- C.** Rectally at bedtime
- D.** As soon as she awakens, prior to any activity

Answer: **D** [\(LEAVE A REPLY\)](#)

Explanation/Reference:

Explanation:

(A) Monitoring temperature twice a day predicts the biphasic pattern of ovulation. (B) Prediction of ovulation relies on consistency in taking temperature. (C) Nightly rectal temperatures are more accurate in predicting ovulation. (D) Activity changes the accuracy of basal body temperature and ability to detect the luteinizing hormone surge.

NEW QUESTION: 232

A female client with major depression stated that "life is hopeless and not worth living." The nurse should place highest priority on which of the following questions?

- A. "How has your appetite been recently?"
- B. "Have you thought about hurting yourself?"
- C. "How is your relationship with your husband?"
- D. "How has your depression affected your daily living activities?"

Answer: B (LEAVE A REPLY)

(A) Although eating habits are important to assess, they are less important than suicidal intent. (B) Maintenance of the client's life is the priority; assessment of suicidal intent is imperative. (C) Relationships and support systems are an important part of assessment, but they are less important than suicidal intent. (D) Daily living activities will give additional information about the level of depression, and are less significant than suicidal intent, although this information may give additional information about the actual plan for a suicidal attempt.

NEW QUESTION: 233

An 82-year-old former restaurant owner walks to the nursing station and states, "I have to go. The restaurant opens at 11 am." Which response by the nurse is the most appropriate?

- A. "Go back to your room. You do not own a restaurant."
- B. "You are in the hospital now. Calm down."
- C. "You once owned a restaurant. Tell me about it."
- D. "It is snowing outside. The restaurant is closed."

Answer: C (LEAVE A REPLY)

Explanation

(A) This response cuts off communication with the client. It does not address her feelings. (B) Reality orientation frequently does not work alone. Feelings must be addressed. Telling a client to calm down is frequently ineffective. (C) Reminiscence is used here to reorient and recall past pleasant events. Talking about the restaurant will allay anxiety. (D) This response may confirm to the client that she indeed does still own a restaurant, buying into her confusion. Her feelings and anxiety require nursing intervention.

NEW QUESTION: 234

A 19-month-old child is admitted to the hospital for surgical repair of patent ductus arteriosus. The child is being given digoxin. Prior to administering the medication, the nurse should:

- A. Not give the digoxin if the pulse is 60
- B. Not give the digoxin if the pulse is 100
- C. Take the apical pulse for a full minute
- D. Monitor for visual disturbances, a side effect of digoxin

Answer: C (LEAVE A REPLY)

Explanation

(A) Digoxin should not be given to adults with an apical pulse < 60 bpm. (B) Digoxin should be given to children with an apical pulse > 100 bpm. With a pulse < 100 bpm, the medication should be withheld and the physician notified. (C) Prior to digoxin administration in both children and adults, an apical pulse should be taken for 1 full minute. Aside from the rate per minute, the nurse should note any sudden increase or decrease in heart rate, irregular rhythm, or regularization of a chronic irregular heart rhythm. (D) Early indications of digoxin toxicity, such as visual disturbances, occur rarely as initial signs in children.

NEW QUESTION: 235

A client had a myocardial infarction 5 days ago. His physician has ordered an echocardiogram to determine how his myocardial infarction has affected his ventricular wall motion. When the client asks if this test is painful, an appropriate response is:

- A. "No, but you must be able to ride on a stationary bicycle while the test is being performed."
- B. "No, but you will have to lie still and the gel that is used may be cool."
- C. "Yes, but your physician will be there and will order pain medicine for you."
- D. "Your physician has ordered medicine, which you will be given before you go for the test, which will make you sleepy."

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Riding a stationary bicycle or walking on a treadmill is done during a stress test. (B) During an echocardiogram, the client must lie supine while a technician performs the test. To perform the test, the technician uses a conductive gel and a transducer to obtain ultrasound tracings of the heart. (C) A physician need not be present during an echocardiogram, and it is neither invasive nor painful. (D) There is no premedication required for an echocardiogram.

NEW QUESTION: 236

The physician prescribes amitriptyline (Elavil) for a client. What does the patient need to know about this medication?

- A. Prolonged use of this medication will result in extrapyramidal side effects.
- B. When the medication is effective, he will experience no anxiety.
- C. The medication should relieve his symptoms of depression.
- D. Blood must be drawn weekly to test for toxicity.

Answer: ([SHOW ANSWER](#))

Explanation

(A) Phenothiazines cause extrapyramidal symptoms. (B) No amount of medication can relieve all anxiety in all cases. (C) The purpose of amitriptyline is to relieve the symptoms

of depression because it is an antidepressant. It increases the action of norepinephrine and serotonin on nerve cells. (D) Periodic blood tests are done when lithium is prescribed.

NEW QUESTION: 237

A 68-year-old man was recently diagnosed with endstage renal disease. He has not yet begun dialysis but is experiencing severe anemia with associated symptoms of dyspnea on exertion and chest pain. Which statement best describes the management of anemia in renal failure?

- A.** Hematocrit levels usually remain slightly below normal in clients with renal failure.
- B.** Transfusion is often begun as early as possible to prevent complications of anemia such as dyspnea and angina.
- C.** Anemia in renal failure is frequently caused by low serum iron and ferritin and corrected by oral iron and ferritin replacement therapy.
- D.** The renal secretion of erythropoiesis is decreased. The bone marrow requires erythropoietin to mature red blood cells.

Answer: ([SHOW ANSWER](#))

Explanation

(A) Clients in renal failure typically have very low hematocrits, often in the range of 16-22%. (B) Transfusion is avoided unless the client exhibits acute symptoms such as dyspnea, chest pain, tachycardia, and extreme fatigue. When the client is given a transfusion, the bone marrow adjusts by producing less red blood cells. (C) Anemia in renal failure is caused primarily by decreased erythropoietin. Low serum iron and ferritin may aggravate the anemia and require treatment. (D) Decreased secretion of erythropoietin by the kidney is the primary cause of anemia. The bone marrow requires this hormone to mature red blood cells. Treatment is with replacement therapy.

NEW QUESTION: 238

The nurse is caring for a client who has had a tracheostomy for 7 years. The client is started on a full-strength tube feeding at 75 mL/hr. Prior to starting the tube feeding, the nurse confirms placement of the tube in the stomach. The hospital policy states that all tube feeding must be dyed blue. On suctioning, the nurse notices the sputum to be a blue color. This is indicative of which of the following?

- A.** The client aspirated tube feeding.
- B.** The nurse has placed the suction catheter in the esophagus.
- C.** This is a normal finding.
- D.** The feeding is infusing into the trachea.

Answer: **A** ([LEAVE A REPLY](#))

Section: Questions Set D

Explanation:

(A) Once the feeding tube placement is confirmed in the stomach, aspiration can occur if the client's stomach becomes too full. When suctioning the trachea, if secretions resemble

tube feeding, the client has aspirated the feeding. (B) Because the trachea provides direct access to a client's airway, it would not be possible to place the catheter in the esophagus. (C) Blue-colored sputum is never considered a normal finding and should be reported and documented. (D) The nurse confirmed placement of the feeding tube in the stomach prior to initiating the tube feeding; therefore, it is highly unlikely that the feeding tube would be located in the trachea.

NEW QUESTION: 239

The primary focus of nursing interventions for the child experiencing sickle cell crisis is aimed toward:

- A.** Maintaining an adequate level of hydration
- B.** Providing pain relief
- C.** Preventing infection
- D.** O₂ therapy

Answer: [\(SHOW ANSWER\)](#)

Section: Questions Set D

Explanation:

(A) Maintaining the hydration level is the focus for nursing intervention because dehydration enhances the sickling process. Both oral and parenteral fluids are used. (B) The pain is a result of the sickling process.

Analgesics or narcotics will be used for symptom relief, but the underlying cause of the pain will be resolved with hydration. (C) Serious bacterial infections may result owing to splenic dysfunction. This is true at all times, not just during the acute period of a crisis. (D) O₂ therapy is used for symptomatic relief of the hypoxia resulting from the sickling process. Hydration is the primary intervention to alleviate the dehydration that enhances the sickling process.

NEW QUESTION: 240

Which of the following blood gas parameters primarily reflects respiratory function?

- A.** PCO₂
- B.** CO₂ content of the blood
- C.** HCO₃
- D.** Base excess

Answer: [A \(LEAVE A REPLY\)](#)

Explanation/Reference:

Explanation:

(A) The lungs are responsible for regulation of CO₂, and this parameter primarily reflects respiratory function. (B) CO₂ content of the blood is an indirect measure of respiratory function. (C) HCO₃ is a measure of kidney function only and is important in acid-base balance. (D) Base excess represents the excess of HCO₃ and is not reflective of respiratory function.

NEW QUESTION: 241

A 30-year-old female client is receiving antineoplastic chemotherapy. Which of the following symptoms should especially concern the nurse when caring for her?

- A. Respiratory rate of 16 breaths/min
- B. Pulse rate of 80 bpm
- C. Complaints of muscle aches
- D. A sore throat

Answer: ([SHOW ANSWER](#))

(A) A respiratory rate of 16 breaths/min is normal and is not a cause for alarm. (B) A pulse rate of 80 bpm is normal and is not a cause for alarm. (C) Complaints of muscle aches are unrelated to her receiving chemotherapy. There may be other causes related to her hospital stay or the disease process. (D) A sore throat is an indication of a possible infection. A client receiving chemotherapy is at risk of neutropenia. An infection in the presence of neutropenia can result in a life-threatening situation.

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NEW QUESTION: 242

Following a gastric resection, a 70-year-old client is admitted to the postanesthesia care unit. He was extubated prior to leaving the suite. On arrival at the postanesthesia care unit, the nurse should:

- A. Check airway, feeling for amount of air exchange noting rate, depth, and quality of respirations
- B. Obtain pulse and blood pressure readings noting rate and quality of pulse
- C. Reassure the client that his surgery is over and that he is in the recovery room
- D. Review physician's orders, administering medications as ordered

Answer: A ([LEAVE A REPLY](#))

(A) Adequate air exchange and tissue oxygenation depend on competent respiratory function. Checking the airway is the nurse's priority action. (B) Obtaining the vital signs is an important action, but it is secondary to airway management. (C) Reorienting a client to time, place, and person after surgery is important, but it is secondary to airway and vital signs. (D) Airway management takes precedence over physician's orders unless they specifically relate to airway management.

NEW QUESTION: 243

When a client questions the nurse as to the purpose of exercise electrocardiography (ECG) in the diagnosis of cardiovascular disorders, the nurse's response should be based on the fact that:

- A. The test provides a baseline for further tests
- B. The procedure simulates usual daily activity and myocardial performance
- C. The client can be monitored while cardiac conditioning and heart toning are done
- D. Ischemia can be diagnosed because exercise increases O₂ consumption and demand

Answer: D (LEAVE A REPLY)

(A)

The purpose of the study is not to provide a baseline for further tests. (B) The test causes an increase in O₂ demand beyond that required to perform usual daily activities.

(C)

Monitoring does occur, but the test is not for the purpose of cardiac toning and conditioning. (D) Exercise ECG, or stress testing, is designed to elevate the peripheral and myocardial needs for O₂ to evaluate the ability of the myocardium and coronary arteries to meet the additional demands.

NEW QUESTION: 244

A client with a C-3-4 fracture has just arrived in the emergency room. The primary nursing intervention is:

- A. Stabilization of the cervical spine
- B. Airway assessment and stabilization
- C. Confirmation of spinal cord injury
- D. Normalization of intravascular volume

Answer: B (LEAVE A REPLY)

Section: Questions Set A

Explanation:

(A) If cervical spine injury is suspected, the airway should be maintained using the jaw thrust method that also protects the cervical spine. (B) Primary intervention is protection of the airway and adequate ventilation. (C, D) All other interventions are secondary to adequate ventilation.

NEW QUESTION: 245

The following medications were noted on review of the client's home medication profile. Which of the medications would most likely potentiate or elevate serum digoxin levels?

- A. KCl
- B. Thyroid agents
- C. Quinidine
- D. Theophylline

Answer: C (LEAVE A REPLY)

(A) Hypokalemia can cause digoxin toxicity. Administration of KCl would prevent this. (B) Thyroid agents decrease digoxin levels. (C) Quinidine increases digoxin levels dramatically. (D) Theophylline is not noted to have an effect on digoxin levels.

NEW QUESTION: 246

A 4 year old has an imaginary playmate, which concerns the mother. The nurse's best response would be:

- A. "I understand your concern and will assist you with a referral."
- B. "Try not to worry because you will just upset your child."
- C. "Just ignore the behavior and it should disappear by age 8."
- D. "This is appropriate behavior for a preschooler and should not be a concern."

Answer: D (LEAVE A REPLY)

Explanation

(A) This is normal for a preschooler, and a referral is not appropriate. (B) Telling a parent not to worry is unhelpful. This response does not address the mother's concern. (C) This response is incorrect. The behavior is normal and will usually disappear by the time the child enters school. (D) This behavior is normal development for a preschooler.

NEW QUESTION: 247

The FHR pattern in a laboring client begins to show early decelerations. The nurse would best respond by:

- A. Notifying the physician
- B. Changing the client to the left lateral position
- C. Continuing to monitor the FHR closely
- D. Administering O2 at 8 L/min via face mask

Answer: C (LEAVE A REPLY)

(A) Early decelerations are reassuring and do not warrant notification of the physician. (B) Because early decelerations is a reassuring pattern, it would not be necessary to change the client's position. (C) Early decelerations warrant the continuation of close FHR monitoring to distinguish them from more ominous signs. (D) O2 is not warranted in this situation, but it is warranted in situations involving variable and/or late decelerations.

NEW QUESTION: 248

In teaching the client about proper umbilical cord care, the nurse recommends that:

- A. Petrolatum be placed around the cord after the sponge bath
- B. A belly binder be applied to prevent umbilical hernia
- C. The area be cleansed at diaper changes with alcohol and inspected for redness or drainage
- D. The cord clamp be left on until the cord stump separates

Answer: C (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) Petrolatum does not allow the cord to dry and will encourage infection. (B) Belly binders do not facilitate drying of the cord and will encourage abdominal relaxation. (C) Frequent applications of alcohol will facilitate drying and discourage infection. (D) The cord clamp can be removed in 24 hours. Leaving it on is cumbersome and could pull on the cord unnecessarily.

NEW QUESTION: 249

When teaching a class of nursing students, the nurse asks why the embryonic period (weeks 4-8) of pregnancy is so critical.

- A. Duplication of genetic information takes place.
- B. Organogenesis occurs.
- C. Subcutaneous fat builds up steadily.
- D. Kidneys begin to secrete urine.

Answer: B (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) Duplication of genetic material occurs during the preembryonic period (weeks 1-3) following conception.

The exact duplication of genetic material is essential for cell differentiation, growth, and biological maintenance of the organism. (B) Weeks 4-8, known as the embryonic period, are the time organogenesis occurs and pose the greatest potential for major congenital malformations. All major internal and external organs and systems are formed. (C) Subcutaneous fat does not develop until the latter weeks of gestation. (D) Kidneys begin to secrete urine during the 13th-16th week.

NEW QUESTION: 250

A 79-year-old client with Alzheimer's disease is exhibiting significant memory impairment, cognitive impairment, extremely impaired judgment in social situations, and agitation when placed in a new situation or around unfamiliar people. The nurse should include the following strategy in the client's care:

- A. Maintain routines and usual structure and adhere to schedules.
- B. Encourage the client to attend all structured activities on the unit, whether she wants to or not.
- C. Ask the client to go to an activity once. If she gives no response right away, change the question around, asking the same thing.
- D. Give the client two or three choices to decide what she wants to do.

Answer: A (LEAVE A REPLY)

Explanation

(A) Alzheimer's clients cope poorly with changes in routine because of memory deficits. Schedule changes cause confusion and frustration, whereas adhering to schedules is helpful and supports orientation. (B) Insisting that the client go to all unit activities may antagonize her and increase her agitation because of cognitive impairments. It may be better to allow the client time for calming down or distraction rather than to insist that she attend every activity. (C) When repeating a question, allow time first for a response; then use the same words the second time to avoid further confusion. (D) The nurse should avoid giving several choices at once. Cognitively impaired clients will become more frustrated with making decisions.

NEW QUESTION: 251

A primigravida is at term. The nurse can recognize the second stage of labor by the client's desire to:

- A.** Push during contractions
- B.** Hyperventilate during contractions
- C.** Walk between contractions
- D.** Relax during contractions

Answer: A (LEAVE A REPLY)

Explanation

(A) The second stage of labor is characterized by uterine contractions, which cause the client to bear down.

(B) Slow, deep, rhythmic breathing facilitates the laboring process. Hyperventilation is abnormal breathing resulting from loss of pain control. (C) The client should remain on bed rest during labor. (D) Contractions result in discomfort.

NEW QUESTION: 252

A 64-year-old client is admitted to the hospital with benign prostatic hypertrophy (BPH). He has a history of adult-onset diabetes and hypertension and is scheduled to undergo a resection of the prostate. When recording his health history, the nurse asks about his chief complaint. The most serious symptom that may accompany BPH is:

- A.** Acute urinary retention
- B.** Hesitancy in starting urination
- C.** Increased frequency of urination
- D.** Decreased force of the urinary stream

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Acute urinary retention requires urgent medical attention. If measures such as a warm tub bath or warm tea do not occur after 6 hours, the client should go to the ED for catheterization. (B, C, D) This choice is a symptom of BPH, but it is not serious or life threatening.

NEW QUESTION: 253

Assessment of the client with pericarditis may reveal which of the following?

- A. Ventricular gallop and substernal chest pain
- B. Narrowed pulse pressure and shortness of breath
- C. Pericardial friction rub and pain on deep inspiration
- D. Pericardial tamponade and widened pulse pressure

Answer: C (LEAVE A REPLY)

Explanation

(A) No S3 or S4 are noted with pericarditis. (B) No change in pulse pressure occurs. (C) The symptoms of pericarditis vary with the cause, but they usually include chest pain, dyspnea, tachycardia, rise in temperature, and friction rub caused by fibrin or other deposits. The pain seen with pericarditis typically worsens with deep inspiration. (D) Tamponade is not typically seen early on, and no change in pulse pressure occurs.

NEW QUESTION: 254

A newborn girl's father expresses concern that the newborn does not have good control of her hands and arms. It is important for the father to realize certain neurological patterns that characterize the newborn:

- A. Mild hypotonia is expected in the upper extremities.
- B. Purposeless, uncoordinated movements of the arms are indicative of neurological dysfunction.
- C. Function progresses in a head-to-toe, proximal-distal fashion.
- D. Asymmetrical movement of the extremities is not unusual and will disappear with maturation of the central nervous system.

Answer: C (LEAVE A REPLY)

(A) Term neonates are predominantly in a flexed position with strong active muscle tone that increases. Newborns are slightly hypertonic. (B) Neonatal movements may be jerky and uncoordinated as the neonate works against gravity in contrast to the buoyancy of the amniotic fluid. Jerky movements must be differentiated from the tremors of hypoglycemia, hypocalcemia, and neurological dysfunction. (C) Growth of the newborn progresses in a cephalocaudal, proximal-distal fashion. Knowledge regarding infant development may facilitate parental involvement and infant stimulation. (D) Asymmetrical movements of the extremities are indicative of neurological dysfunction.

NEW QUESTION: 255

A female client admitted to the labor and delivery unit thinks her bag of water "broke" approximately 2 hours ago. She is having mild contractions 5 minutes apart. The most immediate nursing intervention would be to:

- A. Note the color and amount of fluid on her clothes.
- B. Assess the FHR.

C. Notify the physician.

D. Place the nitrazine test paper at the cervical os and note the color change.

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Amniotic fluid is generally pale and straw colored. Meconium- stained amniotic fluid would indicate a previous hypoxic episode. This intervention, though appropriate, is not the immediate priority. (B) With rupture of the membranes, the umbilical cord may prolapse if the presenting part does not fill the pelvis.

Assessing FHR ascertains fetal well-being. (C) More information regarding fetal status and assessing for membrane rupture is needed prior to contacting the physician. (D) Nitrazine test paper differentiates amniotic fluid from urine. Amniotic fluid is normally alkaline in contrast to urine, which is acidic. This intervention, though appropriate, is not the immediate priority.

NEW QUESTION: 256

Respiratory function is altered in a 16-year-old asthmatic. Which of the following is the cause of this alteration?

A. Altered surfactant production

B. Paradoxical movements of the chest wall

C. Increased airway resistance

D. Continuous changes in respiratory rate and depth

Answer: C (LEAVE A REPLY)

Explanation

(A) Altered surfactant production is found in sudden infant death syndrome. (B) Paradoxical breathing occurs when a negative intrathoracic pressure is transmitted to the abdomen by a weakened, poorly functioning diaphragm. (C) Asthma is characterized by spasm and constriction of the airways resulting in increased resistance to airflow. (D) If the pulmonary tree is obstructed for any reason, inspired air has difficulty overcoming the resistance and getting out. The rate of respiration increases in order to compensate, thus increasing air exchange.

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NEW QUESTION: 257

A physician tells the nurse that he wants to orally intubate a client with a No. 8 endotracheal tube. The finding of normal breath sounds on the right side of the chest and diminished, distant breath sounds on the left side of the chest of a newly intubated client is probably due to:

- A. A left hemothorax
- B. A right hemothorax
- C. Intubation of the right mainstem bronchus
- D. An inadequate mechanical ventilator

Answer: C (LEAVE A REPLY)

(A) Although a left hemothorax could cause diminished and distant breath sounds, it is irrelevant to this situation. (B) A right hemothorax will not cause diminished and distant breath sounds on the left side of the chest. (C) The right mainstem bronchus is most frequently intubated in error because the angle of the right mainstem bronchus is very small as compared with that of the left mainstem bronchus. Because ventilation is only occurring on the right side, the nurse would auscultate diminished and distant breath sounds on the left. (D) An inadequate mechanical ventilator has no relationship to this situation.

NEW QUESTION: 258

A 7-year-old girl has been diagnosed with juvenile arthritis and has been placed on daily aspirin. Which statement made by the parent indicates a need for further teaching?

- A. "My daughter takes her aspirin with her meals."
- B. "Her gums have been bleeding frequently. Maybe she is brushing too hard."
- C. "I give her aspirin on a regular schedule every day."
- D. "One sign of aspirin toxicity can be ringing in the ears."

Answer: B (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) Aspirin should not be given on an empty stomach because it is irritating to the mucosa. (B) Bleeding from decreased clotting capacity may be caused by aspirin toxicity. (C) A regular schedule of aspirin administration is important to maintain a satisfactory drug level in the body. (D) Aspirin toxicity may affect cranial nerve VIII, leading to tinnitus (ringing in the ears).

NEW QUESTION: 259

A child is admitted with severe headache, fever, vomiting, photophobia, drowsiness, and stiff neck associated with viral meningitis. She will be more comfortable if the nurse:

- A. Dims the lights in her room
- B. Encourages her to breathe slowly and deeply
- C. Offers sips of warm liquids

D. Places a large, soft pillow under her head

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation:

(A) The discomfort of photophobia is alleviated by dimming the lights. (B) Helping the child to breathe slowly and deeply may help to reduce anxiety, but it will not alleviate other discomforts of viral meningitis. (C) It is important to maintain fluid balance, but sips of warm liquids do not alleviate the discomforts of meningitis. (D) A large, soft pillow under her head causing neck flexion is likely to increase her discomfort owing to stretching of the meninges.

NEW QUESTION: 260

A 67-year-old man had a physical examination prior to beginning volunteer work at the hospital. A routine chest x-ray demonstrated left ventricular hypertrophy. His blood pressure was 180/110. He is 45 lb overweight. His diet is high in sodium and fat. He has a strong family history of hypertension. The client is placed on antihypertensive medication; a low-sodium, low-fat diet; and an exercise regimen. On his next visit, compliance would best be determined by:

- A.** A blood pressure reading of 130/70 with a 5-lb weight loss
- B.** No side effects from antihypertensive medication and an accurate pill count
- C.** No evidence of increased left ventricular hypertrophy on chest x-ray
- D.** Serum blood levels of the antihypertensive medication within therapeutic range

Answer: ([SHOW ANSWER](#))

Explanation

(A) A blood pressure within acceptable range best demonstrates compliance, but weight loss cannot be accomplished without adherence to medication, diet, and exercise. (B) Absence of side effects does not indicate compliance with medication. Pill counts can be misleading because the client can alter pill counts prior to visit. (C) Left ventricular hypertrophy is not an accurate measure of compliance because hypertrophy frequently does not decrease even with pharmacological management. (D) Therapeutic blood levels measure the drug level at the time of the test. There is no indication of compliance several days before testing.

NEW QUESTION: 261

The parents of a 2-year-old child are ready to begin toilet training activities with him. His parents feel he is ready to train because he is now 2 years old. What would the nurse identify as readiness in this child?

- A.** Patience by the child when wearing soiled diapers
- B.** Communicating the urge to defecate or urinate
- C.** The child awakening wet from his naps
- D.** The age at which the child's siblings were trained

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) Children experience impatience with soiled diapers when readiness for training is apparent. They often desire to be changed immediately. (B) A child must be able to use verbal or nonverbal skills to communicate needs. (C) A readiness indicator would be awaking dry from naps. (D) The age at which a sibling was toilet trained has no implications for training this child.

NEW QUESTION: 262

A baby who was diagnosed with pyloric stenosis has continued to have projectile vomiting. With prolonged vomiting, the infant is prone to:

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

Answer: D (LEAVE A REPLY)

Explanation

(A) Respiratory acidosis is the result of problematic ventilation. Plasma pH decreases, while plasma PCO₂ and plasma HCO₃ increase. (B) Respiratory alkalosis results from increased respiratory rate and depth. Plasma pH increases, while plasma PCO₂ and plasma HCO₃ decrease. (C) Metabolic acidosis occurs when there is strong acid gain in the body. Plasma pH, PCO₂, and HCO₃ decrease. (D) Increased risk for metabolic alkalosis is due to a loss of hydrogen ions; depletion of potassium, sodium, and chloride when vomiting occurs. Plasma pH and plasma PCO₂ increase; plasma HCO₃ may decrease and then increase to compensate.

NEW QUESTION: 263

The nurse assesses a client's monitor strip and finds the following: uterine contractions every 3-4 minutes, lasting 60-70 seconds; FHR baseline 134-146 bpm, with accelerations to 158 bpm with fetal movement.

Which nursing intervention is appropriate?

- A.** Notify physician of nonreassuring FHR pattern.
- B.** Turn the client to her left side.
- C.** Start IV for fetal distress and administer O₂ at 6-8 liters by mask.
- D.** Evaluate to see if the monitor strip is reassuring.

Answer: (SHOW ANSWER)

Explanation

(A) These indices are within normal parameters; therefore, the nurse does not need to contact the physician.

(B) The purpose of turning a client to her left side is to maximize uteroplacental blood flow. Based on the above assessment, there is no indication that blood flow is compromised. (C) These interventions are appropriate nursing interventions for late and prolonged decelerations. Following these interventions, the nurse should notify the physician. These indices are within normal parameters; therefore, the nurse does not need to start an IV and administer O₂. (D) Variations of 20 bpm above or below the baseline FHR is considered normal. Normal FHRs range from 120-160 bpm. As the fetus moves, the FHR increases, and accelerations often occur in concert with contractions. During the active phase of labor, the frequency of uterine contractions is every 2-4 minutes, with an appropriate duration of 60 sec.

NEW QUESTION: 264

A client is experiencing visual problems at school. She has complained of difficulty seeing the blackboard and squinting. She no longer likes to participate in physical activities such as softball. The client has displayed possible classic symptoms of which refractive error?

- A. Astigmatism
- B. Hyperopia
- C. Myopia
- D. Amblyopia

Answer: C (LEAVE A REPLY)

Explanation

(A) Visual images are blurred and distorted. (B) Symptoms are headaches, burning eyes, fatigue, squinting, and difficulty reading. (C) These symptoms are classic for myopia. (D) Amblyopia is not a refractive error. It is a loss of vision in one or both eyes.

NEW QUESTION: 265

Which of the following nursing orders has the highest priority for a child with epiglottitis?

- A. Vital signs every shift
- B. Tracheostomy set at bedside
- C. Intake and output
- D. Specific gravity every shift

Answer: B (LEAVE A REPLY)

(A) Because of the possibility of fever or respiratory failure, vital signs should be done more often than every eight hours. (B) If the epiglottitis worsens, the edema and laryngospasm may close the airway and an emergency tracheostomy may be necessary. (C) Although intake and output are a part of the nursing care of a child with epiglottitis, it is not as important as the safety measure of keeping the tracheostomy set at the bedside. (D) Specific gravity will indicate hydration status, but it is not as important as keeping the tracheostomy set at the bedside.

NEW QUESTION: 266

A client decided early in her pregnancy to breast-feed her first baby. She gave birth to a normal, full-term girl and is now progressing toward the establishment of successful lactation. To remove the baby from her breast, she should be instructed to:

- A.** Gently pull the infant away
- B.** Withdraw the breast from the infant's mouth
- C.** Compress the areolar tissue until the infant drops the nipple from her mouth
- D.** Insert a clean finger into the baby's mouth beside the nipple

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) In pulling the infant away from the breast without breaking suction, nipple trauma is likely to occur. (B) In pulling the breast away from the infant without breaking suction, nipple trauma is likely to occur. (C) Compressing the maternal tissue does not break the suction of the infant on the breast and can cause nipple trauma. (D) By inserting a finger into the infant's mouth beside the nipple, the lactating mother can break the suction and the nipple can be removed without trauma.

NEW QUESTION: 267

A client at 9 weeks' gestation comes for an initial prenatal visit. On assessment, the nurse discovers this is her second pregnancy. Her first pregnancy resulted in a spontaneous abortion. She is 28 years old, in good health, and works full-time as an elementary school teacher. This information alerts the nurse to which of the following:

- A.** An increased risk in maternal adaptation to pregnancy
- B.** The need for anticipatory guidance regarding the pregnancy
- C.** The need for teaching regarding family planning
- D.** An increased risk for subsequent abortions

Answer: **B** ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A, D) There are no data to support this. (B) Anticipatory guidance and health maintenance is a first-line defense in the promotion of healthy mothers and healthy babies. (C) There are no data to support this at this time. This will be a concern later.

NEW QUESTION: 268

Early in her ninth month of pregnancy, a client has been diagnosed as having mild preeclampsia. In counseling her about her diet, the nurse must emphasize the importance of:

- A.** Decreasing her sodium intake
- B.** Decreasing her fluids
- C.** Increasing her carbohydrate intake
- D.** Eating a moderate to high-protein diet

Answer: D (LEAVE A REPLY)

(A) Women with pregnancy-induced hypertension have a reduced plasma volume secondary to venous vessel constriction, not hypovolemia; therefore, sodium restriction is not recommended. It is suggested that these women avoid extremely salty foods. (B) Drinking six to eight glasses of water per day facilitates optimal fluid volume and renal perfusion, but it will not decrease the venous vessel constriction of pregnancy-induced hypertension. (C) Carbohydrate needs increase during pregnancy, specifically during the second and third trimesters, but they have not been linked to pregnancy-induced hypertension. (D) Loss of urinary protein (proteinuria) is associated with increased permeability of the large protein molecules with pregnancy-induced hypertension. Additional dietary protein also helps increase the plasma colloidal osmotic pressure. Diets deficient in protein have been linked to pregnancy-induced hypertension.

NEW QUESTION: 269

The nurse enters the room of a client on which a "do not resuscitate" order has been written and discovers that she is not breathing. Once the husband realizes what has occurred he yells, "please save her!" The nurse's action would be:

- A. Call the physician and inform him that the client has expired.
- B. Remind the husband that the physician wrote an order not to resuscitate.
- C. Discuss with the husband that these orders are written only on clients who are not likely to recover with resuscitative efforts.
- D. Call a code and proceed with cardiopulmonary resuscitation.

Answer: D (LEAVE A REPLY)

Explanation

(A, B, C) The last request from the husband overrides the decision not to initiate resuscitation efforts. (D) The nurse should begin cardiopulmonary resuscitation unless a living will and durable power of attorney are in force. In the meantime, the nurse should talk with the husband and notify the doctor.

NEW QUESTION: 270

A term neonate has experienced no distress at birth and has an Apgar score of 9. Her mother has asked to breastfeed her following delivery. Immediately after birth, the neonate was most susceptible to heat loss. The most appropriate intervention to conserve heat loss and promote bonding is to:

- A. Place her under the radiant warmer
- B. Dry her with blankets
- C. Place her to her mother's breast
- D. Place her on a heated pad

Answer: C (LEAVE A REPLY)

(A) A radiant warmer maintains an optimal thermal environment by use of a thermal skin sensor taped to the infant. The warmer limits parental attachment, so, although

appropriate, it is not an intervention that promotes infant attachment. (B) Warmed blankets prevent heat loss in the neonate by conduction. In addition, tactile stimuli promote crying and lung expansion. This intervention does not promote attachment, however. (C) Skin-to-skin contact is an effective way to conserve heat after delivery and promotes parental attachment following birth in the healthy term infant. The first period of reactivity lasts approximately 30 minutes following birth. A strong sucking reflex and an active, awake newborn characterize this period. (D) Surfaces of objects warmer than the infant promote overheating by conduction, and neonatal hyperthermia may result.

NEW QUESTION: 271

A client has been uncomfortable in crowds all her life. After the birth of her child, she has been housebound unless her husband can accompany her to the grocery store and for medical appointments. His schedule will not allow for this, and he has insisted that she must be more independent. Her anxiety has increased to the point of panic. The client has been diagnosed with agoraphobia. Which statement is true about this disorder?

- A. The behavior is not considered disabling.
- B. More men suffer from agoraphobia than women.
- C. The fears are persistent, and avoidance is used as the coping mechanism.
- D. Agoraphobia moves into remission when treated with chlorpromazine.

Answer: ([SHOW ANSWER](#))

Explanation

(A) Agoraphobia is the most pervasive and serious phobic disorder. (B) Women compose 70%-85% of agoraphobia sufferers. (C) Agoraphobia is an acute disorder that immobilizes the sufferer with extreme anxiety. (D) Chlorpromazine is not a drug used to treat phobias.

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NEW QUESTION: 272

Children often experience visual impairments. Refractive errors affect the child's visual activity. The main refractive error seen in children is myopia. The nurse explains to the child's parents that myopia may also be described as:

- A. Cataracts
- B. Farsightedness
- C. Nearsightedness

D. Lazy eye

Answer: C (LEAVE A REPLY)

Explanation

(A) Cataracts are not considered refractive errors. Cataracts can be described as opacity of the lens.

(B) Hyperopia is the term for farsightedness. One can see objects at a distance more clearly than close objects.

(C) Myopia is the term for nearsightedness. Objects that are close in distance are more clearly seen. (D) Lazy eye refers to strabismus or misalignment of the eyes.

NEW QUESTION: 273

A 55-year-old man has recently been diagnosed with hypertension. His physician orders a low-sodium diet for him. When he asks, "What does salt have to do with high blood pressure?" the nurse's initial response would be:

A. "The reason is not known why hypertension is associated with a high-salt diet."

B. "Large amounts of salt in your diet can cause you to retain fluid, which increases your blood pressure."

C. "Salt affects your blood vessels and causes your blood pressure to be high."

D. "Salt is needed to maintain blood pressure, but too much causes hypertension."

Answer: B (LEAVE A REPLY)

(A) This response is untrue. (B) Decreasing salt intake reduces fluid retention and decreases blood pressure. (C) Salt does not have an effect on the blood vessels themselves, but on fluid retention, which accompanies salt intake. (D) This response is untrue.

NEW QUESTION: 274

A 20-year-old male client is being treated for protein deficiency. If he likes all of the following foods, which one would the nurse recommend to increase in the diet?

A. Cantaloupe

B. Rice

C. Chicken

D. Green beans

Answer: C (LEAVE A REPLY)

(A) Cantaloupe is a good source of carbohydrates, vitamin C, and vitamin A.

(B) Rice contains about 4 g of protein per 200 g. (C) Chicken contains 35 g protein per breast. Chicken is a rich source of vitamin B6 (pyridoxine), which is needed for adequate protein synthesis. As protein intake increases, vitamin B6 intake must also be increased. Vitamin B6 is a coenzyme in amino acid metabolism. (D) Green beans only contain 2 g of protein per cup.

NEW QUESTION: 275

A client had abdominal surgery this morning. The nurse notices that there is a small amount of bloody drainage on his surgical dressing. The nurse would document this as what type of drainage?

- A. Serosanguinous
- B. Purulent
- C. Sanguinous
- D. Catarrhal

Answer: ([SHOW ANSWER](#))

Explanation

(A) Drainage from a surgical incision usually proceeds from sanguinous to serosanguinous. (B) Purulent drainage usually indicates infection and should not be seen initially from a surgical incision. (C) Drainage from a surgical incision is initially sanguinous, proceeding to serosanguinous, and then to serous. (D) Catarrhal is a type of exudate seen in upper respiratory infections, not in surgical incisions.

NEW QUESTION: 276

A child is to receive atropine 0.15 mg (1/400 g) as part of his preoperative medication. A vial containing atropine 0.4 mg (1/150 g)/mL is on hand. How much atropine should be given?

- A. 0.06 mL
- B. 0.38 mL
- C. 2.7 mL
- D. Information given insufficient to determine the amount of atropine to be administered

Answer: ([SHOW ANSWER](#))

(A, C) Information was incorrectly placed in the formula, resulting in an incorrect answer.
(B) The answer is correct.

$$0.4 \text{ mg} = 1 \text{ mL}; 0.15 \text{ mg } x = \text{mL}$$

$$0.4 x = 0.15 \text{ } x = 0.15/0.4 \text{ } x = 0.375 \text{ or } 0.38 \text{ mL}$$

(D) Sufficient information is provided to determine the amount of atropine to administer. The amount of atropine available and the amount of atropine ordered is required to determine the amount of atropine to be given.

NEW QUESTION: 277

A 28-year-old client performs a long, involved ritual in getting up and preparing for the day. He became unable to get to his job before noon. His family, in desperation, has admitted him to the hospital's psychiatric unit. On the unit, he is always late for breakfast, which is served at 8 am. The nurse identifies that the best approach to this problem is to:

- A. Allow him to eat late
- B. Suggest that he do the rituals after breakfast
- C. Get him up early so that he can complete the ritual before breakfast
- D. Ask him to get all the other clients up so that he will forget about his ritual

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) Allowing him to eat late is not a solution to the problem because the ritual affects more than just this meal.

(B) He is helpless to change this behavior because the rituals occur as a result of an

irrational effort to control his anxiety. (C) To interfere with the ritual will increase anxiety.

Until the basic problem is resolved, and in turn his need for the ritual relieved, arrange the schedule so that essential activities may be included (such as meals with the group). (D)

This approach would be very disruptive to the other clients and would not serve to relieve the anxiety of the client.

NEW QUESTION: 278

A client has just received an epidural block. She is laboring on her right side. The nurse notes that her blood pressure has dropped from 132/68 to 78/42 mm Hg. The nurse's first action would be to:

A. Call the physician immediately and give dopamine IM

B. Turn her on her left side and recheck her blood pressure in 5 minutes

C. Administer oxytocin (Pitocin) immediately and increase the rate of IV fluids

D. Increase the rate of IV fluids and start O2 by mask

Answer: D ([LEAVE A REPLY](#))

Section: Questions Set E

Explanation:

(A) Nursing measures to support fetal oxygenation and promote maternal blood pressure would precede calling the physician. (B) Systolic pressures below 100 mm Hg or a reduction in the systolic pressure of >30% necessitate treatment. Assessing the blood pressure in 5 minutes may allow for further fetal and/or maternal compromise. Turning the client on her left side will promote uteroplacental perfusion and is appropriate. (C) Oxytocin (Pitocin) increases the strength of uterine contractions and may cause maternal hypotension; thus it is an inappropriate drug for use in this clinical situation. IV fluids would be increased to expand the circulating blood volume and promote increased blood pressure. (D) Turning the mother to her left lateral side promotes uteroplacental perfusion. IV fluids are administered to increase the circulating blood volume, and O2 is administered to promote fetal oxygenation and decrease the nausea accompanying the hypotension.

NEW QUESTION: 279

A 24-year-old client presents to the emergency department protesting "I am God." The nurse identifies this as a:

A. Delusion

B. Illusion

C. Hallucination

D. Conversion

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Delusion is a false belief. (B) Illusion is the misrepresentation of a real, external sensory experience. (C) Hallucination is a false sensory perception involving any of the senses. (D) Conversion is the expression of intrapsychic conflict through sensory or motor manifestations.

NEW QUESTION: 280

During the active phase of rheumatic fever, the nurse teaches parents of a child with acute rheumatic fever to assist in minimizing joint pain and promoting healing by:

- A.** Putting all joints through full range-of-motion twice daily
- B.** Massaging the joints briskly with lotion or liniment after bath
- C.** Immobilizing the joints in functional position using splints, rolls, and pillows
- D.** Applying warm water bottle or heating pads over involved joints

Answer: C ([LEAVE A REPLY](#))

Section: Questions Set G

Explanation

Explanation:

(A) Any movement of the joint causes severe pain. (B) Touching or moving the joint causes severe pain. (C) Immobilization in a functional position allows the joint to rest and heal. (D) Pressure from the warm water bottle or pads can cause severe pain or burning of the skin.

NEW QUESTION: 281

When discussing the relationship between exercise and insulin requirements, a 26-year-old client with IDDM should be instructed that:

- A.** When exercise is increased, insulin needs are increased
- B.** When exercise is increased, insulin needs are decreased
- C.** When exercise is increased, there is no change in insulin needs
- D.** When exercise is decreased, insulin needs are decreased

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) If the client's insulin is increased when activity level is increased, hypoglycemia may result. (B) Exercise decreased the blood sugar by promoting uptake of glucose by the muscles. Consequently, less insulin is needed to metabolize ingested carbohydrates. Extra food may be required for extra activity. (C) This statement directly contradicts the correct answer and is inaccurate. (D) When exercise is decreased, the client's insulin dose does not need to be altered unless the blood sugar becomes unstable.

NEW QUESTION: 282

Medication is administered to a client who has been placed in restraints after a sudden violent episode, and his EPSs subside. Restraints can be removed when:

- A.** The physician orders it
- B.** A therapeutic alliance has been established, and violent behavior subsides
- C.** The violent behavior subsides, and the client agrees to behave
- D.** The nurse deems that removal of restraints is necessary

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set F

Explanation:

(A) The physician may order release of restraints, but prior to that, the client must meet criteria for release. (B) While the client is still restrained, but after violent behavior has subsided, a therapeutic bridge is built. This alliance encourages dialogue between nurse and client, allowing the client to determine causative factors, feelings prior to loss of control, and adaptive alternatives to violence. (C) If the client only "agrees to behave" after violent behavior subsides, he has developed no insight into cause and effect of violence or his response to stress. (D) Removal of restraints occurs only when the client meets the criteria for release, not just because the nurse says it is necessary.

NEW QUESTION: 283

A 27-year-old primigravida stated that she got up from the chair to fix dinner and bright red blood was running down her legs. She denies any pain previously or currently. The client is very concerned about whether her baby will be all right. Her vital signs include P 120 bpm, respirations 26 breaths/min, BP 104/58 mm Hg, temperature 98.2_F, and fetal heart rate 146 bpm. Laboratory findings revealed hemoglobin 9.0 g/dL, hematocrit 26%, and coagulation studies within normal range. On admission, the peripad she wore was noted to be half saturated with bright red blood. A medical diagnosis of placenta previa is made.

The priority nursing diagnosis for this client would be:

- A.** Decreased cardiac output related to excessive bleeding
- B.** Potential for fluid volume excess related to fluid resuscitation
- C.** Anxiety related to threat to self
- D.** Alteration in parenting related to potential fetal injury

Answer: (SHOW ANSWER)

Explanation

(A) Based on the client's history, presence of bright red vaginal bleeding, and hemoglobin value on admission, the priority nursing diagnosis would be decreased cardiac output related to excessive bleeding. (B) This nursing diagnosis is a potential problem that does not exist at the present time, and therefore is not the priority problem. (C) The client's expressed anxiety is for her child. The fetus will remain physiologically safe if the decreased cardiac output is resolved. (D) Initial spontaneous bleeding with placenta previa is rarely life threatening to the mother or the fetus. Delivery of the fetus will be postponed until fetal maturity is achieved and survival is likely.

NEW QUESTION: 284

A 28-year-old multigravida has class II heart disease. At her prenatal visit at 34 weeks' gestation, all of the following observations are made. Which would require intervention?

- A. Weight gain of 2 kg in 4 weeks
- B. Blood pressure of 128/78
- C. Subjective data: shortness of breath after showering
- D. Ankle edema reported present in late afternoon and evenings

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) This is not an excessive weight gain indicative of fluid retention. (B) The blood pressure is within normal range. (C) Showering should not cause shortness of breath. This could be a sign of cardiac decompensation. (D) Dependent ankle edema is normal late in the day among pregnant women.

Progressive edema would be a dangerous development.

NEW QUESTION: 285

A client had a myocardial infarction 5 days ago. His physician has ordered an echocardiogram to determine how his myocardial infarction has affected his ventricular wall motion. When the client asks if this test is painful, an appropriate response is:

- A. "No, but you must be able to ride on a stationary bicycle while the test is being performed."
- B. "No, but you will have to lie still and the gel that is used may be cool."
- C. "Yes, but your physician will be there and will order pain medicine for you."
- D. "Your physician has ordered medicine, which you will be given before you go for the test, which will make you sleepy."

Answer: (SHOW ANSWER)

Explanation

(A) Riding a stationary bicycle or walking on a treadmill is done during a stress test. (B) During an echocardiogram, the client must lie supine while a technician performs the test. To perform the test, the technician uses a conductive gel and a transducer to obtain ultrasound tracings of the heart. (C) A physician need not be present during an echocardiogram, and it is neither invasive nor painful. (D) There is no premedication required for an echocardiogram.

NEW QUESTION: 286

When providing dietary teaching to an individual who has diabetes mellitus, type II, the nurse discusses the importance of consuming the recommended daily allowance of which of the following electrolytes?

- A. Potassium

- B. Magnesium
- C. Sodium
- D. HCO₃

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Potassium intake that meets the recommended daily allowance is important, especially in clients who have a history of cardiac disease. (B) Low levels of magnesium can cause an increase in resistance to insulin and can lead to carbohydrate intolerance. (C) Sodium is an important electrolyte for all clients but has no direct effect on diabetes mellitus. (D) Bicarbonate plays an important role in acid-base balance. It is equally necessary for maintenance of all body functions.

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NEW QUESTION: 287

A 71-year-old client fell and injured her left leg while cooking in the kitchen. Her husband calls the ambulance, and she is taken to the emergency department at a local hospital. X-ray reports confirm that she has an intertrochanteric fracture of the left femur. Her left leg will require skeletal traction initially and then surgery. The nurse knows that this type of traction will be used:

- A. By inserting pins to provide steady pull on the bone
- B. To suspend the leg in a sling without pull on the extremity
- C. Intermittently to place a pull over the pelvis and lower spine
- D. With weights at both ends of the bed to maintain pull on the upper extremity

Answer: A ([LEAVE A REPLY](#))

(A) Skeletal traction is the application of traction directly to bone with the use of pins and wires or tongs for the purpose of providing a strong, steady, continuous longitudinal pull on the bone. It is indicated for preoperative immobilization and positioning of hip and femur fractures. (B) A type of skeletal traction (balanced suspension with a Thomas splint and Pearson attachment) uses a sling to support the extremity, but it also uses weights to provide a strong, steady continuous pull on the extremity. A sling is used instead of pins. (C) Pelvic traction provides an intermittent pull over the pelvis and bone, whereas skeletal traction is continuous. Pelvic traction does not use pins. (D) Skeletal traction uses weights

at the end of the bed to provide a continuous pull on long bones. Weights are not applied to both ends of the bed.

NEW QUESTION: 288

Parents of children receiving chemotherapy should be warned that alopecia is a side effect and that:

- A. Children seldom show concern about losing their hair
- B. The hair will come out gradually, and the loss will not be noticeable for some time
- C. It is best for girls to choose a wig similar to their hair style and color before the hair falls out
- D. The parents will soon get used to seeing their children without hair, and it will no longer bother them

Answer: ([SHOW ANSWER](#))

Explanation

(A) Children may become depressed with a changed appearance and not want to look at themselves or have others see them. (B) The hair will fall out in clumps, causing patchy baldness that is quite noticeable and traumatic to children and their families. (C) Having a wig that looks like a girl's own hair can be a psychological boost to children and is helpful in fostering later adjustments to hair loss. (D) Families may become accustomed to seeing their children without hair, but the loss is traumatic to them and will continue to bother them.

NEW QUESTION: 289

The nurse is developing a plan of care for a client with an electrolyte imbalance and identifies a nursing diagnosis of decreased physical mobility. Which alteration is most likely the etiology?

- A. Hypernatremia
- B. Hypocalcemia
- C. Hypokalemia
- D. Hypomagnesemia

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) A deficit in sodium concentration results in muscular weakness and lethargy. (B) Muscle fatigue and hypotonia are caused by hypercalcemia. (C) Muscle weakness and fatigue are classic signs of hypokalemia. (D) Hypermagnesemia can cause muscle weakness, paralysis, and coma.

NEW QUESTION: 290

The nurse practitioner determines that a client is approximately 9 weeks' gestation. During the visit, the practitioner informs the client about symptoms of physical changes that she will experience during her first trimester, such as:

- A. Nausea and vomiting
- B. Quickening
- C. A 6-8 lb weight gain
- D. Abdominal enlargement

Answer: A (LEAVE A REPLY)

Explanation

(A) Nausea and vomiting are experienced by almost half of all pregnant women during the first 3 months of pregnancy as a result of elevated human chorionic gonadotropin levels and changed carbohydrate metabolism.

(B) Quickening is the mother's perception of fetal movement and generally does not occur until 18-20 weeks after the last menstrual period in primigravidas, but it may occur as early as 16 weeks in multigravidas. (C) During the first trimester there should be only a modest weight gain of 2-4 lb. It is not uncommon for women to lose weight during the first trimester owing to nausea and/or vomiting. (D) Physical changes are not apparent until the second trimester, when the uterus rises out of the pelvis.

NEW QUESTION: 291

A female client admitted to the labor and delivery unit thinks her bag of water "broke" approximately 2 hours ago. She is having mild contractions 5 minutes apart. The most immediate nursing intervention would be to:

- A. Note the color and amount of fluid on her clothes.
- B. Assess the FHR.
- C. Notify the physician.
- D. Place the nitrazine test paper at the cervical os and note the color change.

Answer: B (LEAVE A REPLY)

(A) Amniotic fluid is generally pale and straw colored. Meconium- stained amniotic fluid would indicate a previous hypoxic episode. This intervention, though appropriate, is not the immediate priority. (B) With rupture of the membranes, the umbilical cord may prolapse if the presenting part does not fill the pelvis. Assessing FHR ascertains fetal well-being. (C) More information regarding fetal status and assessing for membrane rupture is needed prior to contacting the physician. (D) Nitrazine test paper differentiates amniotic fluid from urine. Amniotic fluid is normally alkaline in contrast to urine, which is acidic. This intervention, though appropriate, is not the immediate priority.

NEW QUESTION: 292

A client on the infectious disease unit is discussing transmission of human immunodeficiency virus (HIV).

The nurse would need to provide more client education based on which client statement?

- A. "HIV is a virus transmitted by sexual contact."
- B. "Condoms reduce the transmission of HIV."
- C. "HIV is a virus that is easily transmitted by casual contact."
- D. "HIV can be transmitted to an unborn infant."

Answer: ([SHOW ANSWER](#))

(A) HIV is transmitted through unprotected sexual contact. (B) Condoms are an effective barrier to prevent HIV transmission. (C) HIV is not easily transmitted by casual contact. (D) HIV can be transmitted intrauterinely at the time of delivery, and by breast-feeding.

NEW QUESTION: 293

A hyperactive client is experiencing flight of ideas. The most therapeutic activity for him would be:

- A. Doing crafts in occupational therapy
- B. Working a 1000-piece puzzle
- C. Playing bridge with three other clients
- D. Playing basketball in the gym

Answer: D ([LEAVE A REPLY](#))

(A) This activity requires motor skills and therefore would be difficult for a hyperactive client. (B) This activity would take too long, and the client would have difficulty concentrating owing to a limited attention span. (C) This client would not be able to concentrate enough to play card games. He would respond to all the stimuli in the area, become distracted, and leave the table. (D) This activity would allow the client to channel his energy in a positive way.

NEW QUESTION: 294

The nurse is assisting a 4th-day postoperative cholecystectomy client in planning her meals for tomorrow's menu. Which vitamin is the most essential in promoting tissue healing?

- A. Vitamin C
- B. Vitamin B1
- C. Vitamin D
- D. Vitamin A

Answer: ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) Vitamin C (ascorbic acid) is essential in promoting wound healing and collagen formation. (B) Vitamin B1 (thiamine) maintains normal gastrointestinal (GI) functioning, oxidizes carbohydrates, and is essential for normal functioning of nervous tissue. (C) Vitamin D regulates absorption of calcium and phosphorus from the GI tract and helps prevent rickets. (D) Vitamin A is necessary for the formation and maintenance of skin and

mucous membranes. It is also essential for normal growth and development of bones and teeth.

NEW QUESTION: 295

Following a bicycle accident, a 12-year-old client sustained a complete fracture of the left femur. He was placed in 90-90 skeletal traction with a pin in the distal end of the femur to achieve realignment and immobilization of the left femur. When providing nursing care, it is important for the nurse to remember that:

- A.** The nurse may lift only the weights that are applying traction in order to reposition him in bed
- B.** The client will need special skin care at the pin site according to hospital policy or the physician's preference
- C.** The traction pull should result in an immediate increase in comfort and reduce the need for pain medication
- D.** The client should be discouraged from participating in self-care activities to avoid the risk of disrupting the traction

Answer: (SHOW ANSWER)

Explanation

(A) Skeletal traction, including the weights that are applying the traction, is never released by the nurse. (B) It is necessary to keep the pin site clean and free from infection. (C) When first placed in traction, the client may experience increased discomfort as a result of the traction pull fatiguing the muscle. (D) When the child in traction is allowed to participate in his care, it gives him a measure of control and helps him to cope with the situation.

NEW QUESTION: 296

A 52-year-old female client is admitted to the hospital in acute renal failure. She has been on hemodialysis for the past 2 years. Stat arterial blood gases are drawn on the client yielding the following results: pH 7.30, PCO₂ 51 mm Hg, HCO₃, 18 mEq/L, PaO₂, 84 mm Hg. The nurse would interpret these results as:

- A.** Compensated metabolic alkalosis
- B.** Respiratory acidosis
- C.** Partially compensated metabolic alkalosis
- D.** Combined respiratory and metabolic acidosis

Answer: D (LEAVE A REPLY)

Explanation

(A) Compensated metabolic alkalosis would be reflected by the following: pH within normal limit (7.35-7.45), PCO₂ > 45 mm Hg, HCO₃ >26 mEq/L. (B) Respiratory acidosis would be reflected by the following: pH < 7.35, PCO₂ > 45 mm Hg, HCO₃ within normal limits (22-26 mEq/L). (C) Partially compensated metabolic alkalosis would be reflected by the following: pH > 7.45, PCO₂ > 45 mm Hg, HCO₃

> 26 mEq/L. (D) Combined respiratory and metabolic acidosis would be reflected by the following: pH < 7.35, PCO₂ > 45 mm Hg, HCO₃ < 22 mEq/L.

NEW QUESTION: 297

A client has been diagnosed with thrombophlebitis. She asks, "What is the most likely cause of thrombophlebitis during my pregnancy?" The nurse explains:

- A.** Increased levels of the coagulation factors and a decrease in fibrinolysis
- B.** An inadequate production of platelets
- C.** An inadequate intake of folic acid during pregnancy
- D.** An increase in fibrinolysis and a decrease in coagulation factors

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) During pregnancy, the potential for thromboses increases owing to the increased levels of coagulation factors and a decrease in the breakdown of fibrin. (B) An inadequate production of platelets would result in thrombocytopenia with resulting signs and symptoms of bleeding such as petechiae, hematuria, or hematemesis. (C) A deficiency of folic acid during pregnancy produces a megaloblastic anemia. It is usually found in combination with iron deficiency. (D) This combination would result in bleeding disorders because more fibrin would be broken down and fewer clotting factors would be available.

NEW QUESTION: 298

A 35-year-old client is admitted to the hospital with diabetic ketoacidosis. Results of arterial blood gases are pH 7.2, PaO₂ 90, PaCO₂ 45, and HCO₃ 16. The nursing assessment of arterial blood gases indicate the presence of:

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

Answer: D (LEAVE A REPLY)

Explanation

(A) Respiratory alkalosis is determined by elevated pH and low PaCO₂. (B) Respiratory acidosis is determined by low pH and elevated PaCO₂. (C) Metabolic alkalosis is determined by elevated pH and HCO₃. (D) Metabolic acidosis is determined by low pH and HCO₃.

NEW QUESTION: 299

A dose of theophylline may need to be altered if a client with COPD:

- A.** Is allergic to morphine
- B.** Has a history of arthritis
- C.** Operates machinery

D. Is concurrently on cimetidine for ulcers

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The effects of morphine or an allergic response to the drug will not affect theophylline clearance. (B) Xanthines are used cautiously in clients with severe cardiac disease, liver disease, cor pulmonale, hypertension, or hyperthyroidism. Arthritis does not influence the dosage of theophylline. (C) Theophylline does not cause sedation or drowsiness.

Conversely, its side effects may be exhibited by central nervous system stimulation. (D) Cimetidine decreases theophylline clearance from the system and increases theophylline levels in the blood, thus increasing the risk of toxicity.

NEW QUESTION: 300

A male client has been hospitalized with congestive heart failure. Medical management of heart failure focuses on improving myocardial contractility. This can be achieved by administering:

A. Digoxin (Lanoxin) 0.25 mg po every day

B. Furosemide (Lasix) 40 mg po every morning

C. O22 L/min via nasal cannula

D. Nitroglycerin (Nitrol) 1 inch topically every 4 hours

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Digoxin is a cardiac glycoside given to clients in heart failure to improve their myocardial contractility.

(B) Furosemide is a loop diuretic given to clients in heart failure to promote diuresis. (C) O2 is given to clients in heart failure to increase oxygenation and to prevent or treat hypoxemia. (D) Nitroglycerin is a nitrate given to clients in heart failure to increase their cardiac output by decreasing the peripheral resistance that the left ventricle must pump against.

NEW QUESTION: 301

The nurse would assess the client's correct understanding of the fertility awareness methods that enhance conception, if the client stated that:

A. "My sexual partner and I should have intercourse when my cervical mucosa is thick and cloudy."

B. "At ovulation, my basal body temperature should rise about 0.5F."

C. "I should douche immediately after intercourse."

D. "My sexual partner and I should have sexual intercourse on day 14 of my cycle regardless of the length of the cycle."

Answer: B (LEAVE A REPLY)

(A)

At ovulation, the cervical mucus is increased, stretchable, and watery clear. (B) Under the influence of progesterone, the basal body temperature increases slightly after ovulation.

(C)

To enhance fertility, measures should be taken that promote retention of sperm rather than removal. (D) Ovulation, the optimal time for conception, occurs 14+2 days before the next menses; therefore, the date of ovulation is directly related to the length of the menstrual cycle.

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NEW QUESTION: 302

Prenatal clients are routinely monitored for early signs of pregnancy-induced hypertension (PIH). For the prenatal client, which of the following blood pressure changes from baseline would be most significant for the nurse to report as indicative of PIH?

A. 136/88 to 144/93

B. 132/78 to 124/76

C. 114/70 to 140/88

D. 140/90 to 148/98

Answer: C (LEAVE A REPLY)

Explanation

(A) These blood pressure changes reflect only an 8 mm Hg systolic and a 5 mm Hg diastolic increase, which is insufficient for blood pressure changes indicating PIH. (B) These blood pressure changes reflect a decrease in systolic pressure of 8 mm Hg and diastolic pressure of 2 mm Hg; these values are not indicative of blood pressure increases reflecting PIH. (C) The definition of PIH is an increase in systolic blood pressure of 30 mm Hg and/or diastolic blood pressure of 15 mm Hg. These blood pressures reflect a change of 26 mm Hg systolically and 18 mm Hg diastolically. (D) These blood pressures reflect a change of only 8 mm Hg systolically and 8 mm Hg diastolically, which is insufficient for blood pressure changes indicating PIH.

NEW QUESTION: 303

A client has developed congestive heart failure secondary to his myocardial infarction. Discharge diet instructions should emphasize the reduction or avoidance of:

- A. Fresh vegetables and fruit
- B. Canned vegetables and fruit
- C. Breads, cereals, and rice
- D. Fish

Answer: B ([LEAVE A REPLY](#))

(A) Fresh vegetables and fruits are excellent sources of essential vitamins. (B) Canned and frozen foods have a high sodium content. Labels of all canned foods should be read to determine if sodium is used in any form. (C) Bread, cereal, and rice are excellent sources of carbohydrates. (D) Fish is an excellent source of protein.

NEW QUESTION: 304

A child is admitted with severe headache, fever, vomiting, photophobia, drowsiness, and stiff neck associated with viral meningitis. She will be more comfortable if the nurse:

- A. Dims the lights in her room
- B. Encourages her to breathe slowly and deeply
- C. Offers sips of warm liquids
- D. Places a large, soft pillow under her head

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) The discomfort of photophobia is alleviated by dimming the lights. (B) Helping the child to breathe slowly and deeply may help to reduce anxiety, but it will not alleviate other discomforts of viral meningitis.

(C) It is important to maintain fluid balance, but sips of warm liquids do not alleviate the discomforts of meningitis. (D) A large, soft pillow under her head causing neck flexion is likely to increase her discomfort owing to stretching of the meninges.

NEW QUESTION: 305

A 15-year-old female adolescent is frequently breaking the rules of the unit. She has left the unit and was found smoking in the bathroom and spending a large amount of time in the male ward. Which statement by the nurse would best explain to the teenager why she must follow the rules of the unit?

- A. "It is not easy, but the rules must be followed so that everyone can get a fair chance."
- B. "If you do not follow the rules, you will be transferred to the closed, locked unit."
- C. "You are not being fair to the other clients by getting them involved in your deviant behavior."
- D. "Break the rules, all you want, but don't get caught again!"

Answer: ([SHOW ANSWER](#))

(A) This statement acknowledges that it is difficult but is not threatening or punitive. (B) This statement is threatening and describes specific punishment for further deviant

behavior. (C) This response elicits shame by blaming her for involving others. (D) This response gives her permission to break the rules but indicates that getting caught is wrong.

NEW QUESTION: 306

Prior to administering digoxin to a client with congestive heart failure, the nurse needs to assess:

- A. Respiratory rate for 1 minute
- B. Radial pulse for 1 minute
- C. Radial pulse for 2 minutes
- D. Apical pulse for 1 minute

Answer: [\(SHOW ANSWER\)](#)

(A) Respiratory rate is not directly affected by digoxin therapy. (B) A radial pulse is not as accurate as an apical pulse. Dysrhythmias may not be detected. (C) A radial pulse is not as accurate as an apical pulse, regardless of assessment time. (D) Apical pulse should be measured for 1-minute prior to digoxin administration. Digoxin decreases the heart rate. Digoxin should be withheld if apical rates are <60 bpm or >120 bpm.

NEW QUESTION: 307

A laboratory technique specific for diagnosing Lyme disease is:

- A. Polymerase chain reaction
- B. Heterophil antibody test
- C. Decreased serum calcium level
- D. Increased serum potassium level

Answer: [A \(LEAVE A REPLY\)](#)

(A) Polymerase chain reaction is the laboratory technique specific for Lyme disease. (B) Heterophil antibody test is used to diagnose mononucleosis. (C) Lyme disease does not decrease the serum calcium level. (D) Lyme disease does not increase the serum potassium level.

NEW QUESTION: 308

Primary nursing diagnoses for the antisocial client are:

- A. Alteration in perception and altered self-concept
- B. Impaired social interaction, ineffective individual coping, and altered self-concept
- C. Altered communication processes and altered recreational patterns
- D. Altered body image and altered thought processes

Answer: [B \(LEAVE A REPLY\)](#)

(A)

This answer is incorrect. Perception is not altered because the client is not psychotic.

(B)

This answer is correct. The antisocial client lacks responsibility, accountability, and social commitment; has impaired problem-solving ability; tends to overuse defense mechanisms;

lies and steals; and is often grandiose concerning self. (C) This answer is incorrect. Altered communication processes do not characterize this client. The antisocial person communicates well and tends to have a charming personality. (D) This answer is incorrect. Altered thought processes refer to delusional thinking, which is bizarre and fixed, and do not characterize this client.

NEW QUESTION: 309

The most commonly known vectors of Lyme disease are:

- A.** Mites
- B.** Fleas
- C.** Ticks
- D.** Mosquitoes

Answer: [\(SHOW ANSWER\)](#)

(A) Mites are not the common vector of Lyme disease. (B) Fleas are not the common vector of Lyme disease. (C) Ticks are the common vector of Lyme disease. (D) Mosquitoes are not the common vector of Lyme disease.

NEW QUESTION: 310

Discharge teaching was effective if the parents of a child with atopic dermatitis could state the importance of:

- A.** Maintaining a high-humidified environment
- B.** Furry, soft stuffed animals for play
- C.** Showering 3-4 times a day
- D.** Wrapping hands in soft cotton gloves

Answer: **D** [\(LEAVE A REPLY\)](#)

Explanation

(A) Maintaining a low-humidified environment. (B) Avoiding furry, soft stuffed animals for play, which may increase symptoms of allergy. (C) Avoiding showering, which irritates the dermatitis, and encouraging bathing 4 times a day in colloid bath for temporary relief. (D) Wrapping hands in soft cotton gloves to prevent skin damage during scratching.

NEW QUESTION: 311

One week ago, a 21-year-old client with a diagnosis of bipolar disorder was started on lithium 300 mg po qid.

A lithium level is ordered. The client's level is 1.3 mEq/L. The nurse recognizes that this level is considered to be:

- A.** Within therapeutic range
- B.** Below therapeutic range
- C.** Above therapeutic range
- D.** At a level of toxic poisoning

Answer: A ([LEAVE A REPLY](#))

Explanation

- (A) This answer is correct. The therapeutic range is 1.0-1.5 mEq/L in the acute phase. Maintenance control levels are 0.6-1.2 mEq/L. (B, C) This answer is incorrect. A level of 1.3 mEq/L is within therapeutic range.
- (D) This answer is incorrect. Toxic poisoning is usually at the 2.0 level or higher.

NEW QUESTION: 312

Provide the 1-minute Apgar score for an infant born with the following findings: Heart rate: Above 100 Respiratory effort: Slow, irregular Muscle tone: Some flexion of extremities Reflex irritability: Vigorous cry Color: Body pink, blue extremities

- A. 7**
- B. 10**
- C. 8**
- D. 9**

Answer: ([SHOW ANSWER](#))

(A)

Seven out of a possible perfect score of 10 is correct. Two points are given for heart rate above 100; 1 point is given for slow, irregular respiratory effort; 1 point is given for some flexion of extremities in assessing muscle tone; 2 points are given for vigorous cry in assessing reflex irritability; 1 point is assessed for color when the body is pink with blue extremities (acrocyanosis). (B) For a perfect Apgar score of 10, the infant would have a heart rate over 100 but would also have a good cry, active motion, and be completely pink.

(C)

For an Apgar score of 8 the respiratory rate, muscle tone, or color would need to fall into the 2-point rather than the 1-point category. (D) For this infant to receive an Apgar score of 9, four of the areas evaluated would need ratings of 2 points and one area, a rating of 1 point.

NEW QUESTION: 313

A client has consented to have a central venous catheter placed. The best position in which to place the client is the Trendelenburg position. The reason is that the Trendelenburg position:

- A. Allows the physician to visualize the subclavian vein**
- B. Reduces the possibility of air embolism**
- C. Reduces the possibility of hematoma formation**
- D. Makes the procedure more comfortable for the client**

Answer: B ([LEAVE A REPLY](#))

Explanation

- (A) The subclavian vein is not visible during central line insertion regardless of the client's position. (B) The Trendelenburg position reduces the possibility of air embolism because it

places slight positive pressure on the central veins. It also distends the veins, and distention facilitates insertion. (C) This response is untrue; it has no effect on hematoma formation. (D) This position is not necessarily more comfortable for the client, and many clients, especially those who may be short of breath, may find the position uncomfortable and difficult to maintain.

NEW QUESTION: 314

A client has received preoperative teaching for the vertical partial laryngectomy that he is scheduled to have in the morning. The nurse determines that the teaching has been effective when the client states:

- A. "I know I will need special swallowing training after my surgery."
- B. "The quality of my voice will be excellent after surgery."
- C. "I will have very little difficulty swallowing after surgery."
- D. "I may also have to have a radical neck dissection done."

Answer: [\(SHOW ANSWER\)](#)

(A) A client with a supraglottic (horizontal partial) laryngectomy would require special swallowing training, not a vertical partial laryngectomy. (B) The quality of the client's voice will be altered but adequate for communication. (C) The client will have minimal difficulty swallowing. (D) A radical neck dissection may be done with a total laryngectomy, but not with a partial laryngectomy.

NEW QUESTION: 315

A 55-year-old client is unconscious, and his physician has decided to begin tube feeding him using a smallbore silicone feeding tube (Keofeed, Duo-Tube). After the tube is inserted, the nurse identifies the most reliable way to confirm appropriate placement is to:

- A. Aspirate gastric contents
- B. Auscultate air insufflated through the tube
- C. Obtain a chest x-ray
- D. Place the tip of the tube under water and observe for air bubbles

Answer: [C \(LEAVE A REPLY\)](#)

Explanation

(A) Aspiration of gastric contents is usually a reliable way to verify tube placement. However, if the client has dark respiratory secretions from bleeding, tube feedings could be mistaken for respiratory secretions; in other words, aspirating an empty stomach is less reliable in this instance. In addition, it is common for small-bore feeding tubes to collapse when suction pressure is applied. (B) Insufflation of air into large-bore nasogastric tubes can usually be clearly heard. In small-bore tubes, it is more difficult to hear air, and it is difficult to distinguish between air in the stomach and air in the esophagus. (C) A chest x-ray is the most reliable means to determine placement of small-bore nasogastric tubes. (D) Observing for air bubbles when the tip is held under water is an unreliable means to determine correct tube placement for all types of nasogastric tubes. Air may come from

both the respiratory tract and the stomach, and the client who is breathing shallowly may not force air out of the tube into the water.

NEW QUESTION: 316

One of the most reliable assessment tools for adequacy of fluid resuscitation in burned children is:

- A. Blood pressure
- B. Level of consciousness
- C. Skin turgor
- D. Fluid intake

Answer: B (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) Blood pressure can remain normotensive in a state of hypovolemia. (B) Capillary refill, alterations in sensorium, and urine output are the most reliable indicators for assessing hydration. (C) Skin turgor is not a reliable indicator for assessing hydration in a burn client. (D) Fluid intake does not indicate adequacy of fluid resuscitation in a burn client.

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NEW QUESTION: 317

A 30-year-old male client is admitted to the psychiatric unit with a diagnosis of bipolar disorder. For the last 2 months, his family describes him as being "on the move," sleeping 3-4 hours nightly, spending lots of money, and losing approximately 10 lb. During the initial assessment with the client, the nurse would expect him to exhibit which of the following?

- A. Short, polite responses to interview questions
- B. Introspection related to his present situation
- C. Exaggerated self-importance
- D. Feelings of helplessness and hopelessness

Answer: C (LEAVE A REPLY)

(A)

During the manic phase of bipolar disorder, clients have short attention spans and may be abusive toward authority figures. (B) Introspection requires focusing and concentration; clients with mania experience flight of ideas, which prevents concentration.

(C)

Grandiosity and an inflated sense of self-worth are characteristic of this disorder. (D) Feelings of helplessness and hopelessness are symptoms of the depressive stage of bipolar disorder.

NEW QUESTION: 318

A client has been admitted to the nursing unit with the diagnosis of severe anemia. She is slightly short of breath, has episodes of dizziness, and complains her heart sometimes feels like it will "beat out of her chest." The physician has ordered her to receive 2 U of packed red blood cells. The most important nursing action to be taken is:

- A. Starting an 18-gauge IV infusion
- B. Having the consent form on the chart
- C. Administering the correct blood product to the correct client
- D. Transfusing the blood in a 2-hour time frame

Answer: C ([LEAVE A REPLY](#))

(A) An 18-gauge IV is an appropriate size for administering blood; however, client safety demands that the right blood product must be administered. (B) The consent form is legally necessary to be on the chart, but client safety is maintained by giving the correct blood component to the correct client. (C) Administering the correct blood product to the correct client will maintain physiological safety and minimize transfusion reactions. (D) The blood administration should take place over the ordered time frame designated by the physician.

NEW QUESTION: 319

A female client is anticipating a visit with her parents over the Thanksgiving holidays. She has recently begun experiencing periods of extreme shortness of breath, which her physician has labeled as panic attacks. Which of the following statements by the nurse would enhance therapeutic communication?

- A. "Why do you feel this way?"
- B. "Tell me about your dislike for your parents."
- C. "Don't worry, everything will be all right on your visit with your parents."
- D. "Perhaps you and I can discover what produces your anxiety."

Answer: (SHOW ANSWER)

(A) Asking the client to provide an explanation for her feelings is often intimidating. (B) This response is probing and may make the client feel used and valued only for the information she can provide. (C) This underrates the client's feelings and belittles her concerns. It may cause the client to stop sharing feelings for fear that they will be ridiculed. (D) The emphasis is on working with the client. It shows that there is hope for change through collaboration.

NEW QUESTION: 320

The nurse is caring for a 2-year-old girl with a subdural hematoma of the temporal area as a result of falling out of bed and notices that she has a runny nose. The nurse should:

- A. Call the doctor immediately
- B. Help her to blow her nose carefully
- C. Test the discharge for sugar
- D. Turn her to her side

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) The nasal discharge could be due to a cold. It is necessary to gather additional assessment data to identify a possible cerebrospinal fluid leak. (B) If the discharge is cerebrospinal fluid, it would not be safe to encourage the girl to blow her nose. (C) Cerebrospinal fluid is positive for sugar; mucus is not. (D) Turning her to her side will have no effect on her "runny nose." It is necessary to gather further assessment data.

NEW QUESTION: 321

Prior to his discharge from the hospital, a cardiac client is started on digoxin (Lanoxin) 25 mg po qd. The nurse initiates discharge teaching. Which of the following statements by the client would validate an understanding of his medication?

- A. "I would notify my physician immediately if I experience nausea, vomiting, and double vision."
- B. "I could stop taking this medication when I begin to feel better."
- C. "I should only take the medication if my heart rate is greater than 100 bpm."
- D. "I should always take this medication with an antacid."

Answer: A ([LEAVE A REPLY](#))

(A) The first signs of digoxin toxicity include abdominal pain, anorexia, nausea, vomiting, and visual disturbances. The physician should be notified if any of these symptoms are experienced. (B) The positive inotropic effects of digoxin increase cardiac output and result in an enhanced activity tolerance. "Feeling better" indicates the drug is working and medication therapy must be continued. (C) Clients should be taught to take their pulse prior to taking the digoxin. If their pulse rate becomes irregular, slows significantly, or is >100 bpm the physician should be notified. (D) Antacids decrease the effectiveness of digoxin.

NEW QUESTION: 322

After a liver biopsy, the best position for the client is:

- A. High Fowler
- B. Prone
- C. Supine
- D. Right lateral

Answer: ([SHOW ANSWER](#))

Explanation

(A) This position does not help to prevent bleeding. (B) This position does not help to prevent bleeding. (C) This position does not help to prevent bleeding. (D) The right lateral position would allow pressure on the liver to prevent bleeding.

NEW QUESTION: 323

A schizophrenic is admitted to the psychiatric unit. What affect would the nurse expect to observe?

- A. Anger
- B. Apathy and flatness
- C. Smiling
- D. Hostility

Answer: B ([LEAVE A REPLY](#))

(A) Anger is an emotion that is not necessarily present in schizophrenia. (B) Lack of response to or involvement with environment and distancing are characteristic of schizophrenia. (C) Euphoria is more characteristic of manic-depressive disorder (bipolar disorder). (D) Hostility is an emotion that is not necessarily present in schizophrenia.

NEW QUESTION: 324

An 80-year-old widow is living with her son and daughter-in-law. The home health nurse has been making weekly visits to draw blood for a prothrombin time test. The client is taking 5 mg of coumadin per day. She appears more debilitated, and bruises are noted on her face. Elder abuse is suspected. Which of the following are signs of persons who are at risk for abusing an elderly person?

- A. A family member who is having marital problems and is regularly abusing alcohol
- B. A person with adequate communication and coping skills who is employed by the family
- C. A friend of the family who wants to help but is minimally competent
- D. A lifelong friend of the client who is often confused

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) This answer is correct. Two risk factors are identified in this answer. (B) This answer is incorrect. Persons at risk tend to lack communication skills and effective coping patterns. (C) This answer is incorrect. Persons at risk are usually family members or those reluctant to provide care. (D) This answer is incorrect. This individual has a vested interest in providing care.

NEW QUESTION: 325

Children often experience visual impairments. Refractive errors affect the child's visual activity. The main refractive error seen in children is myopia. The nurse explains to the child's parents that myopia may also be described as:

- A. Cataracts
- B. Farsightedness
- C. Nearsightedness
- D. Lazy eye

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Cataracts are not considered refractive errors. Cataracts can be described as opacity of the lens. (B) Hyperopia is the term for farsightedness. One can see objects at a distance more clearly than close objects.

(C) Myopia is the term for nearsightedness. Objects that are close in distance are more clearly seen. (D) Lazy eye refers to strabismus or misalignment of the eyes.

NEW QUESTION: 326

A mother brings her 3-year-old child who is unconscious but breathing to the ER with an apparent drug overdose. The mother found an empty bottle of aspirin next to her child in the bathroom. Which nursing action is the most appropriate?

- A. Put in a nasogastric tube and lavage the child's stomach.
- B. Monitor muscular status.
- C. Teach mother poison prevention techniques.
- D. Place child on respiratory assistance.

Answer: A (LEAVE A REPLY)

Explanation

(A) The immediate treatment for drug overdose is removal of the drug from the stomach by either forced emesis or gastric lavage. The child's unconscious state prohibits forced emesis. (B) Toxic amounts of salicylates directly affect the respiratory system, which could lead to respiratory failure. (C) The mother's anxiety is probably so high that preventive guidance will be ineffective. (D) Respiratory assistance is not needed if the child's respiratory function is unaltered.

NEW QUESTION: 327

A male client is undergoing cardiac tests. He has been instructed to wear a Holter monitor. The nurse knows she has included the appropriate information in her teaching when the client tells her:

- A. "He should remove the electrodes for bathing."
- B. "Damage to his heart muscle will be recorded by the monitor."
- C. "He is to keep a record of everything he does during the day."
- D. "He is to refrain from activities that cause chest pain."

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The client should leave the electrodes in place during the entire time the test is ordered. He should not even remove the electrodes for bathing. (B) The Holter monitor will record cardiac electrical activity but will not record damage to his myocardium. (C) The client should keep a record of all of his activities so the physician can correlate the ECG findings with his activities. (D) The client should continue doing his regular activities. The purpose of the Holter monitor is to record heart activity during routine activities.

NEW QUESTION: 328

A 79-year-old client with Alzheimer's disease is exhibiting significant memory impairment, cognitive impairment, extremely impaired judgment in social situations, and agitation when placed in a new situation or around unfamiliar people. The nurse should include the following strategy in the client's care:

- A.** Maintain routines and usual structure and adhere to schedules.
- B.** Encourage the client to attend all structured activities on the unit, whether she wants to or not.
- C.** Ask the client to go to an activity once. If she gives no response right away, change the question around, asking the same thing.
- D.** Give the client two or three choices to decide what she wants to do.

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Alzheimer's clients cope poorly with changes in routine because of memory deficits. Schedule changes cause confusion and frustration, whereas adhering to schedules is helpful and supports orientation. (B) Insisting that the client go to all unit activities may antagonize her and increase her agitation because of cognitive impairments. It may be better to allow the client time for calming down or distraction rather than to insist that she attend every activity. (C) When repeating a question, allow time first for a response; then use the same words the second time to avoid further confusion. (D) The nurse should avoid giving several choices at once. Cognitively impaired clients will become more frustrated with making decisions.

NEW QUESTION: 329

A client who has been diagnosed with anorexia nervosa refuses to eat lunch. The most therapeutic response by the nurse to her refusal is:

- A.** "Okay, missing one meal won't hurt."
- B.** "You'll have to eat lunch, or we'll force-feed you."
- C.** "It's not appropriate for you to try to manipulate the staff into granting your wishes."
- D.** "We will not allow you to starve yourself. You may choose to eat voluntarily or be fed."

Answer: D (LEAVE A REPLY)

Explanation

(A) This response reinforces the client's maladaptive behavior, thereby contributing to the client's risk. (B) Ultimatums are not therapeutic. (C) This comment invites an argument because it puts the client on the defensive and stabs at her self-esteem, which is already compromised. (D) Setting limits assures the client that staff has genuine concern for her safety and well-being. Giving her an actual choice will give the client an increased sense of control over her life and avoid an argument or power struggle.

NEW QUESTION: 330

A successful executive left her job and became a housewife after her marriage to a plastic surgeon. She started doing volunteer work for a charity organization. She developed pain in her legs that advanced to the point of paralysis. Her physicians can find no organic basis for the paralysis. The client's behavior can be described as:

- A. Housework phobia
- B. Malingering
- C. Conversion reaction
- D. Agoraphobia

Answer: C (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) A typical phobia does not result in physical symptoms (i.e., paralysis). (B) Malingering is pretending to be ill.

This person has a true paralysis. (C) A conversion reaction is a physical expression of an emotional conflict. It has no organic basis. (D) Agoraphobia is fear of public places.

NEW QUESTION: 331

Which of the following procedures is necessary to establish a definitive diagnosis of breast cancer?

- A. Diaphanography
- B. Mammography
- C. Thermography
- D. Breast tissue biopsy

Answer: D (LEAVE A REPLY)

Explanation

(A) Diaphanography, also known as transillumination, is a painless, noninvasive imaging technique that involves shining a light source through the breast tissue to visualize the interior. It must be used in conjunction with a mammogram and physical examination. (B) Mammography is a useful tool for screening but is not considered a means of diagnosing breast cancers. (C) Thermography is a pictorial representation of heat patterns on the surface of the breast. Breast cancers appear as a "hot spot" owing to their higher metabolic rate.

(D) Biopsy either by needle aspiration or by surgical incision is the primary diagnostic technique for confirming the presence of cancer cells.

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NEW QUESTION: 332

A 19-year-old client has sustained a C-7 fracture, which resulted in his spinal cord being partially transected. By 2 weeks' postinjury, his neck has been surgically stabilized, and he has been transferred from the intensive care unit. A potential life-threatening complication the nurse monitors the client for is:

- A. Autonomic dysreflexia
- B. Bradycardia
- C. Central cord syndrome
- D. Spinal shock

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Autonomic dysreflexia is the exaggerated sympathetic nervous system response to various stimuli in the anesthetized area. Sympathetic stimulation results in severe, uncontrolled hypertension, which may result in myocardial infarction or cerebral hemorrhage. (B) Bradycardia occurs as a result of sympathetic blockade in the immediate postinjury period. After spinal shock recedes, cardiovascular stability returns, but the client will be bradycardiac for life. (C) Central cord syndrome is a specific type of spinal cord injury that occurs as a result of either hyperextension injuries or disrupted blood flow to the spinal cord. (D) Spinal shock occurs in the immediate postinjury phase and usually resolves in approximately 72 hours.

NEW QUESTION: 333

A primipara is assessed on arrival to the postpartum unit. The nurse finds her uterus to be boggy. The nurse's first action should be to:

- A. Call the physician
- B. Assess her vital signs
- C. Give the prescribed oxytocic drug
- D. Massage her fundus

Answer: (SHOW ANSWER)

Explanation

(A) The nurse should first implement independent and dependent measures to achieve uterine tone before calling the physician. (B) Assessment of vital signs will not help to restore uterine atony, which is the priority need. (C) Giving a prescribed oxytocic drug would be necessary if the uterus did not maintain tone with massage. (D) Fundal massage generally restores uterine tone within a few moments and should be attempted first.

NEW QUESTION: 334

A client is taught to eat foods high in potassium. Which food choices would indicate that this teaching has been successful?

- A. Pork chop, baked acorn squash, brussel sprouts
- B. Chicken breast, rice, and green beans
- C. Roast beef, baked potato, and diced carrots
- D. Tuna casserole, noodles, and spinach

Answer: A (LEAVE A REPLY)

(A) Both acorn squash and brussels sprouts are potassium-rich foods. (B) None of these foods is considered potassium rich. (C) Only the baked potato is a potassium-rich food. (D) Spinach is the only potassium-rich food in this option.

NEW QUESTION: 335

When a client arrives on the labor and delivery unit, she informs the nurse that she has been having contractions for the last 5 hours. Now the pain is constant and not cyclical as it was earlier. The nurse considers the possibility of uterine rupture. Which of the following symptoms would be consistent with a uterine rupture?

- A. A large gush of clear fluid from the vagina
- B. Systolic hypertension
- C. Abdominal rigidity
- D. Increased fetal movements

Answer: C (LEAVE A REPLY)

Explanation

(A) This symptom would indicate a rupture of the membranes, which would be expected during labor. There would be no cause for alarm if the fluid were clear. (B) With uterine rupture and the risk of maternal shock secondary to blood loss, the most likely sign would be hypotension indicating hypovolemic shock. (C) In the event of a uterine rupture, an abdominal examination would likely reveal rigidity or tenderness. (D) The most likely finding would be a decrease in fetal movement related to fetal distress due to impaired uteroplacental blood flow. Maintaining the client on her left side would help to maximize uterine blood flow.

NEW QUESTION: 336

The nurse is caring for a client who has diabetes insipidus. The nurse would describe this client's urine output pattern as:

- A. Anuria
- B. Oliguria
- C. Dysuria
- D. Polyuria

Answer: D ([LEAVE A REPLY](#))

Section: Questions Set D

Explanation:

Explanation

(A) Anuria is defined as absence of urine output, which is not indicative of the urinary pattern of diabetes insipidus. (B) Oliguria is defined as <500 mL of urine per day, which is not a urinary output pattern associated with diabetes insipidus. (C) Dysuria is defined as difficult urination. Clients with diabetes insipidus do not have dysuria as a symptom of their disease. (D) Polyuria is a primary symptom of diabetes insipidus. These clients have decreased or absent vasopressin secretion, which causes water loss in the urine and sodium increases.

NEW QUESTION: 337

The primary focus of nursing interventions for the child experiencing sickle cell crisis is aimed toward:

- A. Maintaining an adequate level of hydration
- B. Providing pain relief
- C. Preventing infection
- D. O₂ therapy

Answer: (A) ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Maintaining the hydration level is the focus for nursing intervention because dehydration enhances the sickling process. Both oral and parenteral fluids are used. (B) The pain is a result of the sickling process.

Analgesics or narcotics will be used for symptom relief, but the underlying cause of the pain will be resolved with hydration. (C) Serious bacterial infections may result owing to splenic dysfunction. This is true at all times, not just during the acute period of a crisis. (D) O₂ therapy is used for symptomatic relief of the hypoxia resulting from the sickling process. Hydration is the primary intervention to alleviate the dehydration that enhances the sickling process.

NEW QUESTION: 338

A female baby was born with talipes equinovarus. Her mother has requested that the nurse assigned to the baby come to her room to discuss the baby's condition. The nurse knows

that the pediatrician has discussed the baby's condition with her mother and that an orthopedist has been consulted but has not yet seen the baby.

What should the nurse do first?

- A.** Call the orthopedist and request that he come to see the baby now.
- B.** Question the mother and find out what the pediatrician has told her about the baby's condition.
- C.** Tell the mother that this is not a serious condition.
- D.** Tell the mother that this condition has been successfully treated with exercises, casts, and/or braces.

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set G

Explanation:

(A) The nurse should call the orthopedist after assessing the mother's knowledge. (B) The nurse must first assess the knowledge of the parent before attempting any explanation. (C) The nurse should assess the mother's knowledge of the baby's condition as the first priority. (D) This answer is correct, but the priority is B.

NEW QUESTION: 339

Which of the following would differentiate acute from chronic respiratory acidosis in the assessment of the trauma client?

- A.** Increased PaCO₂
- B.** Decreased PaO₂
- C.** Increased HCO₃
- D.** Decreased base excess

Answer: (SHOW ANSWER)

(A) Increased CO₂ will occur in both acute and chronic respiratory acidosis. (B) Hypoxia does not determine acid-base status. (C) Elevation of HCO₃ is a compensatory mechanism in acidosis that occurs almost immediately, but it takes hours to show any effect and days to reach maximum compensation. Renal disease and diuretic therapy may impair the ability of the kidneys to compensate. (D) Base excess is a nonrespiratory contributor to acid-base balance. It would increase to compensate for acidosis.

NEW QUESTION: 340

A 26-year-old female client presents at 10 weeks' gestation. She currently is a G3 1-0-1-1. Her mother and grandmother have heart disease. Her grandmother also has insulin-dependent diabetes. The client's previous delivery was a term female infant weighing 9 lb 13 oz. The client is 5 ft 6 inches tall and her current weight is 130 lb. Based on her history, she is at risk for developing diabetes in pregnancy. Which of the following factors places her at risk for gestational diabetes?

- A.** Age > 25 years
- B.** Maternal weight

C. Previous birth of an infant weighing >9 lb

D. Family history of heart disease

Answer: C (LEAVE A REPLY)

(A)

Maternal age older than 30 years is an identified risk factor for diabetes. Age younger than 30 years is insignificant for diabetes unless there is a familial history of diabetes. (B) The client's weight is appropriate for her height. Obesity or pregnancy weight >20% of the ideal weight is a contributing factor to the development of gestational diabetes. (C) The birth of an infant weighing >9 lb (4000 g) is an identified risk factor for gestational diabetes.

(D)

A familial history of heart disease is insignificant in the development of diabetes. However, a familial history of type II diabetes mellitus is identified as a risk factor in the development of diabetes during pregnancy.

NEW QUESTION: 341

A client returns for her 6-month prenatal checkup and has gained 10 lb in 2 months. The results of her physical examination are normal. How does the nurse interpret the effectiveness of the instruction about diet and weight control?

A. She is compliant with her diet as previously taught.

B. She needs further instruction and reinforcement.

C. She needs to increase her caloric intake.

D. She needs to be placed on a restrictive diet immediately.

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) She is probably not compliant with her diet and exercise program. Recommended weight gain during second and third trimesters is approximately 12 lb. (B) Because of her excessive weight gain of 10 lb in 2 months, she needs re-evaluation of her eating habits and reinforcement of proper dietary habits for pregnancy. A 2200-calorie diet is recommended for most pregnant women with a weight gain of 27-30 lb over the 9-month period. With rapid and excessive weight gain, PIH should also be suspected. (C) She does not need to increase her caloric intake, but she does need to re-evaluate dietary habits. Ten pounds in 2 months is excessive weight gain during pregnancy, and health teaching is warranted. (D) Restrictive dieting is not recommended during pregnancy.

NEW QUESTION: 342

A 26-year-old female client presents at 10 weeks' gestation. She currently is a G3 1-0-1-1. Her mother and grandmother have heart disease. Her grandmother also has insulin-dependent diabetes. The client's previous delivery was a term female infant weighing 9 lb 13 oz. The client is 5 ft 6 inches tall and her current weight is

130 lb. Based on her history, she is at risk for developing diabetes in pregnancy. Which of the following factors places her at risk for gestational diabetes?

- A. Age >25 years
- B. Maternal weight
- C. Previous birth of an infant weighing >9 lb
- D. Family history of heart disease

Answer: (SHOW ANSWER)

Section: Questions Set F

Explanation:

(A) Maternal age older than 30 years is an identified risk factor for diabetes. Age younger than 30 years is insignificant for diabetes unless there is a familial history of diabetes. (B) The client's weight is appropriate for her height. Obesity or pregnancy weight >20% of the ideal weight is a contributing factor to the development of gestational diabetes. (C) The birth of an infant weighing >9 lb (4000 g) is an identified risk factor for gestational diabetes. (D) A familial history of heart disease is insignificant in the development of diabetes. However, a familial history of type II diabetes mellitus is identified as a risk factor in the development of diabetes during pregnancy.

NEW QUESTION: 343

A 24-year-old graduate student recognizes that he has a phobia. He suffers severe anxiety when he is in darkness. It has altered his lifestyle because he is unable to go to a movie theater, concert, and other events that may require absence of light. The client is seeking assistance because he is no longer able to socialize with friends due to his phobia. The psychologist working with him is using desensitization. He has asked the nursing staff to assist the client in muscle relaxation techniques. What result would indicate client education has been successful?

- A. He enters a movie theater, sits in his chair, and replaces anxiety with relaxation as the theater darkens.
- B. He enters a concert, but as the lights dim, he does not experience anxiety.
- C. He states that he no longer fears dark places.
- D. He takes a part-time job as a photographic assistant. His job necessitates his working in a darkroom.

Answer: A (LEAVE A REPLY)

(A) This situation provides specific evidence that the client is able to integrate muscle relaxation technique into his lifestyle to alleviate anxiety. (B) The client may not experience anxiety at the concert, but there is no evidence regarding the technique that he used to alleviate anxiety. (C) The client may state he no longer experiences anxiety, but there is no evidence demonstrating this. He may be denying anxiety to discontinue therapy prematurely. (D) Does he experience anxiety in the darkroom? He may have taken this job to force himself to deal with the phobia directly.

NEW QUESTION: 344

To prevent transmission of bacterial meningitis, the nurse would instruct an infected baby's mother to:

- A. Avoid touching the baby while in the room.
- B. Stay outside of the baby's room.
- C. Wear a gown and gloves and wash her hands before and after leaving the room.
- D. Wear a mask while in the room.

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) The mother should be allowed and encouraged to touch her baby. (B) With care, transmission can be prevented. There is no need for the mother to stay outside the room. (C) Everyone entering the baby's room should take appropriate measures to prevent transmission of pathogens. (D) Wearing a mask will not protect against transmission of pathogens.

NEW QUESTION: 345

The physician prescribes phenytoin (Dilantin) for a client with seizure disorders. Phenytoin can only be mixed with which of the following solutions?

- A. Ringer's lactate
- B. D5 in water
- C. D5 with Ringer's lactate
- D. Normal saline

Answer: ([SHOW ANSWER](#))

Explanation

(A) Phenytoin will precipitate if mixed with Ringer's lactate and should not be administered. (B, C) Phenytoin will precipitate if mixed with D5 in Ringer's lactate and should not be administered. (D) Phenytoin is compatible only with normal saline and should be mixed only with normal saline for administration.

NEW QUESTION: 346

An 18-year-old client enters the emergency room complaining of coughing, chest tightness, dyspnea, and sputum production. On physical assessment, the nurse notes agitation, nasal flaring, tachypnea, and expiratory wheezing. These signs should alert the nurse to:

- A. A tension pneumothorax
- B. An asthma attack
- C. Pneumonia
- D. Pulmonary embolus

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) A tension pneumothorax is an accumulation of air in the pleural space. Important physical assessment findings to confirm this condition include cyanosis, jugular vein distention, absent breath sounds on the affected side, distant heart sounds, and lowered blood pressure. (B) Asthma is a disorder in which there is an airflow obstruction in the bronchioles and smaller bronchi secondary to bronchospasm, swelling of mucous membranes, and increased mucus production. Physical assessment reveals some important findings: agitation, nasal flaring, tachypnea, and expiratory wheezing. (C) Pneumonia is an acute bacterial or viral infection that causes inflammation of the lung in the alveolar and interstitial tissue and results in consolidation. Specific assessment findings to confirm this condition include decreased chest expansion caused by pleuritic pain, dullness on percussion over consolidated areas, decreased breath sounds, and increased vocal fremitus. (D) A pulmonary embolus is the passage of a foreign substance (blood clot, fat, air, or amniotic fluid) into the pulmonary artery or its branches, with subsequent obstruction of blood supply to lung tissue. Specific assessment findings that confirm this condition include tachypnea, tachycardia, crackles (rales), transient friction rub, diaphoresis, edema, and cyanosis.

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NEW QUESTION: 347

A client is 2 hours post ventriculoperitoneal shunt placement. How should the nurse position the client?

- A.** Head of bed elevated 30 degrees on nonoperative side
- B.** Head of bed elevated 30 degrees on operative side
- C.** Bed flat on operative side
- D.** Bed flat on nonoperative side

Answer: D (LEAVE A REPLY)

Explanation

(A) Elevation of head on nonoperative side would be the position for the late postoperative period. (B) Positioning on operative side puts pressure on the suture lines and on the shunt valve. Elevation of head in immediate postoperative period may cause rapid reduction of cerebrospinal fluid. (C) Placement on operative side puts pressure on the suture lines and shunt valve. (D) Flat position on nonoperative side in the immediate postoperative period prevents pressure on shunt valve and rapid reduction in cerebrospinal fluid.

NEW QUESTION: 348

An infant weighing 15 lb has just been treated for severe diarrhea in the hospital. Discharge instructions by the nurse will include maintenance fluid requirements for the pediatric client. Which of the following values best indicates the nurse's understanding of normal fluid requirements for this infant?

- A. 240 mL/day
- B. 680 mL/day
- C. 330 mL/day
- D. 960 mL/day

Answer: [\(SHOW ANSWER\)](#)

(A, C, D) These answers are incorrect. (B) Normal fluid requirement for this pediatric client is based on the fact that 0-10 kg of weight equals 100 mL/kg per day. This infant weighs 15 pounds (6.8 kg). Thus, $100 \text{ mL} \times 6.8 = 680 \text{ mL/day}$.

NEW QUESTION: 349

A laboratory technique specific for diagnosing Lyme disease is:

- A. Polymerase chain reaction
- B. Heterophil antibody test
- C. Decreased serum calcium level
- D. Increased serum potassium level

Answer: [A \(LEAVE A REPLY\)](#)

Explanation/Reference:

Explanation:

(A) Polymerase chain reaction is the laboratory technique specific for Lyme disease. (B) Heterophil antibody test is used to diagnose mononucleosis. (C) Lyme disease does not decrease the serum calcium level. (D) Lyme disease does not increase the serum potassium level.

NEW QUESTION: 350

A male client is admitted to the psychiatric unit after experiencing severe depression. He states that he intends to kill himself, but he asks the nurse not to repeat his intentions to other staff members. Which response demonstrates understanding and appropriate action on the part of the nurse?

- A. "I understand you're depressed, but killing yourself is not a reasonable option."
- B. "We need to discuss this further, but right now let's complete these forms."
- C. "Don't do that, you have so much to live for. You have a wonderful wife and children. The client in the next room has no one."
- D. "This is very serious. I do not want any harm to come to you. I will have to report this to the rest of the staff."

Answer: [D \(LEAVE A REPLY\)](#)

Explanation

(A) To the client, suicide may be a reasonable action and the only one he can cope with at this time. (B) This response indicates to the client that his intention to commit suicide is not important to the nurse at this time.

(C) The client is so depressed that he is not able to see the positive aspects of his life. At no time should the nurse discuss another client's problems in conversation. (D) This statement tells the client that the nurse recognizes his problem is of a serious nature and will take all steps necessary to help him.

NEW QUESTION: 351

After instructing a female client on circumcision care, the nursery nurse asks her to restate some of the key points covered. Which statement shows that the client will properly care for her son's circumcision?

- A. "I'll make sure I soak the gauze with warm water first, before I take it off each time."
- B. "I'll make sure that I report any drainage around where they operated."
- C. "I'll apply alcohol to the area daily to clean it and prevent any infection."
- D. "I'll keep a close watch on it for a day or two."

Answer: A ([LEAVE A REPLY](#))

(A) Before petrolatum gauze is removed, it should be soaked with warm water to prevent trauma to adherent tissues. (B) A yellow exudate often forms normally over the surgical site. Only if it becomes foul-smelling and purulent would it need to be reported. (C) Alcohol should never be used on the site; this would be extremely painful to the infant. (D) Special care and observance should continue until the site is completely covered with clean, pink granulation tissue, which could take 7-10 days.

NEW QUESTION: 352

A baby is circumcised. Immediate postoperative care should include:

- A. Applying a loose diaper
- B. Keeping the baby NPO for 4 hours to avoid vomiting
- C. Changing the dressing frequently using dry, sterile gauze
- D. Taking the baby to his mother for cuddling

Answer: ([SHOW ANSWER](#))

(A) A pressure diaper should be applied to discourage hemorrhage. (B) The baby can be fed by his mother soon after the procedure, once it is assessed that he is not in any distress and is stable. (C) Dressing changes should not be dry. Dry dressing will stick. (D) Cuddling after the procedure will hopefully quiet the baby. Feeding is also important if his feeding was withheld prior to the procedure or it is time for a feeding.

NEW QUESTION: 353

A 3-month-old infant has had a unilateral cleft lip repair. He has resumed feedings of oral formula. The nurse should feed the infant with:

- A. Gavage tube
- B. Nipple and bottle
- C. A straw and cup
- D. Syringe

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) A gavage tube may damage suture line. It is the most invasive and should be the last measure. (B) A nipple and bottle require sucking, which may damage sutures. (C) A 3-month-old infant is not able to drink from a straw. (D) A syringe allows for the formula to be placed to the side and back of the mouth. This minimizes the amount of sucking needed.

NEW QUESTION: 354

A male client is admitted to the psychiatric unit after experiencing severe depression. He states that he intends to kill himself, but he asks the nurse not to repeat his intentions to other staff members. Which response demonstrates understanding and appropriate action on the part of the nurse?

- A. "I understand you're depressed, but killing yourself is not a reasonable option."
- B. "We need to discuss this further, but right now let's complete these forms."
- C. "Don't do that, you have so much to live for. You have a wonderful wife and children. The client in the next room has no one."
- D. "This is very serious. I do not want any harm to come to you. I will have to report this to the rest of the staff."

Answer: D (LEAVE A REPLY)

(A) To the client, suicide may be a reasonable action and the only one he can cope with at this time. (B) This response indicates to the client that his intention to commit suicide is not important to the nurse at this time. (C) The client is so depressed that he is not able to see the positive aspects of his life. At no time should the nurse discuss another client's problems in conversation. (D) This statement tells the client that the nurse recognizes his problem is of a serious nature and will take all steps necessary to help him.

NEW QUESTION: 355

A 65-year-old client who has a new colostomy is preparing for discharge from the hospital. As part of the instructions on colostomy care, the nurse explains to the client that to regulate the bowel, colostomy irrigation should be performed at the same time each day. The best time is:

- A. After meals
- B. Before meals
- C. Every 2 hours
- D. At bedtime

Answer: (SHOW ANSWER)

Explanation

(A) Bowel movements should be regulated at a specific time each day to prevent "accidents." Irrigating after meals takes advantage of the gastrocolic reflex and time of increased peristalsis, so better results may be produced. After meals is the normal time that peristalsis begins in most persons and evacuation of feces occurs. (B) Irrigating before meals may cause poor results because of decreased gastrocolic reflex and decreased peristalsis. (C) Irrigating a colostomy every 2 hours may produce hyperactivity of the bowel, leading to irritation and diarrhea. This would not aid in regulation of the bowel. (D) If irrigation of a colostomy were done at bedtime, there is greater chance of having an "accident" during sleep. This would not be an advantageous practice of bowel regulation.

NEW QUESTION: 356

After 7 hours in restraints and a total of 30-mg haloperidol in divided doses, a client complains of stiffness in his neck and his tongue "pulling to one side." These extrapyramidal symptoms (EPS) will most likely be relieved by the administration of:

- A. Lorazepam (Ativan)
- B. Benztropine (Cogentin)
- C. Thiothixene (Navane)
- D. Flurazepan (Dalmane)

Answer: B (LEAVE A REPLY)

(A) Lorazepam is an antianxiety agent that produces muscle relaxation and inhibits cortical and limbic arousal. It has no action in the basal ganglia of the brain. (B) Benztropine acts to reduce EPS by blocking excess CNS cholinergic activity associated with dopamine deficiency in the basal ganglia by displacing acetylcholine at the receptor site. (C) Thiothixene is an antipsychotic known to block dopamine in the limbic system, thereby causing EPS. (D) Flurazepan is a hypnotic that acts in the limbic system, thalamus, and hypothalamus of the CNS to produce sleep. It has no known action in the basal ganglia.

NEW QUESTION: 357

A 50-year-old male client is to receive chemotherapy. The physician's orders include antiemetics. When planning his care, the nurse should take into consideration that antiemetics are best administered in the following way:

- A. Give antiemetics when nausea is experienced and continue on a regular schedule for 12-24 hours.
- B. Give antiemetics prior to the client receiving chemotherapy and continue on a regular basis for at least 24-48 hours after chemotherapy.
- C. Give antiemetics one at a time because combinations of antiemetics cause overwhelming side effects.
- D. Give antiemetics intermittently during the entire course of chemotherapy.

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Nausea is more difficult to control if antiemetics are withheld until nausea is experienced. (B) Antiemetics should be given prophylactically at the beginning of chemotherapy and continued on an around-the-clock basis to prevent nausea. (C) Combinations of antiemetics give the best control for nausea by blocking various causes of nausea induced by chemotherapy. (D) Antiemetics should be given around the clock during the course of chemotherapy. This prevents nausea from developing and prevents anticipatory nausea during subsequent chemotherapy administrations.

NEW QUESTION: 358

The following medications were noted on review of the client's home medication profile. Which of the medications would most likely potentiate or elevate serum digoxin levels?

- A. KCl
- B. Thyroid agents
- C. Quinidine
- D. Theophylline

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) Hypokalemia can cause digoxin toxicity. Administration of KCl would prevent this. (B) Thyroid agents decrease digoxin levels. (C) Quinidine increases digoxin levels dramatically. (D) Theophylline is not noted to have an effect on digoxin levels.

NEW QUESTION: 359

A 32-year-old female client is being treated for Guillain-Barre syndrome. She complains of gradually increasing muscle weakness over the past several days. She has noticed an increased difficulty in ambulating and fell yesterday. When conducting a nursing assessment, which finding would indicate a need for immediate further evaluation?

- A. Complaints of a headache
- B. Loss of superficial and deep tendon reflexes
- C. Complaints of shortness of breath
- D. Facial paralysis

Answer: ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) Headaches are not associated with Guillain-Barre syndrome. (B) Loss of superficial and deep tendon reflexes is expected with this diagnosis. (C) Complaints of shortness of breath must be further evaluated. Forty percent of all clients have some detectable respiratory weakness and should be prepared for a possible tracheostomy. Pneumonia is also a common complication of this syndrome. (D) Facial paralysis is expected and is not considered abnormal.

NEW QUESTION: 360

The nurse would expect to include which of the following when planning the management of the client with Lyme disease?

- A. Complete bed rest for 6-8 weeks
- B. Tetracycline treatment
- C. IV amphotericin B
- D. High-protein diet with limited fluids

Answer: B (LEAVE A REPLY)

Explanation

(A) The client is not placed on complete bed rest for 6 weeks. (B) Tetracycline is the treatment of choice for children with Lyme disease who are over the age of 9. (C) IV amphotericin B is the treatment for histoplasmosis. (D) The client is not restricted to a high-protein diet with limited fluids.

NEW QUESTION: 361

A client returned to the unit following a pneumonectomy. As the nurse is assessing her incision, she notices fresh blood on the dressing. The nurse should first:

- A. Reinforce the dressing.
- B. Continue to monitor the dressing.
- C. Notify the physician.
- D. Note the time and amount of blood.

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The dressing should not be reinforced without first notifying the physician. The decision may be made by the physician to reinforce the dressing after assessing the amount of bleeding. (B) Blood on the dressing is unusual and should make the nurse aware that something more than continuing to monitor the dressing should be done. (C) The physician should be notified immediately, because if the bleeding persists, the client may have to be taken back to surgery. (D) The time and amount of blood do need to be recorded after the physician is notified.

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NEW QUESTION: 362

After 3 weeks of treatment, a severely depressed client suddenly begins to feel better and starts interacting appropriately with other clients and staff. The nurse knows that this client has an increased risk for:

- A. Suicide
- B. Exacerbation of depressive symptoms
- C. Violence toward others
- D. Psychotic behavior

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) When the severely depressed client suddenly begins to feel better, it often indicates that the client has made the decision to kill himself or herself and has developed a plan to do so. (B) Improvement in behavior is not indicative of an exacerbation of depressive symptoms. (C) The depressed client has a tendency for self-violence, not violence toward others. (D) Depressive behavior is not always accompanied by psychotic behavior.

NEW QUESTION: 363

A client with a diagnosis of C-4 injury has been stabilized and is ready for discharge. Because this client is at risk for autonomic dysreflexia, he and his family should be instructed to assess for and report:

- A. Dizziness and tachypnea
- B. Circumoral pallor and lightheadedness
- C. Headache and facial flushing
- D. Pallor and itching of the face and neck

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Tachypnea is not a symptom. (B) Circumoral pallor is not a symptom. (C) Autonomic dysreflexia is an uninhibited and exaggerated reflex of the autonomic nervous system to stimulation, which results in vasoconstriction and elevated blood pressure. (D) Pallor and itching are not symptoms.

NEW QUESTION: 364

A couple is experiencing difficulties conceiving a baby. The nurse explains basal body temperature (BBT) by instructing the female client to take her temperature:

- A. Orally in the morning and at bedtime
- B. Only one time during the day as long as it is always at the same time of day
- C. Rectally at bedtime
- D. As soon as she awakens, prior to any activity

Answer: (SHOW ANSWER)

Explanation

(A) Monitoring temperature twice a day predicts the biphasic pattern of ovulation. (B) Prediction of ovulation relies on consistency in taking temperature. (C) Nightly rectal temperatures are more accurate in predicting ovulation. (D) Activity changes the accuracy of basal body temperature and ability to detect the luteinizing hormone surge.

NEW QUESTION: 365

A client undergoes a transurethral resection, prostate (TURP). He returns from surgery with a three-way continuous Foley irrigation of normal saline in progress. The purpose of this bladder irrigation is to prevent:

- A.** Bladder spasms
- B.** Clot formation
- C.** Scrotal edema
- D.** Prostatic infection

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) The purpose of bladder irrigation is not to prevent bladder spasms, but to drain the bladder and decrease clot formation and obstruction. (B) A three-way system of bladder irrigation will cleanse the bladder and prevent formation of blood clots. A catheter obstructed by clots or other debris will cause prostatic distention and hemorrhage. (C) Scrotal edema seldom occurs after TURP. Bladder irrigation will not prevent this complication. (D) Prostatic infection seldom occurs after TURP. Bladder irrigation will not prevent this complication.

NEW QUESTION: 366

A client was admitted to the hospital after falling in her home. At the time of admission, her blood alcohol level was 0.27 mg%. Her family indicates that she has been drinking a fifth of vodka a day for the past 9 months. She had her last drink 30 minutes prior to admission. Alcohol withdrawal symptoms would most likely be exhibited by her:

- A.** Two to 4 hours after the last drink
- B.** Six to 8 hours after the last drink
- C.** Immediately on admission
- D.** Twenty-four hours after the last drink

Answer: ([SHOW ANSWER](#))

Explanation

(A) This answer is incorrect. Alcohol withdrawal usually begins approximately 6-8 hours after the last drink.

(B) This answer is correct. It takes approximately 6-8 hours for metabolism of alcohol. (C) This answer is incorrect. The alcohol is still in the system, as indicated by the high blood alcohol level. (D) This answer is incorrect. Symptoms of alcohol withdrawal usually begin within 6-8 hours of the last drink.

NEW QUESTION: 367

The nurse will be alert to the most potentially lifethreatening side effect associated with the administration of monoamine oxidase (MAO) inhibitor. This is:

- A. Oculogyric crisis
- B. Hypertensive crisis
- C. Orthostatic hypotension
- D. Tardive dyskinesia

Answer: B (LEAVE A REPLY)

(A) Oculogyric crisis, involuntary upward deviation and fixation of the eyeballs, is usually associated with either postencephalitic parkinsonian or drug-induced extrapyramidal symptoms (EPS). (B) Hypertensive crisis is a potentially life-threatening side effect. This may occur if the client ingests foods, beverages, or medications containing tyramine. (C) Orthostatic hypotension, a drop in blood pressure resulting from a rapid change of body position, can occur with the administration of antidepressants. (D) Tardive dyskinesia, characterized by slow, rhythmical, automatic or stereotyped muscular movements, usually is associated with the administration of certain antipsychotic medications.

NEW QUESTION: 368

A client is being discharged and will continue enteral feedings at home. Which of the following statements by a family member indicates the need for further teaching?

- A. "If he develops diarrhea lasting for more than 2-3 days, I will contact the doctor or nurse."
- B. "I should anticipate that he will gain about 1 lb/day now that he is on continuous feedings."
- C. "It is important to keep the head of his bed elevated or sit him in the chair during feedings."
- D. "I should use prepared or open formula within 24 hours and store unused portions in the refrigerator."

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Diarrhea is a complication of tube feedings that can lead to dehydration. Diarrhea may be the result of hypertonic formulas that can draw fluid into the bowel. Other causes of diarrhea may be bacterial contamination, fecal impaction, medications, and low albumin. (B) A consistent weight gain of more than 0.22 kg/day (1/2 lb/day) over several days should be reported promptly. The client should be evaluated for fluid volume excess. (C) Elevating the client's head prevents reflux and thus formula from entering the airway. (D) Bacteria proliferate rapidly in enteral formulas and can cause gastroenteritis and even sepsis.

NEW QUESTION: 369

A 5-year-old child has suffered second-degree thermal burns over 30% of her body. Forty-eight hours after the burn injury, the nurse must begin to monitor the child for which one of the following complications?

- A. Fluid volume deficit
- B. Fluid volume excess
- C. Decreased cardiac output
- D. Severe hypotension

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) Fluid volume deficit resulting from fluid shifts to the interstitial spaces occurs in the first 48 hours. (B) Forty-eight hours to 72 hours after the burn injury and fluid resuscitation, capillary permeability is restored and fluid requirements decrease. Interstitial fluid returns rapidly to the vascular compartment, and the nurse must monitor the child for signs and symptoms of hypervolemia. (C) Increased cardiac output results as fluids shift back to the vascular compartment. (D) Hypertension is the result of hypervolemia.

NEW QUESTION: 370

A client with IDDM is given IV insulin for a blood glucose level of 520 mg/dL. Life-threatening complications may occur initially, so the nurse will monitor him closely for serum:

- A. Chloride level of 99 mEq/L
- B. Sodium level of 136 mEq/L
- C. Potassium level of 3.1 mEq/L
- D. Potassium level of 6.3 mEq/L

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) The chloride level is within acceptable limits. (B) The sodium level is within acceptable limits. (C) This value indicates hypokalemia, rather than the hyperkalemia that occurs during diabetic ketoacidosis. (D) When diabetic ketoacidosis exists, intracellular dehydration occurs and potassium leaves the cells and enters the vascular system, thus increasing the serum level beyond an acceptable range. When insulin and fluids are administered, cell walls are repaired and potassium is transported back into the cells. Normal serum potassium levels range from 3.5-5.0 mEq/L.

NEW QUESTION: 371

The most commonly known vectors of Lyme disease are:

- A. Mites
- B. Fleas
- C. Ticks
- D. Mosquitoes

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Mites are not the common vector of Lyme disease. (B) Fleas are not the common vector of Lyme disease. (C) Ticks are the common vector of Lyme disease. (D) Mosquitoes are not the common vector of Lyme disease.

NEW QUESTION: 372

The nurse would be concerned if a client exhibited which of the following symptoms during her postpartum stay?

- A.** Pulse rate of 50-70 bpm by her third postpartum day
- B.** Diuresis by her second or third postpartum day
- C.** Vaginal discharge or rubra, serosa, then rubra
- D.** Diaphoresis by her third postpartum day

Answer: C ([LEAVE A REPLY](#))

(A)

Bradycardia is an expected assessment during the postpartum period. (B) Diuresis can occur during labor and the postpartum period and is an expected physiological adaptation.

(C)

A return of rubra after the serosa period may indicate a postpartal complication. (D) Diaphoresis, especially at night, is an expected physiological change and does not indicate an infectious process. Bradycardia, diuresis, and diaphoresis are normal postpartum physiological responses to adjust the cardiac output and blood volume to the nonpregnant state.

NEW QUESTION: 373

A client who was started on antipsychotic medication 2 weeks ago is preparing for discharge from the hospital. Compliance with the medication regimen is important despite the mild side effects encountered. In order to increase the likelihood of medication compliance, the nurse would:

- A.** Discuss the disease process and the importance of the medication in prevention of symptoms.
- B.** Inform the client that additional side effects are to be expected and need not be reported.
- C.** Discuss the importance of getting blood drawn weekly to determine medication therapeutics.
- D.** Inform the client to cease taking the medication when all psychotic symptoms have cleared.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) This answer is correct. If the client is well informed about what reactions to expect from her medication, she is more likely to follow the treatment regimen. (B) This answer is incorrect. There are many side effects that are reversible by medication, and these must be reported to the nurse or physician. There are also more severe side effects, such as neuroleptic malignant syndrome, characterized by fever, tachycardia, and diaphoresis, which can be life threatening. (C) This answer is incorrect. There is no need for weekly blood tests if the drug regimen has been followed properly. (D) This answer is incorrect. The client should continue the medication until the physician recommends any change in the drug regimen. Symptoms will usually reappear if medication is discontinued.

NEW QUESTION: 374

The child with iron poisoning is given IV deferoxamine mesylate (Desferal). Following administration, the child suffers hypotension, facial flushing, and urticaria. The initial nursing intervention would be to:

- A.** Discontinue the IV
- B.** Stop the medication, and begin a normal saline infusion
- C.** Take all vital signs, and report to the physician
- D.** Assess urinary output, and if it is 30 mL an hour, maintain current treatment

Answer: [\(SHOW ANSWER\)](#)

Explanation/Reference:

Explanation:

- (A) The IV line should not be discontinued because other IV medications will be needed. (B) Stop the medication and begin a normal saline infusion. The child is exhibiting signs of an allergic reaction and could go into shock if the medication is not stopped. The line should be kept opened for other medication. (C) Taking vital signs and reporting to the physician is not an adequate intervention because the IV medication continues to flow. (D) Assessing urinary output and, if it is 30 mL an hour, maintaining current treatment is an inappropriate intervention owing to the child's obvious allergic reaction.

NEW QUESTION: 375

A 29-year-old client delivered her fifth child by the Lamaze method and developed a postpartal hemorrhage in the recovery room. What are the initial symptoms of shock that she may experience?

- A.** Marked elevation in blood pressure, respirations, and pulse
- B.** Decreased systolic pressure, cold skin, and anuria
- C.** Rapid pulse; narrowed pulse pressure; cool, moist skin
- D.** No urinary output, tachycardia, and restlessness

Answer: **C** [\(LEAVE A REPLY\)](#)

- (A) Early shock does not exhibit the symptom of marked elevation in blood pressure. A narrowing of the pulse pressure is indicative of early shock. (B) Anuria is a clinical finding

in late shock. (C) All of these clinical findings are congruent with early shock. (D) Absence of urinary output is a clinical finding in the late phase of shock.

NEW QUESTION: 376

A client is dilated 8 cm and entering the transition phase of labor. Common behaviors of the laboring woman during transition are:

- A. Frustration, vague in communication
- B. Seriousness, some difficulty following directions
- C. Calmness, follows directions easily
- D. Excitement, openness to instructions

Answer: ([SHOW ANSWER](#))

(A) During the transition phase, the mother may become frustrated and unclear in her communication owing to severe pain and fear of loss of control. (B) These behaviors are common in the active phase of labor. (C) These behavioral clues are seen in the latent phase of labor. (D) These characteristics are observed in the latent phase of labor.

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NEW QUESTION: 377

A 5-year-old child has suffered second-degree thermal burns over 30% of her body. Forty-eight hours after the burn injury, the nurse must begin to monitor the child for which one of the following complications?

- A. Fluid volume deficit
- B. Fluid volume excess
- C. Decreased cardiac output
- D. Severe hypotension

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set B

Explanation:

(A) Fluid volume deficit resulting from fluid shifts to the interstitial spaces occurs in the first 48 hours. (B) Forty- eight hours to 72 hours after the burn injury and fluid resuscitation, capillary permeability is restored and fluid requirements decrease. Interstitial fluid returns rapidly to the vascular compartment, and the nurse must monitor the child for signs and

symptoms of hypervolemia. (C) Increased cardiac output results as fluids shift back to the vascular compartment. (D) Hypertension is the result of hypervolemia.

NEW QUESTION: 378

A 32-year-old male client is a marketing representative. His job requires him to have a tremendous amount of energy during the day. He frequently uses cocaine to sustain his energy level. Lately he has increased his use of cocaine and even experimented with crack cocaine. Realizing he can no longer continue this destructive behavior, he is seeking treatment for cocaine addiction. In planning nursing care for the client's inpatient stay, which expected outcome is most appropriate?

- A. He will attend four consecutive group educational sessions on substance abuse.
- B. He will name activities that he would most likely be involved in posttreatment.
- C. He will meet with his family in counseling sessions and discuss his feelings.
- D. He will be able to deal with his feelings through participation in group therapy sessions.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) This expected outcome is specific as related to attendance, but not specific as related to outcome criteria. (B) Stating activities does not guarantee involvement. (C) This goal may help the recovery process, but postcounseling behavior is not addressed. (D) This statement best describes the expected outcome. The client will be attending group therapy sessions and through them he will deal with his feelings.

NEW QUESTION: 379

The nurse is caring for a 3-month-old girl with meningitis. She has a positive Kernig's sign. The nurse expects her to react to discomfort if she:

- A. Dorsiflexes her ankle
- B. Flexes her spine
- C. Plantiflexes her wrist
- D. Turns her head to the side

Answer: ([SHOW ANSWER](#))

Section: Questions Set F

Explanation:

(A) Discomfort with ankle dorsiflexion is not expected with meningitis. (B) Spinal flexion, flexing the neck or the hips with legs extended, causes discomfort if the meninges are irritated. (C) Discomfort with wrist flexion is not expected with meningitis. (D) Rotating the cervical spine may cause discomfort with meningitis, but pain with flexion is more indicative of meningeal irritation.

NEW QUESTION: 380

A 16-year-old student has a long history of bronchial asthma and has experienced several severe asthmatic attacks during the school year. The school nurse is required to administer 0.2 mL of 1/1000 solution of epinephrine SC during an asthma attack. How does the school nurse evaluate the effectiveness of this intervention?

- A. Increased pulse rate
- B. Increased expectorate of secretions
- C. Decreased inspiratory difficulty
- D. Increased respiratory rate

Answer: C (LEAVE A REPLY)

Section: Questions Set B

Explanation:

(A) A side effect of epinephrine is fatal ventricular fibrillation owing to its effects on cardiac stimulation. (B) Medications used to treat asthma are designed to decrease bronchospasm, not to increase expectorate of secretions. (C) Epinephrine decreased inspiratory difficulty by stimulating α -, β_1 , and β_2 -receptors causing sympathomimetic stimulation (e.g., bronchodilation). (D) The person with asthma fights to inspire sufficient air thus increasing respiratory rate.

NEW QUESTION: 381

A 14-year-old boy has had diabetes for 7 years. He takes 30 U of NPH insulin and 10 U of regular insulin every morning at 7 AM. He eats breakfast at 7:30 AM and lunch at noon. What time should he expect the greatest risk for hypoglycemia?

- A. 9 AM
- B. 1 PM
- C. 11 AM
- D. 3 PM

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This time is incorrect because regular insulin would peak after the teenager has eaten breakfast. (B) This time is incorrect because it is after lunch when the NPH peaks. (C) Regular insulin peaks in 2-3 hours and has a duration of 4-6 hours. NPH insulin's onset is 4-6 hours and peaks in 8-16 hours. Blood sugar would peak after meals and be lowest before meals and during the night. (D) This time is incorrect because it is before the NPH and after the regular insulin peak times.

NEW QUESTION: 382

A client has been taking lithium 300 mg po bid for the past two weeks. This morning her lithium level was 1 mEq/L. The nurse should:

- A. Notify the physician immediately
- B. Hold the morning lithium dose and continue to observe the client

C. Administer the morning lithium dose as scheduled

D. Obtain an order for benztropine (Cogentin)

Answer: C (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) There is no need to phone the physician because the lithium level is within therapeutic range and because there are no indications of toxicity present. (B) There is no reason to withhold the lithium because the blood level is within therapeutic range. Also, it is necessary to give the medication as scheduled to maintain adequate blood levels. (C) The lab results indicate that the client's lithium level is within therapeutic range (0.2-1.4 mEq/L), so the medication should be given as ordered. (D) Benztropine is an antiparkinsonism drug frequently given to counteract extrapyramidal symptoms associated with the administration of antipsychotic drugs (not lithium).

NEW QUESTION: 383

On admission to the inpatient unit, a 34-year-old client is able to follow simple directions, but with great difficulty.

He is worried about how he can keep clean in such a public place and repeatedly dusts his bureau, straightens his bed, and adjusts the clothes in his closet. The client is experiencing a severe level of anxiety. Which response by the nurse would be most therapeutic in initially attempting to reduce his anxiety?

A. "You will not be allowed to remain in your room if you continue to bother things."

B. "I can see how uncomfortable you are, but I would like you to walk with me so I can show you around the unit."

C. "Tell me why your room needs to be so clean."

D. "I've inspected this room and it is perfectly clean."

Answer: B (LEAVE A REPLY)

(A) This statement is punitive. (B) Acknowledging the anxiety and channeling it into some positive activity is therapeutic. (C) The client cannot say "why"; this statement puts the client on the defensive. (D) A rational approach, especially a judgmental one, is nontherapeutic.

NEW QUESTION: 384

A client is hyperactive and not sleeping. She will not remain at the table during mealtime. She is getting very limited calories and is using a lot of energy in her hyperactive state. The most therapeutic nursing action is to:

A. Insist that she remain at the table and eat a balanced diet.

B. Order a high-calorie diet with supplements.

C. Provide nutritious finger foods several times a day.

D. Offer to go to the dining room with her and allow her to open the food and inspect what she eats.

Answer: C (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) The client is not able to sit for long periods. Forcing her to remain at the table will increase her anxiety and cause her to become hostile. (B) This action will not ensure that the client eats what is ordered. Dietary orders are not within the nurse's scope of practice. (C) Providing finger foods increases the likelihood of eating for hyperactive persons. They may be eating "on the run." (D) These clients are not suspicious of the food or insecure in moving about the unit alone.

NEW QUESTION: 385

A 48-year-old client is being seen in her physician's office for complaints of indigestion, heartburn, right upper quadrant pain, and nausea of 4 days' duration, especially after meals. The nurse realizes that these symptoms may be associated with cholecystitis and therefore would check for which specific sign during the abdominal assessment?

- A. Cullen's sign
- B. Rebound tenderness
- C. Murphy's sign
- D. Turner's sign

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This sign is a faint blue discoloration around the umbilicus found in clients who have hemorrhagic pancreatitis. (B) This sign indicates areas of inflammation within the peritoneum, such as with appendicitis.

It is a deep palpation technique used on a nontender area of the abdomen, and when the palpating hand is removed suddenly, the client experiences a sharp, stabbing pain at an area of peritoneal inflammation. (C) This sign is considered positive with acute cholecystitis when the client is unable to take a deep breath while the right upper quadrant is being deeply palpated. The client will elicit a sudden, sharp gasp, which means the gallbladder is acutely inflamed. (D) This is a sign of acute hemorrhagic pancreatitis and manifests as a green or purple discoloration in the flanks.

NEW QUESTION: 386

A 20-year-old female client delivers a stillborn infant. Following the delivery, an appropriate response by the labor nurse to the question, "Why did this happen to my baby?" is:

- A. "It's God's will. It was probably for the best. There was something probably wrong with your baby."
- B. "You're young. You can have other children later."
- C. "I know your other children will be a great comfort to you."
- D. "I can see you're upset. Would you like to see and hold your baby?"

Answer: D ([LEAVE A REPLY](#))

(A) The mother and the father require support; the nurse should not minimize their grief in this situation. (B) Attachment to this infant occurs during the pregnancy for both the mother and father. Another child cannot replace this child. (C) Attachment to this infant occurs during the pregnancy for both the mother and father. Siblings will not replace their feelings or minimize their loss of this infant. (D) Holding and viewing the infant decreases denial and may facilitate the grief process. The nurse should prepare family members for how the infant appears ("she is bruised") and provide support.

NEW QUESTION: 387

A client diagnosed with severe anemia is to receive 2 U of packed red blood cells. Prior to starting the blood transfusion, the nurse must:

- A.** Take a baseline set of vital signs
- B.** Hang Ringer's lactate as the companion fluid
- C.** Use microdrip tubing for the blood administration
- D.** Have the registered nurse in charge assume responsibility for verifying the client and blood product information

Answer: ([SHOW ANSWER](#))

Explanation

(A) A baseline set of vital signs is necessary to determine if any transfusion reactions occur as the blood product is being administered. (B) The only companion fluid to be used during a blood transfusion is normal saline. The calcium in Ringer's lactate can cause clotting. (C) Only a blood administration set should be used.

A microdrip tube would cause lysis of the red blood cells. (D) Proper identification of the recipient and the blood product must be validated by at least two people.

NEW QUESTION: 388

At 32 weeks' gestation, a client is scheduled for a fetal activity test (nonstress test). She calls the clinic and asks the RN, "How do I prepare for the test I am scheduled for?" The RN will most likely inform her of the following instructions to help prepare her for the test:

- A.** "You need to know that an IV is always started before the test."
- B.** "You will need to drink 6 to 8 glasses of water to fill your bladder."
- C.** "Do not eat any food or drink any liquids before the test is started."
- D.** "You will have to remain as still as you possibly can."

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) An IV line is not started in a nonstress test, because this test is used as an indicator of fetal well-being.

This test measures fetal activity and heart rate acceleration. (B) The bladder does not have to be full prior to this test. It is not a sonogram test where a full bladder enables other

structures to be scanned. (C) It has been proved that eating or drinking liquids prior to the test can assist in increasing fetal activity. (D) Any maternal activity will interfere with the results of the test.

NEW QUESTION: 389

A 3-year-old child has had symptoms of influenza including fever, productive cough, nausea, vomiting, and sore throat for the past several days. In caring for a young child with symptoms of influenza, the mother must be cautioned about:

- A.** Giving aspirin and bismuth subsalicylate (Pepto-Bismol) to treat the symptoms
- B.** Giving clear liquids too soon
- C.** Allowing the child to come in contact with other children for 3 days
- D.** The possibility of pneumonia as a complication

Answer: (SHOW ANSWER)

Explanation

(A) Aspirin should never be given to children with influenza because of the possibility of causing Reye's syndrome. Pepto- Bismol is also classified as a salicylate and should be avoided. (B) Depending on the severity of symptoms, the child may be receiving IV therapy or clear liquids. (C) The disease has a 1-3 day incubation period and affected children are most infectious 24 hours before and after the onset of symptoms.

(D) Although viral pneumonia can be a complication of influenza, this would not be an initial priority.

NEW QUESTION: 390

A 22-year-old client is 16 weeks pregnant. She and her husband are expecting their first baby. The client tells the nurse that her last normal menstrual period was February 16, with 3 days of spotting on February 17, 18, and 19. The nurse calculates her expected date of delivery to be:

- A.** November 23rd
- B.** December 26th
- C.** September 14th
- D.** December 9th

Answer: A (LEAVE A REPLY)

(A) Naele's rule is as follows: add 7 days to the 1st day of the last menstrual period, subtract 3 months, and then add 1 year. (B) Naele's rule presumes that the woman has a 28-day menstrual cycle, with conception occurring on the 14th day of the cycle. Slight vaginal spotting may occur in early gestation for unknown reasons but is insignificant in the calculation of Naele's rule. (C) Naele's rule presumes that the woman has a 28-day menstrual cycle, with conception occurring on the 14th day of the cycle. Slight vaginal spotting may occur in early gestation for unknown reasons but is insignificant in the calculation of Naele's rule. (D) Naele's rule presumes that the woman has a 28-day menstrual cycle, with conception occurring on the 14th day of the cycle. Slight vaginal

spotting may occur in early gestation for unknown reasons but is insignificant in the calculation of Naele's rule.

NEW QUESTION: 391

The nurse working with a client who is out of control should follow a model of intervention that includes which of the following?

- A. Approach the client on a continuum of least restrictive care.
- B. Challenge client's behavior immediately with steps to prevent injury to self or others.
- C. Leave the aggressive client to himself or herself, and take other clients away.
- D. To ensure safety of other clients, place client in seclusion immediately when he or she begins shouting.

Answer: A (LEAVE A REPLY)

(A) Approaching a client's aggressive behavior on a continuum of least restrictive care is in agreement with his or her rights (i.e., verbal methods to help maintain control, medication, seclusion, and restraints, as necessary). (B) Approaching a client in a challenging manner is threatening and inappropriate. A nonchallenging and calm approach reflects staff in control and may increase client's internal control. (C) It is inappropriate to leave an aggressive client who is acting out alone. The nurse should acquire qualified help to prevent client from harm or injury to self or others. (D) Moving a client to seclusion immediately for shouting is inappropriate. The nurse should offer the client an opportunity to control self with limit setting. The client should understand that the staff will assist with control if necessary (i.e., quietly accompany out of environment to decrease stimulation and allow for verbalization) employing the least restrictive care model of intervention.

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NEW QUESTION: 392

A 70-year-old client has pneumonia and has just had a respiratory arrest. He has just been intubated with an 8- mm endotracheal tube. During auscultation of his chest, breath sounds were found to be absent on the left side. The nurse identifies the most likely cause of this as:

- A. Inappropriate endotracheal tube size
- B. Left-sided pneumothorax
- C. Right mainstem bronchus intubation

D. Pneumonia

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Appropriate endotracheal tube sizes for adults range from 7.0-8.5 mm. (B) Pneumothorax could be indicated by an absence of breath sounds on the affected side. However, in a recently intubated client, the first priority would be to consider tube malposition. (C) During intubation, the right mainstem bronchus can be inadvertently entered if the endotracheal tube is inserted too far. Left mainstem bronchus intubation almost never occurs because of the angle of the left mainstem bronchus. (D) Breath sounds for someone with pneumonia may be decreased over the areas of consolidation. However, in a recently intubated client, the first priority would be to consider tube malposition.

NEW QUESTION: 393

A 4 year old has an imaginary playmate, which concerns the mother. The nurse's best response would be:

- A.** "I understand your concern and will assist you with a referral."
- B.** "Try not to worry because you will just upset your child."
- C.** "Just ignore the behavior and it should disappear by age 8."
- D.** "This is appropriate behavior for a preschooler and should not be a concern."

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) This is normal for a preschooler, and a referral is not appropriate. (B) Telling a parent not to worry is unhelpful. This response does not address the mother's concern. (C) This response is incorrect. The behavior is normal and will usually disappear by the time the child enters school. (D) This behavior is normal development for a preschooler.

NEW QUESTION: 394

A physician's order reads: Administer KCl 10% oral solution 1.5 mL. The KCl bottle reads 20 mEq/15 mL.

What dosage should the nurse administer to the infant?

- A.** 1 mEq
- B.** 1.13 mEq
- C.** 2 mEq
- D.** Not enough information to calculate

Answer: ([SHOW ANSWER](#))

Section: Questions Set C

Explanation:

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) $1.33 \text{ mEq} = 1 \text{ mL}$, then $1.5 \text{ mL} \times 1.99$, or 2 mEq . (D) Information is adequate for calculation.

NEW QUESTION: 395

Pregnant women with diabetes often have problems related to the effectiveness of insulin in controlling their glucose levels during their second half of pregnancy. The nurse teaches the client that this is due to:

- A. Decreased glomerular filtration and increased tubular absorption
- B. Decreased estrogen levels
- C. Decreased progesterone levels
- D. Increased human placental lactogen levels

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) There is a rise in glomerular filtration rate in the kidneys in conjunction with decreased tubular glucose reabsorption, resulting in glycosuria. (B) Insulin is inhibited by increased levels of estrogen. (C) Insulin is inhibited by increased levels of progesterone. (D) Human placental lactogen levels increase later in pregnancy.

This hormonal antagonist reduces insulin's effectiveness, stimulates lipolysis, and increases the circulation of free fatty acids.

NEW QUESTION: 396

The nurse is notified that a 27-year-old primigravida diagnosed with complete placenta previa is to be admitted to the hospital for a cesarean section. The client is now at 36 weeks' gestation and is presently having bright red bleeding of moderate amount. On admission, the nursing intervention that the nurse should give the highest priority to is:

- A. Shave the client's abdomen and arrange her lab work
- B. Determine the status of the fetus by fetal heart tones
- C. Start an IV infusion in the client's arm
- D. Insert an indwelling catheter into her bladder

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) These nursing actions are necessary prior to the cesarean section, but not immediately necessary to maintain physiological equilibrium. (B) Determining the physiological status of the fetus would constitute the highest priority in evaluating and maintaining fetal life. (C) These nursing actions are necessary prior to the cesarean section, but not immediately necessary to maintain physiological equilibrium. (D) These nursing actions are necessary prior to the cesarean section, but not immediately necessary to maintain physiological equilibrium.

NEW QUESTION: 397

A 16-year-old diabetic girl has been selected as a cheerleader at her school. She asks the nurse whether she should increase her insulin when she is planning to attend cheerleading practice sessions lasting from 8 to 11 AM. The most appropriate answer would be:

- A. "You should ask your doctor about this."
- B. "Yes, increase your insulin by 1 U for each hour of practice because exercise causes the body to need more insulin."
- C. "No, do not increase your insulin. Exercise will not affect your insulin needs."
- D. "No, do not increase your insulin, but eating a snack prior to practice exercise will make insulin more effective and move more glucose into the cells."

Answer: D (LEAVE A REPLY)

(A) A nurse can give this information to a client. (B) Exercise makes insulin more efficient in moving more glucose into the cells. No more insulin is needed. (C) Exercise makes insulin more efficient unless the diabetes is poorly controlled. (D) Exercise makes insulin more efficient in moving more glucose into the cells.

NEW QUESTION: 398

A long-term goal for the nurse in planning care for a depressed, suicidal client would be to:

- A. Provide him with a safe and structured environment.
- B. Assist him to develop more effective coping mechanisms.
- C. Have him sign a "no-suicide" contract.
- D. Isolate him from stressful situations that may precipitate a depressive episode.

Answer: (SHOW ANSWER)

(A) This statement represents a short-term goal. (B) Long-term therapy should be directed toward assisting the client to cope effectively with stress. (C) Suicide contracts represent short-term interventions. (D) This statement represents an unrealistic goal. Stressful situations cannot be avoided in reality.

NEW QUESTION: 399

In the client with a diagnosis of coronary artery disease, the nurse would anticipate the complication of bradycardia with occlusion of which coronary artery?

- A. Right coronary artery
- B. Left main coronary artery
- C. Circumflex coronary artery
- D. Left anterior descending coronary artery

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Sinus bradycardia and atrioventricular (AV) heart block are usually a result of right coronary artery occlusion. The right coronary artery perfuses the sinoatrial and AV nodes in most individuals. (B) Occlusion of the left main coronary artery causes bundle branch

blocks and premature ventricular contractions. (C) Occlusion of the circumflex artery does not cause bradycardia. (D) Sinus tachycardia occurs primarily with left anterior descending coronary artery occlusion because this form of occlusion impairs left ventricular function.

NEW QUESTION: 400

A child with celiac disease is being discharged from the hospital. The mother demonstrates knowledge of nutritional needs of her child when she is able to state the foods which are included in a:

- A. Lactose-restricted diet
- B. Gluten-restricted diet
- C. Phenylalanine-restricted diet
- D. Fat-restricted diet

Answer: ([SHOW ANSWER](#))

(A)

A lactose-restricted diet is prescribed for children with lactose intolerance or diarrhea.

(B)

A gluten-restricted diet is the diet for children with celiac disease. (C) A phenylalanine-restricted diet is prescribed for children with phenylketonuria. (D) A fat-restricted diet is prescribed for children with disorders of the liver, gallbladder, or pancreas.

NEW QUESTION: 401

The following nursing diagnosis is written for a comatose client with cirrhosis of the liver and secondary splenomegaly-High risk for injury: Increased susceptibility to bleeding related to:

- A. Increased absorption of vitamin K
- B. Thrombocytopenia due to hypersplenism
- C. Diminished function of the Kupffer cells
- D. Increased synthesis of the clotting factors

Answer: ([SHOW ANSWER](#))

Explanation

(A) There is a decreased absorption of vitamin K with cirrhosis of the liver. This decrease impairs blood coagulation and the formation of prothrombin. (B) Thrombocytopenia, an increased destruction of platelets, occurs secondary to hypersplenism. (C) A diminished function of the Kupffer cells occurs with cirrhosis of the liver, causing the client to become more susceptible to infections. (D) A decrease in the synthesis of fibrinogen and clotting factors VII, IX, and X occurs with cirrhosis of the liver and increases the susceptibility to bleeding.

NEW QUESTION: 402

A 14-year-old boy has a head injury with laceration of his scalp over his ear. The nurse should call the physician to report:

- A. Blood pressure increase from 100/80 to 115/85 after lunch
- B. Headache that is unresponsive to acetaminophen (Tylenol)
- C. Pulse rate ranges between 68 bpm and 76 bpm
- D. Temperature rise to 102°F rectally

Answer: D (LEAVE A REPLY)

Explanation

(A) This change in blood pressure may not be significant and does not indicate a widening pulse pressure, a late sign of increased ICP. It is important to continue to monitor for change in blood pressure. (B) Acetaminophen may be ineffective in relieving headache after head injury. Stronger analgesics are contraindicated because they mask neurological signs and may depress the CNS. (C) Pulse rates between 68 bpm and 76 bpm are within normal limits for a 14-year-old child. It is important to monitor for a consistent drop in pulse rate, which is a late sign of increasing ICP. (D) An elevated temperature is abnormal and requires further assessment and medical intervention. The temperature may be unrelated to the head injury, but CNS infection is serious and difficult to control.

NEW QUESTION: 403

Which of the following should be included in discharge teaching for a client with hepatitis C?

- A. He should take aspirin as needed for muscle and joint pain.
- B. He may become a blood donor when his liver enzymes return to normal.
- C. He should avoid alcoholic beverages during his recovery period.
- D. He should use disposable dishes for eating and drinking.

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Aspirin is hepatotoxic, may increase bleeding, and should be avoided. (B) Blood should not be donated by a client who has had hepatitis C because of the possibility of transmission of disease. (C) Alcohol is detoxified in the liver. (D) Hepatitis C is not spread through the oral route.

NEW QUESTION: 404

During an examination, the nurse notes that an infant has diaper rash on the convex surfaces of his buttocks, inner thighs, and scrotum. Which of the following nursing interventions will be most effective in resolving the condition?

- A. Coating the inflamed areas with zinc oxide
- B. Using talcum powder on the inflamed areas to promote drying
- C. Removing the diaper entirely for extended periods of time
- D. Cleaning the inflamed area thoroughly with disposable wet "wipes" at each diaper change

Answer: (SHOW ANSWER)

(A) Zinc oxide is not usually applied to inflamed areas because it contributes to sweat retention. (B) Talcum powder is of questionable benefit and poses a hazard of accidental inhalation. (C) Removing the diaper and exposing the area to air and light facilitate drying and healing. (D) Infants may be sensitive to one or more agents in the wet "wipes." It is better to simply clean with a wet cloth.

NEW QUESTION: 405

The nurse and prenatal client discuss the effects of cigarette smoking on pregnancy. It would be correct for the nurse to explain that with cigarette smoking there is increased risk that the baby will have:

- A. Nicotine withdrawal
- B. A birth defect
- C. Anemia
- D. A low birth weight

Answer: D ([LEAVE A REPLY](#))

(A) Women who smoke during pregnancy are at increased risk for miscarriage, preterm labor, and IUGR in the fetus. (B) Although smoking produces harmful effects on the maternal vascular system and the developing fetus, it has not been directly linked to fetal anomalies. (C) Smoking during pregnancy has not been directly linked to anemia in the fetus. (D) Smoking during pregnancy has not been linked to nicotine withdrawal symptoms in the newborn.

NEW QUESTION: 406

The following medications were noted on review of the client's home medication profile. Which of the medications would most likely potentiate or elevate serum digoxin levels?

- A. KCl
- B. Thyroid agents
- C. Quinidine
- D. Theophylline

Answer: ([SHOW ANSWER](#))

Section: Questions Set A

Explanation:

(A) Hypokalemia can cause digoxin toxicity. Administration of KCl would prevent this. (B) Thyroid agents decrease digoxin levels. (C) Quinidine increases digoxin levels dramatically. (D) Theophylline is not noted to have an effect on digoxin levels.

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NEW QUESTION: 407

In performing the initial nursing assessment on a client at the prenatal clinic, the nurse will know that which of the following alterations is abnormal during pregnancy?

- A. Striae gravidarum
- B. Chloasma
- C. Dysuria
- D. Colostrum

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Striae gravidarum are the normal stretch marks that frequently occur on the breasts, abdomen, and thighs as pregnancy progresses. (B) Chloasma is the "mask of pregnancy" that normally occurs in many pregnant women. (C) Dysuria is an abnormal danger sign during pregnancy and may indicate a urinary tract infection. (D) Colostrum is a yellow breast secretion that is normally present during the last trimester of pregnancy.

NEW QUESTION: 408

A client delivered her first-born son 4 hours ago. She asks the nurse what the white cheeselike substance is under the baby's arms. The nurse should respond:

- A. "This is a normal skin variation in newborns. It will go away in a few days."
- B. "Let me have a closer look at it. The baby may have an infection."
- C. "This material, called vernix, covered the baby before it was born. It will disappear in a few days."
- D. "Babies sometimes have sebaceous glands that get plugged at birth. This substance is an example of that condition."

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This response identifies the fact that vernix is a normal neonatal variation, but it does not teach the client medical terms that may be useful in understanding other healthcare personnel. (B) This response may raise maternal anxiety and incorrectly identifies a normal neonatal variation. (C) This response correctly identifies this neonatal variation and helps the client to understand medical terms as well as the characteristics of her newborn. (D) Blocked sebaceous glands produce milia, particularly present on the nose.

NEW QUESTION: 409

A male client is diagnosed with hypoparathyroidism. He has been on dialysis for several years. He is experiencing symptoms such as numbness of the lips, muscle weakness, carpopedal spasms, and wheezing.

Given the client's symptoms, nursing assessment would focus on:

- A. Detection of tetany
- B. Detection of hypocalcemia to prevent seizures
- C. Evidence of depression
- D. Detection of premature cataract formation

Answer: A (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) Assessment should focus on detection of tetany, which is the most common symptom of hypoparathyroidism. Left undetected and untreated, tetany resulting from hypocalcemia can progress to seizures. (B) Hypocalcemia is difficult to detect on nursing assessment alone. Abdominal cramping may be an indication of hypocalcemia, but laboratory data are required to confirm diagnosis. (C) Depression can be a symptom of hypoparathyroidism, but it is not definitive. (D) Premature cataract formation can occur, but it also is not specific to parathyroidism and poses no immediate danger to the client.

NEW QUESTION: 410

Painless vaginal bleeding in the last trimester may be caused by:

- A. Menstruation
- B. Abruptio placentae
- C. Placenta previa
- D. Polyhydramnios

Answer: C (LEAVE A REPLY)

(A) Menstruation should not occur during pregnancy. (B) Abruptio placentae is marked by painful vaginal bleeding following a premature placental detachment after 20th week of gestation. (C) A low-lying placenta separates from the uterine wall as the uterus contracts and cervix dilates. This separation causes painless bleeding in the 7th-8th month. (D) Polyhydramnios is excessive amniotic fluid.

NEW QUESTION: 411

A premature infant needs supplemental O₂ therapy. A nursing intervention that reduces the risk of retrolental fibroplasia is to:

- A. Maintain O₂ at <40%
- B. Maintain O₂ at >40%
- C. Give moist O₂ at >40%
- D. Maintain on 100% O₂

Answer: A (LEAVE A REPLY)

(A) Retrolental fibroplasia is the result of prolonged exposure to high levels of O₂ in premature infants. Complications are hemorrhage and retinal detachment. (B, C, D) O₂ concentration is too high.

NEW QUESTION: 412

A male client is scheduled to have angiography of his left leg. The nurse needs to include which of the following when preparing the client for this procedure?

- A.** Validate that he is not allergic to iodine or shellfish.
- B.** Instruct him to start active range of motion of his left leg immediately following the procedure.
- C.** Inform him that he will not be able to eat or drink anything for 4 hours after the procedure.
- D.** Inform him that vital signs will be taken every hour for 4 hours after the procedure.

Answer: A (LEAVE A REPLY)

Explanation

(A) Angiography, an invasive radiographic examination, involves the injection of a contrast solution (iodine) through a catheter that has been inserted into an artery. (B) The client is kept on complete bed rest for 6-12 hours after the procedure. The extremity in which the catheter was inserted must be immobilized and kept straight during this time. (C) The contrast dye, iodine, is nephrotoxic. The client must be instructed to drink a large quantity of fluids to assist the kidneys in excreting this contrast media. (D) The major complication of this procedure is hemorrhage. Vital signs are assessed every 15 minutes initially for signs of bleeding.

NEW QUESTION: 413

A female client has been diagnosed with chronic renal failure. She is a candidate for either peritoneal dialysis or hemodialysis and must make a choice between the two. Which information should the nurse give her to help her decide?

- A.** Hemodialysis involves less time to filter the blood; but the client must consider travel time, distance, and inconvenience.
- B.** Hemodialysis involves more time to filter the blood than does peritoneal dialysis.
- C.** Peritoneal dialysis has almost no complications and is less time consuming than hemodialysis. Therefore it is preferred.
- D.** Peritoneal dialysis requires that a home health nurse prepare and administer the treatments.

Answer: A (LEAVE A REPLY)

Explanation

(A) Hemodialysis is faster in clearing the blood of toxins than peritoneal dialysis. However, clients must consider the time that they spend traveling to the dialysis center and the disruption in their daily lives. (B) Peritoneal dialysis requires several exchanges with dwelling time for the dialysate and therefore takes longer than hemodialysis. (C) Several

serious complications of peritoneal dialysis include peritonitis, catheter displacement and/or plugging, or pain during dialysis. (D) A client can be taught to self-administer peritoneal dialysis without the aid of a professional.

NEW QUESTION: 414

At 32 weeks' gestation, a client is scheduled for a fetal activity test (nonstress test). She calls the clinic and asks the RN, "How do I prepare for the test I am scheduled for?" The RN will most likely inform her of the following instructions to help prepare her for the test:

- A. "You need to know that an IV is always started before the test."
- B. "You will need to drink 6 to 8 glasses of water to fill your bladder."
- C. "Do not eat any food or drink any liquids before the test is started."
- D. "You will have to remain as still as you possibly can."

Answer: D (LEAVE A REPLY)

(A) An IV line is not started in a nonstress test, because this test is used as an indicator of fetal well-being. This test measures fetal activity and heart rate acceleration. (B) The bladder does not have to be full prior to this test. It is not a sonogram test where a full bladder enables other structures to be scanned. (C) It has been proved that eating or drinking liquids prior to the test can assist in increasing fetal activity. (D) Any maternal activity will interfere with the results of the test.

NEW QUESTION: 415

A primigravida with a blood type A negative is at 28 weeks' gestation. Today her physician has ordered a RhoGAM injection. Which statement by the client demonstrates that more teaching is needed related to this therapy?

- A. "I'm getting this shot so that my baby won't develop antibodies against my blood, right?"
- B. "I understand that if my baby is Rh positive I'll be getting another one of these injections."
- C. "This shot should help to protect me in future pregnancies if this baby is Rh positive, like my husband."
- D. "This shot will prevent me from becoming sensitized to Rh-positive blood."

Answer: (SHOW ANSWER)

(A) RhoGAM is given to Rh-negative mothers to prevent the maternal Rh immune response to fetal Rh-positive antigens. (B) If the infant is Rh positive, the mother will receive another dose postdelivery to prevent maternal sensitization. (C) Prevention of maternal sensitization will protect future pregnancies because the mother's blood will be free of antibodies against her fetus. (D) RhoGAM prevents maternal sensitization to Rh-positive blood.

NEW QUESTION: 416

A client is admitted to the labor room. She is dilated 4 cm. She is placed on electric fetal monitoring. Which of the following observations necessitates notifying the physician?

- A. Contractions every 2 minutes, lasting 100 seconds
- B. Fetal heart decelerations during a contraction
- C. Beat-to-beat variability between contractions
- D. Fetal heart decelerations at the beginning of contractions

Answer: [\(SHOW ANSWER\)](#)

(A) These are tetanic in nature and can cause rupture of the uterus. (B) The FHR decreases during contractions owing to vasoconstriction and should recover after the contraction. (C) Beat-to-beat variability is a normal finding and demonstrates fetal wellbeing. (D) The FHR may decrease at the beginning of a contraction owing to head compression.

NEW QUESTION: 417

The nurse observes that a client has difficulty chewing and swallowing her food. A nursing response designed to reduce this problem would include:

- A. Ordering a full liquid diet for her
- B. Ordering five small meals for her
- C. Ordering a mechanical soft diet for her
- D. Ordering a pureed diet for her

Answer: [C \(LEAVE A REPLY\)](#)

(A) Full liquids would be difficult to swallow if the muscle control of the swallowing act is affected; this is a probable reason for her difficulties, given her medical diagnosis of multiple sclerosis. (B) Five small meals would do little if anything to decrease her swallowing difficulties, other than assure that she tires less easily. (C) A mechanical soft diet should be easier to chew and swallow, because foods would be more evenly consistent. (D) A pureed diet would cause her to regress more than might be needed; the mechanical soft diet should be tried first.

NEW QUESTION: 418

A client is hyperactive and not sleeping. She will not remain at the table during mealtime. She is getting very limited calories and is using a lot of energy in her hyperactive state. The most therapeutic nursing action is to:

- A. Insist that she remain at the table and eat a balanced diet.
- B. Order a high-calorie diet with supplements.
- C. Provide nutritious finger foods several times a day.
- D. Offer to go to the dining room with her and allow her to open the food and inspect what she eats.

Answer: [C \(LEAVE A REPLY\)](#)

Explanation/Reference:

Explanation:

(A) The client is not able to sit for long periods. Forcing her to remain at the table will increase her anxiety and cause her to become hostile. (B) This action will not ensure that the client eats what is ordered.

Dietary orders are not within the nurse's scope of practice. (C) Providing finger foods increases the likelihood of eating for hyperactive persons. They may be eating "on the run." (D) These clients are not suspicious of the food or insecure in moving about the unit alone.

NEW QUESTION: 419

A 52-year-old female client is admitted to the hospital in acute renal failure. She has been on hemodialysis for the past 2 years. Stat arterial blood gases are drawn on the client yielding the following results: pH 7.30, PCO₂ 51 mm Hg, HCO₃, 18 mEq/L, PaO₂, 84 mm Hg. The nurse would interpret these results as:

- A.** Compensated metabolic alkalosis
- B.** Respiratory acidosis
- C.** Partially compensated metabolic alkalosis
- D.** Combined respiratory and metabolic acidosis

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Compensated metabolic alkalosis would be reflected by the following: pH within normal limit (7.35-

7.45), PCO₂ > 45 mm Hg, HCO₃ >26 mEq/L. (B) Respiratory acidosis would be reflected by the following:

pH < 7.35, PCO₂ > 45 mm Hg, HCO₃ within normal limits (22-26 mEq/L). (C) Partially compensated metabolic alkalosis would be reflected by the following: pH > 7.45, PCO₂ > 45 mm Hg, HCO₃ > 26 mEq/L.

(D) Combined respiratory and metabolic acidosis would be reflected by the following: pH < 7.35, PCO₂ > 45 mm Hg, HCO₃ < 22 mEq/L.

NEW QUESTION: 420

A 50-year-old depressed client has recently lost his job. He has been reluctant to leave his hospital room.

Nursing care would include:

- A.** Forcing the client to attend all unit activities
- B.** Encouraging the client to discuss why he is so sad
- C.** Monitoring elimination patterns
- D.** Providing sensory stimulation

Answer: C (LEAVE A REPLY)

Explanation

(A) The client should be encouraged to attend the unit activities. The nurse and client should choose a few activities for the client to attend that will be positive experiences for him. (B) The nurse should encourage the client to discuss his feelings and to begin to deal with the depression. (C) Depressed persons often have little appetite and poor fluid intake. Constipation is common. (D) A calm, consistent level of stimuli is most effective. Sensory deprivation and overstimulation should be avoided.

NEW QUESTION: 421

The nurse is assessing and getting a history from a client treated for depression with a monoamine oxidase (MAO) antidepressant. The most serious side effect associated with this antidepressant and the ingestion of tyramine in aged foods may be:

- A. Hypertensive crisis
- B. Severe rash
- C. Severe hypotension
- D. Severe diarrhea

Answer: A (LEAVE A REPLY)

(A) The most serious adverse reactions of MAO inhibitors involve blood pressure and ingestion of tyramine-containing foods, which may provoke a hypertensive crisis. (B) MAO inhibitors cause adverse reactions affecting the central nervous system and serious adverse reactions involving blood pressure. (C) MAO inhibits false neurotransmitters (phenylalanines) and may produce hypotensive reactions from gradual accumulation of these neurotransmitters. (D) The most serious adverse reactions of MAO inhibitors involve blood pressure.

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NEW QUESTION: 422

A 6-year-old child is attending a pediatric clinic for a routine examination. What should the nurse assess for while conducting a vision screening?

- A. Hearing test
- B. Gait
- C. Strabismus
- D. Papilledema

Answer: C ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

(A) Hearing should be assessed separately. (B) Gait should be assessed separately. Client usually remains in one place for vision screening. Gait is part of neurological assessment. (C) Strabismus is crossing of eyes or outward deviation, which may cause diplopia or amblyopia. It is easily assessed during vision screening. (D) Papilledema is assessed by an ophthalmoscopic examination, which follows vision screening. It is part of neurological assessment.

NEW QUESTION: 423

What is the appropriate nursing action for a child with increased intracranial pressure?

- A.** Head of bed elevated 45 degrees with child's head maintained in a neutral position
- B.** Child lying flat
- C.** Head turned to side
- D.** Frequent visitation for stimulation

Answer: A ([LEAVE A REPLY](#))

(A) Elevation of head of bed and neutral head position promote drainage of cerebrospinal fluid. (B) Flat position increases intracranial pressure and impedes cerebrospinal fluid drainage. (C) Head turned to either side impedes cerebrospinal fluid drainage. (D) Child should be in a calm, quiet environment with minimal stimulation.

NEW QUESTION: 424

At 16 weeks' gestation, a pregnant client is admitted to the maternity unit to have a McDonald procedure (cerclage) done. She tells the RN who is admitting her to the unit that her physician had explained what this procedure was, but that she did not understand. The RN explains to the client that the purpose for this procedure is to:

- A.** Reinforce an incompetent cervix
- B.** Repair the amniotic sac
- C.** Evaluate cephalopelvic disproportion
- D.** Dilate the cervix

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

(A) The treatment most commonly uses the Shirodkar-Barter procedure (McDonald procedure) or cerclage to enforce the weakened cervix by encircling it with a suture at the level of the internal os. (B) There is no known procedure that is used to repair the amniotic sac. (C) Cephalopelvic disproportion is evaluated later in pregnancy. It is not related to this procedure. (D) No procedure is done to dilate the cervix at 16 weeks' gestation unless the pregnancy is to be terminated.

NEW QUESTION: 425

When teaching a sex education class, the nurse identifies the most common STDs in the United States as:

- A. Chlamydia
- B. Herpes genitalis
- C. Syphilis
- D. Gonorrhea

Answer: ([SHOW ANSWER](#))

Explanation

(A) Chlamydia trachomatis infection is the most common STD in the United States. The Centers for Disease Control and Prevention recommend screening of all high-risk women, such as adolescents and women with multiple sex partners. (B) Herpes simplex genitalia is estimated to be found in 5-20 million people in the United States and is rising in occurrence yearly. (C) Syphilis is a chronic infection caused by *Treponema pallidum*. Over the last several years the number of people infected has begun to increase. (D) Gonorrhea is a bacterial infection caused by the organism *Neisseria gonorrhoeae*. Although gonorrhea is common, chlamydia is still the most common STD.

NEW QUESTION: 426

A mother is unsure about the type of toys for her 17-month-old child. Based on knowledge of growth and development, what toy would the nurse suggest?

- A. A pull toy to encourage locomotion
- B. A mobile to improve hand-eye coordination
- C. A large toy with movable parts to improve pincer grasp
- D. Various large colored blocks to teach visual discrimination

Answer: ([SHOW ANSWER](#))

Explanation

(A) Increased locomotive skills make push-pull toys appropriate for the energetic toddler. (B) Infants progress from reflex activity through simple repetitive behaviors to imitative behavior. Hand-eye coordination forms the foundation of other movements. (C) At age 8 months, infants begin to have pincer grasp. Toys that help infants develop the pincer grasp are recommended for this age group. (D) Various large colored blocks are suggested toys for infants 6-12 months of age to help visual stimulation.

NEW QUESTION: 427

A 22-year-old single woman was admitted to the psychiatric hospital by her mother, who reported bizarre behavior. Except for going to work, she spends all her time in her room and expresses concern over neighbors spying on her. She has fears of the telephone being "bugged." Her diagnosis is schizophrenia. One nurse per shift is assigned to work with the client. The primary reason for this plan would be to:

- A. Protect her from suicide

- B. Enable her to develop trust
- C. Supervise her medication regimen
- D. Involve her in groups for social interaction

Answer: B (LEAVE A REPLY)

Explanation

(A) Suicide is a greater risk in depression than in schizophrenia. (B) The client is suspicious and needs help to develop trust, which is basic to her improvement. (C) Although she will be taking medication, drug therapy would not necessitate consistency in the nurses assigned. (D) A suspicious client should have limited exposure to groups, because group participation increases discomfort.

NEW QUESTION: 428

A family is experiencing changes in their lifestyle in many ways. The invalid grandmother has moved in with them. The couple have a 2-year-old son by their marriage, and the wife has two children by her previous marriage. The older children are in high school. In applying systems theory to this family, it is important for the nurse to remember which of the following principles?

- A. The parts of a system are only minimally related.
- B. Dysfunction in one part affects every other part.
- C. A family system has no boundaries.
- D. Healthy families are enmeshed.

Answer: B (LEAVE A REPLY)

Explanation

(A) The parts of a system are interrelated. (B) Any change in any part of the system affects all other parts. (C) A family system, like any other system, has boundaries. (D) Healthy families are neither enmeshed nor disengaged.

NEW QUESTION: 429

A client's renal calculi are identified as consisting of calcium phosphate. Which of the following diets would be appropriate?

- A. High calcium, low phosphorus
- B. Low calcium, high phosphorus
- C. Two-gram sodium diet
- D. Low calcium and phosphorus, acid ash

Answer: D (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) The stones consist of calcium and phosphorus; therefore, these minerals should be avoided. A high- calcium diet is contraindicated. (B) A high-phosphorus diet is contraindicated. (C) A 2-g sodium diet is a cardiac diet. (D) A low-calcium and phosphorus diet will reduce further calculi formation.

NEW QUESTION: 430

The nurse teaches a male client ways to reduce the risks associated with furosemide therapy. Which of the following indicates that he understands this teaching?

- A. "I'll be sure to rise slowly and sit for a few minutes after lying down."
- B. "I'll be sure to walk at least 2-3 blocks every day."
- C. "I'll be sure to restrict my fluid intake to four or five glasses a day."
- D. "I'll be sure not to take any more aspirin while I am on this drug."

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) This response will help to prevent the occurrence of postural hypotension, a common side effect of this drug and a common reason for falls. (B) Although walking is an excellent exercise, it is not specific to the reduction of risks associated with diuretic therapy. (C) Clients on diuretic therapy are generally taught to ensure that their fluid intake is at least 2000-3000 mL daily, unless contraindicated. (D) Aspirin is a safe drug to take along with furosemide.

NEW QUESTION: 431

A client at 6 months' gestation complains of tiredness and dizziness. Her hemoglobin level is 10 g/dL, and her hematocrit value is 32%. Her nutritional intake is assessed as sufficient. The most likely diagnosis is:

- A. Iron-deficiency anemia
- B. Physiological anemia
- C. Fatigue due to stress
- D. No problem indicated

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) This clinical situation is indicative of iron-deficiency anemia because the client has inadequate nutritional intake. Her blood volume is increasing faster than her red blood cell volume. Anemia is present in the second trimester when the hemoglobin level is <10.5 and the hematocrit value falls below 35%. She needs increased iron supplements with follow-up. (B) The client's values are below levels for physiological anemia. (C) The client is fatigued because of a low hemoglobin level. (D) Her hemoglobin level is low and will probably decrease even more when the blood volume peaks at 28 weeks.

NEW QUESTION: 432

A client is to be discharged from the hospital and is to continue taking warfarin 2.5 mg po bid. Which of the following should be included in her discharge teaching concerning the warfarin therapy?

- A. "If you forget to take your morning dose, double the night time dose."

- B. "You should take aspirin instead of acetaminophen (Tylenol) for headaches."
- C. "Carry a medications alert card with you at all times."
- D. "You should use a straight-edge razor when shaving your arms and legs."

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) Warfarin must always be taken exactly as directed. Clients should be instructed never to skip or double up on their dosage. (B) Aspirin decreases platelet aggregation, which would potentiate the effects of the coumadin. (C) Healthcare providers need to be aware of persons on warfarin therapy prior to the initiation of any diagnostic tests and/or surgery to help prevent bleeding complications. (D) An electric razor should be used to prevent accidental cutting, which can lead to bleeding.

NEW QUESTION: 433

An elective saline abortion has been performed on a 3- week primigravida. Following the procedure, the nurse should be alert for which early side effect?

- A. Water satiety
- B. Thirst
- C. Edema
- D. Diabetes insipidus

Answer: B ([LEAVE A REPLY](#))

(A) If the client is experiencing water satiety, there is no more desire for water. (B) Absorption of saline into circulation rather than into amniotic sac increases serum sodium and desire for water. (C) Edema can be a late side effect caused by water intoxication. (D) Diabetes insipidus occurs as a result of deficient antidiuretic hormone.

NEW QUESTION: 434

Loss of appetite for a child with leukemia is a major recurrent problem. The plan of care should be designed to:

- A. Reinforce attempts to eat
- B. Help the child gain weight
- C. Increase his appetite
- D. Make mealtimes pleasant

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Ignoring refusals to eat and rewarding eating attempts are the most successful means of increasing intake. (B) This goal is not specific enough or related to the loss of appetite. (C) This goal is not possible at this time based on his illness. (D) This goal is helpful, but alone will not address his loss of appetite.

NEW QUESTION: 435

A client who was started on antipsychotic medication 2 weeks ago is preparing for discharge from the hospital.

Compliance with the medication regimen is important despite the mild side effects encountered. In order to increase the likelihood of medication compliance, the nurse would:

- A.** Discuss the disease process and the importance of the medication in prevention of symptoms.
- B.** Inform the client that additional side effects are to be expected and need not be reported.
- C.** Discuss the importance of getting blood drawn weekly to determine medication therapeutics.
- D.** Inform the client to cease taking the medication when all psychotic symptoms have cleared.

Answer: A (LEAVE A REPLY)

Explanation

(A) This answer is correct. If the client is well informed about what reactions to expect from her medication, she is more likely to follow the treatment regimen. (B) This answer is incorrect. There are many side effects that are reversible by medication, and these must be reported to the nurse or physician. There are also more severe side effects, such as neuroleptic malignant syndrome, characterized by fever, tachycardia, and diaphoresis, which can be life threatening. (C) This answer is incorrect. There is no need for weekly blood tests if the drug regimen has been followed properly. (D) This answer is incorrect. The client should continue the medication until the physician recommends any change in the drug regimen. Symptoms will usually reappear if medication is discontinued.

NEW QUESTION: 436

A client is admitted to the hospital with a diagnosis of aplastic anemia and placed on isolation. The nurse notices a family member entering the room without applying the appropriate apparel. The nurse will approach the family member using the following information as a basis for discussion:

- A.** The risks of exposure of the visitor to infectious organisms is great.
- B.** Hospital regulations mandate that everyone in the facility adhere to appropriate codes.
- C.** The client is at extreme risk of acquiring infections.
- D.** Adherence to the guidelines are the latest Centers for Disease Control and Prevention recommendations on use of protective apparel.

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Although clients with a compromised immune system may acquire infections, the primary emphasis is on protecting the client. (B, D) Most people are aware of the guidelines once they see posted signs, so quoting regulations is not likely to result in

consistent adherence to regulations. (C) Clients with aplastic anemia have white cell counts of 2000 or lower, making them more vulnerable to infections from others.

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NEW QUESTION: 437

A client who has been diagnosed with anorexia nervosa refuses to eat lunch. The most therapeutic response by the nurse to her refusal is:

- A. "Okay, missing one meal won't hurt."
- B. "You'll have to eat lunch, or we'll force-feed you."
- C. "It's not appropriate for you to try to manipulate the staff into granting your wishes."
- D. "We will not allow you to starve yourself. You may choose to eat voluntarily or be fed."

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) This response reinforces the client's maladaptive behavior, thereby contributing to the client's risk. (B) Ultimatums are not therapeutic. (C) This comment invites an argument because it puts the client on the defensive and stabs at her self-esteem, which is already compromised. (D) Setting limits assures the client that staff has genuine concern for her safety and well-being. Giving her an actual choice will give the client an increased sense of control over her life and avoid an argument or power struggle.

NEW QUESTION: 438

A client had a ruptured abdominal aortic aneurysm that was repaired surgically. Her postoperative recovery progressed without complications, and she is ready for discharge. Client education in preparation for discharge began 7 days ago on her admission to the nursing unit. Evaluation of nursing care related to client education is based on evaluation of expected outcomes. Which statement made by the client would indicate that she is ready for discharge?

- A. "I will not drive but ride in the front seat of the car with a seat belt on for my first doctor's appointment."
- B. "When I bathe tomorrow morning, I will be very careful not to get soap on my incision."
- C. "I am allowed to exercise by walking for short periods."
- D. "Teach my husband about the diet. He'll be doing all the cooking now."

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Postoperatively, clients with major abdominal surgery are instructed to avoid driving, riding in the front seat, and wearing seat belts because any sudden impact may injure a fresh incision. She should ride in back seat without a seat belt. (B) Clients should not sit in the tub and allow the incision to soak in water because this may predispose the client to infection. A short, cool shower would be preferable. Allowing soap to come in contact with the incision would not harm it and is frequently used as postoperative wound care at home on discharge from the hospital. (C) Activity instructions include: avoid sitting for long periods and get exercise by walking. Lifting more than 5 lb of weight is also prohibited. (D) The client must also learn her diet. Her husband cooking is probably a temporary measure unless he did the cooking prior to her hospitalization. A statement such as this may indicate the need for further exploration of feelings regarding her illness, dependence, and self-care expectations.

NEW QUESTION: 439

Clients receiving antipsychotic drug therapy will often exhibit extrapyramidal side effects that are reversible with which of the following agents ordered by the physician?

- A. Phenothiazines
- B. Anticholinergics
- C. Anti-Parkinsonian drugs
- D. Tricyclic agents

Answer: ([SHOW ANSWER](#))

Explanation

(A) This answer is incorrect. Phenothiazines are antipsychotic drugs and produce the symptoms. (B) This answer is correct. Anticholinergic agents are often used prophylactically for extrapyramidal symptoms. They balance cholinergic activity in the basal ganglia of the brain. (C) This answer is incorrect. Anti-Parkinsonian drugs would increase the symptoms. (D) This answer is incorrect. Tricyclic agents are used for symptoms of depression.

NEW QUESTION: 440

A 3-year-old child was hospitalized for acute laryngotracheobronchitis. During her hospitalization, the child was placed under an oxygen mist tent. The nurse's frequent monitoring of the child's temperature frightened her parents. Which response by the nurse would be most appropriate?

- A. Monitoring the temperature prevents undue chilling.
- B. Rapid temperature elevations can occur in children.
- C. Checking the temperature will prevent febrile seizures.
- D. Taking the child's temperature can prevent airway obstruction.

Answer: A (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) The refrigerated cool mist tent creates a cool, moist environment. The child as well as bedding and clothing may become dampened. Monitoring the temperature of the child will ensure warmth and prevent chilling. (B) Only a low-grade fever is expected in laryngotracheobronchitis. (C) Febrile seizures are not expected with the low-grade fever. (D) Inflammation of the mucosal lining in the respiratory tract can cause airway obstruction. However, monitoring the child's temperature would not prevent airway obstruction.

NEW QUESTION: 441

A client has returned to the unit following a left femoral popliteal bypass graft. Six hours later, his dorsalis pedis pulse cannot be palpated, and his foot is cool and dusky. The nurse should:

- A. Continue to monitor the foot
- B. Notify the physician immediately
- C. Reposition and reassess the foot
- D. Assure the client that his foot is fine

Answer: B (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) The client is losing blood supply to his left foot. Continuing to monitor the foot will not help restore the blood supply to the foot. (B) The physician should be notified immediately because the client is losing blood supply to his left foot and is in danger of losing the foot and/or leg. (C) The presenting symptoms are of an emergency nature and require immediate intervention. (D) This action would be giving the client false assurance.

NEW QUESTION: 442

A 19-year-old male client arrived via ambulance to the emergency room following a motorcycle accident.

He is comatose. His face has evidence of dried blood. On assessment, the nurse notes an obvious injury to his left eye. The preferred positioning for a client with an obvious eye injury is:

- A. Reclining to control bleeding
- B. Any position in which the client is comfortable
- C. Side-lying, either left or right
- D. Sitting with head support

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) A reclining position can cause a penetrating object to advance further into the eye. (B) Prevention of further injury is the priority, not comfort. (C) A side-lying position may increase intraocular and intracranial pressure if an accompanying head injury is suspected. (D) A sitting position with the head supported will prevent further injury while allowing injury care to take place.

NEW QUESTION: 443

A 60-year-old male client was hospitalized 3 days ago with the diagnosis of acute anterior wall myocardial infarction. Today he has been complaining of increasing weakness and shortness of breath. Crackles in both lung bases are audible on auscultation. He is developing:

- A.** An extension of his myocardial infarction
- B.** Pneumonia
- C.** Pulmonary edema
- D.** Pulmonary emboli

Answer: C ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

(A) Extensions of his myocardial infarction would be chest pain unrelieved with nitroglycerin, cardiac enzyme elevations, and electrocardiographic changes. (B) Persons with pneumonia may complain of weakness and shortness of breath and have crackles in their lung bases. However, they would also have sputum production and leukocytosis. (C) Persons who have had myocardial infarctions (especially anterior wall) are at risk of developing left ventricular heart failure, which is a major cause of pulmonary edema. Pulmonary edema is manifest by shortness of breath, weakness, and crackles on auscultation of the lung fields. (D) Pulmonary emboli may be accompanied by shortness of breath, weakness, and crackles. However, the pulmonary hypertension that accompanies pulmonary emboli results in signs of increased systemic venous pressure as well.

NEW QUESTION: 444

When assessing a child with diabetes insipidus, the nurse should be aware of the cardinal signs of:

- A.** Anemia and vomiting
- B.** Polyuria and polydipsia
- C.** Irritability relieved by feeding formula
- D.** Hypothermia and azotemia

Answer: ([SHOW ANSWER](#))

Section: Questions Set A

Explanation:

(A) Anemia and vomiting are not cardinal signs of diabetes insipidus. (B) Polyuria and polydipsia are the cardinal signs of diabetes insipidus. (C) Irritability relieved by feeding

water, not formula, is a common sign, but not the cardinal sign, of diabetes insipidus. (D) Hypothermia and azotemia are signs, but not cardinal signs, of diabetes insipidus.

NEW QUESTION: 445

The primary reason for sending a burn client home with a pressure garment, such as a Jobst garment, is that the garment:

- A.** Decreases hypertrophic scar formation
- B.** Assists with ambulation
- C.** Covers burn scars and decreases the psychological impact during recovery
- D.** Increases venous return and cardiac output by normalizing fluid status

Answer: [\(SHOW ANSWER\)](#)

(A) Tubular support, such as that received with a Jobst garment, applies tension of 10-20 mm Hg. This amount of uniform pressure is necessary to prevent or reduce hypertrophic scarring. Clients typically wear a pressure garment for 6-12 months during the recovery phase of their care. (B) Pressure garments have no ambulatory assistive properties. (C) Pressure garments can worsen the psychological impact of burn injury, especially if worn on the face. (D) Pressure garments do not normalize fluid status.

NEW QUESTION: 446

The nurse would assess the client's correct understanding of the fertility awareness methods that enhance conception, if the client stated that:

- A.** "My sexual partner and I should have intercourse when my cervical mucosa is thick and cloudy."
- B.** "At ovulation, my basal body temperature should rise about 0.5°F."
- C.** "I should douche immediately after intercourse."
- D.** "My sexual partner and I should have sexual intercourse on day 14 of my cycle regardless of the length of the cycle."

Answer: [B \(LEAVE A REPLY\)](#)

Section: Questions Set B

Explanation:

(A) At ovulation, the cervical mucus is increased, stretchable, and watery clear. (B) Under the influence of progesterone, the basal body temperature increases slightly after ovulation. (C) To enhance fertility, measures should be taken that promote retention of sperm rather than removal. (D) Ovulation, the optimal time for conception, occurs 14±2 days before the next menses; therefore, the date of ovulation is directly related to the length of the menstrual cycle.

NEW QUESTION: 447

A 55-year-old woman entered the emergency room by ambulance. Her primary complaint is chest pain.

She is receiving O₂ via nasal cannula at 2 L/min for dyspnea. Which of the following findings in the client's nursing assessment demand immediate nursing action?

- A. Associated symptoms of indigestion and nausea
- B. Restlessness and apprehensiveness
- C. Inability to tolerate assessment session with the admitting nurse
- D. History of hypertension treated with pharmacological therapy

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Indigestion or nausea may accompany angina or myocardial infarction, but they do not indicate imminent danger for the client. (B) Restlessness and apprehensiveness require immediate nursing action because they are indicative of very low oxygenation of body tissues and are frequently the first indication of impending cardiac or respiratory arrest. (C) It is common for the cardiac client to experience fatigue and inability to physically tolerate long assessment sessions. (D) A history of hypertension requires no immediate nursing intervention. In the situation described, the blood pressure is not given and therefore cannot be assumed to be elevated.

NEW QUESTION: 448

The physician orders fluoxetine (Prozac) for a depressed client. Which of the following should the nurse remember about fluoxetine?

- A. Because fluoxetine is a tricyclic antidepressant, it may precipitate a hypertensive crisis.
- B. The therapeutic effect of the drug occurs 2-4 weeks after treatment is begun.
- C. Foods such as aged cheese, yogurt, soy sauce, and bananas should not be eaten with this drug.
- D. Fluoxetine may be administered safely in combination with monoamine oxidase (MAO) inhibitors.

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Fluoxetine is not a tricyclic antidepressant. It is an atypical antidepressant. (B) This statement is true.

(C) These foods are high in tyramine and should be avoided when the client is taking MAO inhibitors.

Fluoxetine is not an MAO inhibitor. (D) Fatal reactions have been reported in clients receiving fluoxetine in combination with MAO inhibitors.

NEW QUESTION: 449

A client is experiencing muscle weakness and lethargy. His serum K⁺ is 3.2. What other symptoms might he exhibit?

- A. Tetany

- B. Dysrhythmias
- C. Numbness of extremities
- D. Headache

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Tetany is seen with low calcium. (B) Low potassium causes dysrhythmias because potassium is responsible for cardiac muscle activity. (C) Numbness of extremities is seen with high potassium. (D) Headache is not associated with potassium excess or deficiency.

NEW QUESTION: 450

A physician's order reads: Administer furosemide oral solution 0.5 mL stat. The furosemide bottle dosage is 10 mg/mL. What dosage of furosemide should the nurse give to this infant?

- A. 5 mg
- B. 0.5 mg
- C. 0.05 mg
- D. 20 mg

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) 1 mg = 0.1 mL, then 0.5 mL X= 5 mg. (B) This answer is a miscalculation. (C) This answer is a miscalculation. (D) This answer is a miscalculation.

NEW QUESTION: 451

A 74-year-old client seen in the emergency room is exhibiting signs of delirium. His family states that he has not slept, eaten, or taken fluids for the past 24 hours. The planning of nursing care for a delirious client is based on which of the following premises?

- A. The delirious client is capable of returning to his previous level of functioning.
- B. The delirious client is incapable of returning to his previous level of functioning.
- C. Delirium entails progressive intellectual and behavioral deterioration.
- D. Delirium is an insidious process.

Answer: A (LEAVE A REPLY)

(A) This answer is correct. If the cause is removed, the delirious client will recover completely. (B) This answer is incorrect. The delirious client is incapable of returning to previous level of functioning. The delirious client is capable of returning to previous functioning. (C) This answer is incorrect. The delirious client, not the delirious client, has progressive intellectual and behavioral deterioration. (D) This answer is incorrect. Delirium develops rapidly, whereas dementia is insidious.

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NEW QUESTION: 452

The nurse is admitting an infant with bacterial meningitis and is prepared to manage the following possible effects of meningitis:

- A. Constipation
- B. Hypothermia
- C. Seizure
- D. Sunken fontanelles

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Constipation may occur if the child is dehydrated, but it is not directly associated with meningitis. (B) It is more likely the child will have fever. (C) Seizure is often the initial sign of meningitis in children and could become frequent. (D) It is more likely the child will have bulging fontanelles.

NEW QUESTION: 453

A physician tells the nurse that he wants to orally intubate a client with a No. 8 endotracheal tube. The finding of normal breath sounds on the right side of the chest and diminished, distant breath sounds on the left side of the chest of a newly intubated client is probably due to:

- A. A left hemothorax
- B. A right hemothorax
- C. Intubation of the right mainstem bronchus
- D. An inadequate mechanical ventilator

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) Although a left hemothorax could cause diminished and distant breath sounds, it is irrelevant to this situation. (B) A right hemothorax will not cause diminished and distant breath sounds on the left side of the chest. (C) The right mainstem bronchus is most frequently intubated in error because the angle of the right mainstem bronchus is very small as compared with that of the left mainstem bronchus. Because ventilation is only

occurring on the right side, the nurse would auscultate diminished and distant breath sounds on the left.

(D) An inadequate mechanical ventilator has no relationship to this situation.

NEW QUESTION: 454

On the third postpartum day, the nurse would expect the lochia to be:

- A.** Rubra
- B.** Serosa
- C.** Alba
- D.** Scant

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) This discharge occurs from delivery through the 3rd day. There is dark red blood, placental debris, and clots. (B) This discharge occurs from days 4-10. The lochia is brownish, serous, and thin. (C) This discharge occurs from day 10 through the 6th week. The lochia is yellowish white. (D) This is not a classification of lochia but relates to the amount of discharge.

NEW QUESTION: 455

When teaching a class of nursing students, the nurse asks why the embryonic period (weeks 4-8) of pregnancy is so critical.

- A.** Duplication of genetic information takes place.
- B.** Organogenesis occurs.
- C.** Subcutaneous fat builds up steadily.
- D.** Kidneys begin to secrete urine.

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) Duplication of genetic material occurs during the preembryonic period (weeks 1-3) following conception.

The exact duplication of genetic material is essential for cell differentiation, growth, and biological maintenance of the organism. (B) Weeks 4-8, known as the embryonic period, are the time organogenesis occurs and pose the greatest potential for major congenital malformations. All major internal and external organs and systems are formed. (C) Subcutaneous fat does not develop until the latter weeks of gestation. (D) Kidneys begin to secrete urine during the 13th-16th week.

NEW QUESTION: 456

A client has been in labor 10 hours and is becoming very tired. She has dilated to 7 cm and is at 0 station with the fetus in a right occipitoposterior position. She is complaining of severe backache with each contraction.

One comfort measure the nurse can employ is to:

- A. Place her in knee-chest position during the contraction
- B. Use effleurage during the contraction
- C. Apply strong sacral pressure during the contraction
- D. Have her push with each contraction

Answer: C (LEAVE A REPLY)

Explanation

(A) This measure is inappropriate. The knee-chest position is employed to take pressure off the cord. (B) Effleurage is a comfort measure but not the one that will contribute most to the relief of backache caused by a posterior position. (C) Sacral pressure will counteract the pressure created by the position of the fetal head. (D) The client is not completely dilated. Pushing is contraindicated until the second stage of labor.

NEW QUESTION: 457

The mother of a client is apprehensive about taking home her 2 year old who was diagnosed with asthma after being admitted to the emergency room with difficulty breathing and cyanosis. She asks the nurse what symptoms she should look for so that this problem will not happen again. The nurse instructs her to watch for the following early symptoms:

- A. Fever, runny nose, and hyperactivity
- B. Changes in breathing pattern, moodiness, fatigue, and edema of eyes
- C. Fatigue, dark circles under the eyes, changes in breathing pattern, glassy eyes, and moodiness
- D. Fever, cough, paleness, and wheezing

Answer: C (LEAVE A REPLY)

(A) The child with asthma may not have fever unless there is an underlying infection. (B) Edema of the eyes will not be present because the child with asthma is more likely to have dehydration related to excessive water loss during the work of breathing. (C) All of these symptoms indicate decreased oxygenation and are early symptoms of asthma. (D) Coughing and wheezing are not early signs of difficulty.

NEW QUESTION: 458

A 3-year-old child was hospitalized for acute laryngotracheobronchitis. During her hospitalization, the child was placed under an oxygen mist tent. The nurse's frequent monitoring of the child's temperature frightened her parents. Which response by the nurse would be most appropriate?

- A. Monitoring the temperature prevents undue chilling.
- B. Rapid temperature elevations can occur in children.
- C. Checking the temperature will prevent febrile seizures.
- D. Taking the child's temperature can prevent airway obstruction.

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The refrigerated cool mist tent creates a cool, moist environment. The child as well as bedding and clothing may become dampened. Monitoring the temperature of the child will ensure warmth and prevent chilling. (B) Only a low-grade fever is expected in laryngotracheobronchitis. (C) Febrile seizures are not expected with the low-grade fever. (D) Inflammation of the mucosal lining in the respiratory tract can cause airway obstruction. However, monitoring the child's temperature would not prevent airway obstruction.

NEW QUESTION: 459

An elective saline abortion has been performed on a 3- week primigravida. Following the procedure, the nurse should be alert for which early side effect?

- A.** Water satiety
- B.** Thirst
- C.** Edema
- D.** Diabetes insipidus

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) If the client is experiencing water satiety, there is no more desire for water. (B) Absorption of saline into circulation rather than into amniotic sac increases serum sodium and desire for water. (C) Edema can be a late side effect caused by water intoxication. (D) Diabetes insipidus occurs as a result of deficient antidiuretic hormone.

NEW QUESTION: 460

A couple is experiencing difficulties conceiving a baby. The nurse explains basal body temperature (BBT) by instructing the female client to take her temperature:

- A.** Orally in the morning and at bedtime
- B.** Only one time during the day as long as it is always at the same time of day
- C.** Rectally at bedtime
- D.** As soon as she awakens, prior to any activity

Answer: D (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) Monitoring temperature twice a day predicts the biphasic pattern of ovulation. (B) Prediction of ovulation relies on consistency in taking temperature. (C) Nightly rectal temperatures are more accurate in predicting ovulation. (D) Activity changes the accuracy of basal body temperature and ability to detect the luteinizing hormone surge.

NEW QUESTION: 461

Hematotympanum and otorrhea are associated with which of the following head injuries?

- A.** Basilar skull fracture

- B. Subdural hematoma
- C. Epidural hematoma
- D. Frontal lobe fracture

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set A

Explanation:

(A) Basilar skull fractures are fractures of the base of the skull. Blood behind the eardrum or blood or cerebrospinal fluid (CSF) leaking from the ear are indicative of a dural laceration. Basilar skull fractures are the only type with these symptoms. (B, C, D) These do not typically cause dural lacerations and CSF leakage.

NEW QUESTION: 462

The nurse is teaching a client how to perform monthly testicular self-examination (TSE) and states that it is best to perform the procedure right after showering. This statement is made by the nurse based on the knowledge that:

- A. The client is more likely to remember to perform the TSE when in the nude
- B. When the scrotum is exposed to cool temperatures, the testicles become large and bulky
- C. The scrotum will be softer and more relaxed after a warm shower, making the testicles easier to palpate
- D. The examination will be less painful at this time

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) Nudity is not a trigger for reminding males to perform TSE. (B) Testicles become more firm when exposed to cool temperatures, but not large and bulky. (C) The testicles will be lower and more easily palpated with warmer temperatures. A protective mechanism of the body to protect sperm production is for the scrotum to pull closer to the body when exposed to cooler temperatures. (D) The examination should not be painful.

NEW QUESTION: 463

As the nurse assesses a male adolescent with chlamydia, the nurse determines that a sign of chlamydia is:

- A. Enlarged penis
- B. Secondary lymphadenitis
- C. Epididymitis
- D. Hepatomegaly

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) An enlarged penis is not a sign of chlamydia. (B) Secondary lymphadenitis is a complication of lymphogranuloma venereum. (C) Untreated chlamydial infection can

spread from the urethra, causing epididymitis, which presents as a tender, scrotal swelling.
(D) Hepatomegaly is not a complication.

NEW QUESTION: 464

The nurse in the mental health center is instructing a depressed client about the dietary restrictions necessary in taking her medication, which is a monoamine oxidase (MAO) inhibitor. Which of the following is she restricting from the client's diet?

- A.** Cream cheese
- B.** Fresh fruits
- C.** Aged cheese
- D.** Yeast bread

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Cream cheese does not contain tyramine, which might cause a hypertensive crisis. (B) Fresh fruits do not contain tyramine, which might cause a hypertensive crisis. (C) Aged or matured cheese combined with a monoamine oxidase predisposes the client to a hypertensive crisis. (D) Bread products raised with yeast do not contain tyramine.

NEW QUESTION: 465

A 5-year-old child was recently diagnosed as having acute lymphoid leukemia. She is hospitalized for additional tests and to begin a course of chemotherapy designed to induce a remission. She is scheduled to have a bone marrow aspiration tomorrow. She has had a bone marrow test previously and is apprehensive about having another. Which of the following interventions will be most effective in relieving her anxiety?

- A.** Explain what will take place and what she will see, feel, and hear.
- B.** Remind her that she has had this procedure before and that it is nothing to be afraid of.
- C.** Tell her not to worry about it, that it will be over soon and she can join her friends in the playroom.
- D.** Give her a big hug and tell her that she is a big girl now and that she will do just fine.

Answer: A (LEAVE A REPLY)

(A)

Even though the child has had the procedure before, she will probably need additional explanations and emotional support. (B) The fact that the child has had the procedure before and possibly found it painful or uncomfortable may increase, not relieve, her stress.

(C)

This intervention does nothing to reassure the child and may well prevent her from expressing her feelings. (D) This does not prepare the child for the test and burdens her with the expectation that she act bigger and braver than she is.

NEW QUESTION: 466

At 16 weeks' gestation, a pregnant client is admitted to the maternity unit to have a McDonald procedure (cerclage) done. She tells the RN who is admitting her to the unit that her physician had explained what this procedure was, but that she did not understand. The RN explains to the client that the purpose for this procedure is to:

- A. Reinforce an incompetent cervix
- B. Repair the amniotic sac
- C. Evaluate cephalopelvic disproportion
- D. Dilate the cervix

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The treatment most commonly uses the Shirodkar-Barter procedure (McDonald procedure) or cerclage to enforce the weakened cervix by encircling it with a suture at the level of the internal os. (B) There is no known procedure that is used to repair the amniotic sac. (C) Cephalopelvic disproportion is evaluated later in pregnancy. It is not related to this procedure. (D) No procedure is done to dilate the cervix at 16 weeks' gestation unless the pregnancy is to be terminated.

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NEW QUESTION: 467

To prevent thrombophlebitis in a client on complete bed rest, the nursing care plan should include:

- A. Dangle the client's legs over the edge of the bed every shift.
- B. Massage the client's calves briskly every shift.
- C. Keep the client's legs extended and discourage any movement.
- D. Have the client tighten and relax leg muscles several times daily.

Answer: D (LEAVE A REPLY)

Explanation

(A) Dangling the client's legs over the edge of the bed will contribute to stasis and pooling of blood and increases the risk of thrombus formation. (B) Massaging the client's calves could result in dislodging an embolus. (C) Decreased movement will contribute to pooling of blood and increased risk of venous thrombosis. (D) Tightening and relaxing leg muscles increases circulation and decreases the risk of venous thrombosis.

NEW QUESTION: 468

A client is receiving peritoneal dialysis. He has been taught to warm the dialyzing fluid prior to instilling it because:

- A.** Warmed solution helps keep the body temperature maintained within a normal range during instillation
- B.** Warmed solution helps dilate the peritoneal blood vessels
- C.** Warmed solution decreases the risk of peritoneal infection
- D.** Warmed solution promotes a relaxed abdominal muscle

Answer: B (LEAVE A REPLY)

Explanation

(A) Instilling a cool solution does not significantly lower the body temperature during peritoneal dialysis. (B) Warmed solution does help dilate the peritoneal blood vessels, facilitating the exchange of fluids. (C) Warming the dialysate does not decrease the risk of peritoneal infection. Sterile technique decreases this risk. (D) Relaxing the abdominal muscles does not facilitate peritoneal dialysis.

NEW QUESTION: 469

The nurse is developing a plan of care for a client with an electrolyte imbalance and identifies a nursing diagnosis of decreased physical mobility. Which alteration is most likely the etiology?

- A.** Hypernatremia
- B.** Hypocalcemia
- C.** Hypokalemia
- D.** Hypomagnesemia

Answer: C (LEAVE A REPLY)

Explanation

(A) A deficit in sodium concentration results in muscular weakness and lethargy. (B) Muscle fatigue and hypotonia are caused by hypercalcemia. (C) Muscle weakness and fatigue are classic signs of hypokalemia. (D) Hypermagnesemia can cause muscle weakness, paralysis, and coma.

NEW QUESTION: 470

A 20-year-old client presents to the obstetrics-gynecology clinic for the first time. She tells the nurse that she is pregnant and wants to start prenatal care. After collecting some initial assessment data, the nurse measures her fundal height to be at the level of the umbilicus. The nurse estimates the fetal gestational age to be approximately:

- A.** 10 weeks
- B.** 16 weeks
- C.** 20 weeks
- D.** 30 weeks

Answer: C ([LEAVE A REPLY](#))

(A) At 10 weeks, the fundus is located slightly above the symphysis pubis. (B) At 16 weeks, the fundus is halfway between the symphysis pubis and the umbilicus. (C) At 20 weeks, the fundus is located approximately at the umbilicus. (D) At 30 weeks, the fundal height is about 30 cm, or 10 cm above the umbilicus.

NEW QUESTION: 471

A 45-year-old male client was admitted to a chemical dependency treatment center following legal problems related to alcohol abuse. He states, "I know that alcohol is a problem for some people, but I can stop whenever I want to. I'm never sick or miss work, and no one can complain about me." During the initial assessment, the best response by the nurse would be:

- A. "The fact is you are an alcoholic or you wouldn't be here."
- B. "I understand it took strength to admit yourself to the unit, and I will do my part to help you to stay alcohol- free."
- C. "If you can stop drinking when you want to, why don't you stop?"
- D. "It's good that you can stop drinking when you want to."

Answer: ([SHOW ANSWER](#))

Section: Questions Set C

Explanation:

(A) Direct confrontation initially is nontherapeutic and may result in the client becoming frustrated and wanting to leave. (B) A positive, supportive attitude builds trust, and identifying positive strength raises self-esteem.

Offering help allows the client to feel that he is not alone in dealing with problems. (C) Asking the client why or to give an explanation for his behavior puts him in a position of having to justify his behavior to the nurse. (D) Giving approval or placing a value on feelings or a behavior may limit the client's freedom to behave in a way that may displease another. This response may lead to seeking praise instead of progress.

NEW QUESTION: 472

A neonate was admitted to the hospital with projectile vomiting. According to the parents, the baby had experienced vomiting episodes after feeding for the last 2 days. A medical diagnosis of hypertrophic pyloric stenosis was made. On assessment, the infant had poor skin turgor, sunken eyeballs, dry skin, and weight loss. Identify the number-one priority nursing diagnosis.

- A. Fluid volume deficit
- B. Altered nutrition
- C. Altered bowel elimination
- D. Anxiety

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Fluid volume deficit is the major problem. Symptoms of dehydration are evident. The effects of fluid and electrolyte balance may be life threatening. Rehydration can be accomplished effectively through IV fluids and electrolytes. (B) Vomiting may also signal a nutritional problem. However, the nutritional problem would be secondary to fluid and electrolyte disturbances. The infant may also be placed on NPO status. (C) With vomiting, a decrease in the size and number of stools is expected. (D) The infant cannot verbalize feelings of anxiety. Anxiety would not be an appropriate diagnosis.

NEW QUESTION: 473

The nurse needs to be aware that the most common early complication of a myocardial infarction is:

- A. Diabetes mellitus
- B. Anaphylactic shock
- C. Cardiac hypertrophy
- D. Cardiac dysrhythmia

Answer: D (LEAVE A REPLY)

Explanation

(A) Diabetes mellitus is not a common complication of myocardial infarction. (B) Anaphylactic shock is an allergic reaction. (C) Cardiac hypertrophy is a late potential complication. It is a common complication of congestive heart failure. (D) Myocardial infarction causes tissue damage, which may interrupt electrical impulses. Myocardial irritability results from lack of oxygenated tissue.

NEW QUESTION: 474

A mother is unsure about the type of toys for her 17-month-old child. Based on knowledge of growth and development, what toy would the nurse suggest?

- A. A pull toy to encourage locomotion
- B. A mobile to improve hand-eye coordination
- C. A large toy with movable parts to improve pincer grasp
- D. Various large colored blocks to teach visual discrimination

Answer: A (LEAVE A REPLY)

Section: Questions Set B

Explanation:

(A) Increased locomotive skills make push-pull toys appropriate for the energetic toddler. (B) Infants progress from reflex activity through simple repetitive behaviors to imitative behavior. Hand-eye coordination forms the foundation of other movements. (C) At age 8 months, infants begin to have pincer grasp. Toys that help infants develop the pincer grasp are recommended for this age group. (D) Various large colored blocks are suggested toys for infants 6-12 months of age to help visual stimulation.

NEW QUESTION: 475

A 35-year-old primigravida comes to the clinic for her first prenatal visit. The midwife, on examining the client, suspects that she is approximately 11 weeks pregnant. The pregnancy is positively confirmed by finding:

- A. Chadwick's sign
- B. FHR by ultrasound
- C. Enlargement of the uterus
- D. Breast tenderness and enlargement

Answer: B (LEAVE A REPLY)

(A) Chadwick's sign is a presumptive sign of pregnancy. The coloration may not subside from past pregnancy or could be caused by other situations that create vasocongestion. (B) FHR (movement) observed on ultrasound is a positive diagnosis of pregnancy. (C) Enlargement of the uterus may be due to fibroids or infection. It is considered a probable sign. (D) Breast tenderness and enlargement is a presumptive sign because it may be due to other conditions, such as premenstrual changes.

NEW QUESTION: 476

The nurse is assessing and getting a history from a client treated for depression with a monoamine oxidase (MAO) antidepressant. The most serious side effect associated with this antidepressant and the ingestion of tyramine in aged foods may be:

- A. Hypertensive crisis
- B. Severe rash
- C. Severe hypotension
- D. Severe diarrhea

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The most serious adverse reactions of MAO inhibitors involve blood pressure and ingestion of tyramine-containing foods, which may provoke a hypertensive crisis. (B) MAO inhibitors cause adverse reactions affecting the central nervous system and serious adverse reactions involving blood pressure. (C) MAO inhibits false neurotransmitters (phenylalanines) and may produce hypotensive reactions from gradual accumulation of these neurotransmitters. (D) The most serious adverse reactions of MAO inhibitors involve blood pressure.

NEW QUESTION: 477

A 6-year-old girl has been diagnosed with a urinary tract infection secondary to vesicoureteral reflux.

Which statement by her mother indicates a need for further teaching?

- A. "I have taught her to wipe from front to back after urinating."
- B. "I make sure she drinks plenty of fluids every day."

C. "She enjoys wearing nylon panties, but I make her change them everyday."

D. "She tries to empty her bladder completely after she urinates, like I told her."

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Wiping from front to back is wiping from an area of lesser contamination (urethra) to an area of greater contamination (rectum). (B) Generous fluid intake reduces the concentration of urine. (C) Cotton is a natural, absorbent fabric. Nylon often predisposes the client to urinary tract infections. Dark, warm, moist areas are excellent media for bacterial growth. (D) With vesicoureteral reflux, urine refluxes into the ureter (s) during voiding and then returns to the bladder (residual), which becomes a source for future infection.

NEW QUESTION: 478

A pregnant client comes to the office for her first prenatal examination at 10 weeks. She has been pregnant twice before; the first delivery produced a viable baby girl at 39 weeks 3 years ago; the second pregnancy produced a viable baby boy at 36 weeks 2 years ago. Both children are living and well. Using the GTPAL system to record her obstetrical history, the nurse should record:

A. 3-2-0-0-2

B. 2-2-0-2-2

C. 3-1-1-0-2

D. 2-1-1-0-2

Answer: C (LEAVE A REPLY)

(A) This answer is an incorrect application of the GTPAL method. One prior pregnancy was a preterm birth at 36 weeks (T = 1, P = 1; not T = 2). (B) This answer is an incorrect application of the GTPAL method. The client is currently pregnant for the third time (G = 3, not 2), one prior pregnancy was preterm (T = 1, P = 1; not T = 2), and she has had no prior abortions (A = 0). (C) This answer is the correct application of GTPAL method. The client is currently pregnant for the third time (G = 3), her first pregnancy ended at term (>37 weeks) (T = 1), her second pregnancy ended preterm 20-33 weeks) (P = 1), she has no history of abortion (A = 0), and she has two living children (L = 2). (D) This answer is an incorrect application of the GTPAL method. The client is currently pregnant for the third time (G = 3, not 2).

NEW QUESTION: 479

In working with mental health clients who are prescribed medication that must be taken on a routine basis, it is important for education to begin when the drug therapy is initiated.

One of the first steps in the teaching process is to:

A. Explain the side effects of the medication

B. Discuss the danger of overmedication

- C. Distribute written material to supplement verbal instructions
- D. Explore the client's perception regarding medication therapy

Answer: (SHOW ANSWER)

(A, B, C) The nurse must first obtain information regarding the client's perception of the medication regimen. (D) The first step in the teaching process is to determine the client's perception.

NEW QUESTION: 480

A family is experiencing changes in their lifestyle in many ways. The invalid grandmother has moved in with them. The couple have a 2-year-old son by their marriage, and the wife has two children by her previous marriage. The older children are in high school. In applying systems theory to this family, it is important for the nurse to remember which of the following principles?

- A. The parts of a system are only minimally related.
- B. Dysfunction in one part affects every other part.
- C. A family system has no boundaries.
- D. Healthy families are enmeshed.

Answer: B (LEAVE A REPLY)

(A) The parts of a system are interrelated. (B) Any change in any part of the system affects all other parts. (C) A family system, like any other system, has boundaries. (D) Healthy families are neither enmeshed nor disengaged.

NEW QUESTION: 481

A 72-year-old male client had the Foley catheter that was inserted during the transurethral resection of his prostate removed today. He is concerned about the urinary incontinence he is having since removal of the Foley catheter. The nurse explains that:

- A. He should not be concerned about it because it will resolve quickly
- B. This is usually temporary
- C. The nurse will keep him dry, and he should notify the nurse when this happens
- D. This is related to the bladder spasms and will soon stop

Answer: (SHOW ANSWER)

Explanation

(A) This problem is temporary, but it may take some time to resolve, especially in an older man. (B) This problem is usually temporary, but it may take some time to resolve. (C) Keeping the client dry will not relieve his anxiety about his incontinence. (D) The bladder spasms are not the cause of the client's incontinence.

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NEW QUESTION: 482

A 3-month-old infant has had a unilateral cleft lip repair. He has resumed feedings of oral formula. The nurse should feed the infant with:

- A. Gavage tube
- B. Nipple and bottle
- C. A straw and cup
- D. Syringe

Answer: D (LEAVE A REPLY)

Section: Questions Set C

Explanation:

(A) A gavage tube may damage suture line. It is the most invasive and should be the last measure. (B) A nipple and bottle require sucking, which may damage sutures. (C) A 3-month-old infant is not able to drink from a straw. (D) A syringe allows for the formula to be placed to the side and back of the mouth. This minimizes the amount of sucking needed.

NEW QUESTION: 483

A female client is exhibiting signs of respiratory distress. Which of the following signs indicate a possible pneumothorax?

- A. Crackles or rales on the affected side
- B. Bradypnea and bradycardia
- C. Shortness of breath and sharp pain on the affected side
- D. Increased breath sounds on the affected side

Answer: C (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) With a pneumothorax, air occupies the pleural space. Crackles or rales are heard with increased fluid or secretions and would not be present with air in the space. (B) With a pneumothorax, the client would experience tachypnea and tachycardia to compensate for the decrease in oxygenation. (C) Symptoms of pneumothorax include shortness of breath, sharp pain on the affected side with movement or coughing, asymmetrical chest expansion, and diminished or absent breath sounds on the affected side. (D) With a pneumothorax, breath sounds would be decreased on the affected side (indicates air in the pleural space).

NEW QUESTION: 484

Which of the following would differentiate acute from chronic respiratory acidosis in the assessment of the trauma client?

- A. Increased PaCO₂
- B. Decreased PaO₂
- C. Increased HCO₃
- D. Decreased base excess

Answer: C (LEAVE A REPLY)

Explanation

(A) Increased CO₂ will occur in both acute and chronic respiratory acidosis. (B) Hypoxia does not determine acid-base status. (C) Elevation of HCO₃ is a compensatory mechanism in acidosis that occurs almost immediately, but it takes hours to show any effect and days to reach maximum compensation. Renal disease and diuretic therapy may impair the ability of the kidneys to compensate. (D) Base excess is a nonrespiratory contributor to acid-base balance. It would increase to compensate for acidosis.

NEW QUESTION: 485

Which of the following signs and symptoms indicates a tension pneumothorax as compared to an open pneumothorax?

- A. Ventilation-perfusion (V./Q.) mismatch
- B. Hypoxemia and respiratory acidosis
- C. Mediastinal tissue and organ shifting
- D. Decreased tidal volume and tachypnea

Answer: C (LEAVE A REPLY)

Explanation

(A, B, D) These occur in both tension pneumothorax and open pneumothorax. (C) The tension pneumothorax acts like a one-way valve so that the pneumothorax increases with each breath. Eventually, it occupies enough space to shift mediastinal tissue toward the unaffected side away from the midline. Tracheal deviation, movement of point of maximum impulse, and decreased cardiac output will occur. The other three options will occur in both types of pneumothorax.

NEW QUESTION: 486

A mother continues to breast-feed her 3-month-old infant. She tells the nurse that over the past 3 days she has not been producing enough milk to satisfy the infant. The nurse advises the mother to do which of the following?

- A. "Start the child on solid food."
- B. "Nurse the child more frequently during this growth spurt."
- C. "Provide supplements for the child between breastfeeding so you will have enough milk."
- D. "Wait 4 hours between feedings so that your breasts will fill up."

Answer: B (LEAVE A REPLY)

(A) Solid foods introduced before 4-6 months of age are not compatible with the abilities of the GI tract and the nutritional needs of the infant. (B) Production of milk is supply and demand. A common growth spurt occurs at 3 months of age, and more frequent nursing will increase the milk supply to satisfy the infant. (C) Supplementation will decrease the infant's appetite and in turn decrease the milk supply. When the infant nurses less often or with less vigor, the amount of milk produced decreases. (D) Rigid feeding schedules lead to a decreased milk supply, whereas frequent nursing signals the mother's body to produce a correspondingly increased amount of milk.

NEW QUESTION: 487

A 54-year-old client is admitted to the hospital with a possible gastric ulcer. He is a heavy smoker. When discussing his smoking habits with him, the nurse should advise him to:

- A. Smoke low-tar, filtered cigarettes
- B. Smoke cigars instead
- C. Smoke only right after meals
- D. Chew gum instead

Answer: C ([LEAVE A REPLY](#))

Explanation

(A, B, D) Cigarettes, cigars, and chewing gum would stimulate gastric acid secretion. (C) Smoking on a full stomach minimizes effect of nicotine on gastric acid.

NEW QUESTION: 488

The nurse is admitting an infant with bacterial meningitis and is prepared to manage the following possible effects of meningitis:

- A. Constipation
- B. Hypothermia
- C. Seizure
- D. Sunken fontanelles

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) Constipation may occur if the child is dehydrated, but it is not directly associated with meningitis. (B) It is more likely the child will have fever. (C) Seizure is often the initial sign of meningitis in children and could become frequent. (D) It is more likely the child will have bulging fontanelles.

NEW QUESTION: 489

At 12 hours postvaginal delivery, a female client is without complications. Which of the following assessment findings would warrant further nursing interventions?

- A. Apical pulse of 52 bpm
- B. Uterine fundus palpable left of midline
- C. No bowel movement since delivery

D. Oral temperature of 100.4F

Answer: ([SHOW ANSWER](#))

(A) Bradycardia of 50-70 bpm may be considered normal postpartally because the heart compensates for the decreased resistance in the pelvis. (B) The uterus is displaced from the midline by a full bladder. This condition could lead to a boggy uterus and increased risk of postpartal hemorrhage; therefore, the bladder should be kept empty. (C) Reestablishment of normal bowel function is delayed into the first postpartum week. (D) A postpartum woman's oral temperature may go as high as 100.4_F within 24 hours of delivery resulting from muscular exertion, dehydration, and hormonal changes.

NEW QUESTION: 490

A pregnant client comes to the office for her first prenatal examination at 10 weeks. She has been pregnant twice before; the first delivery produced a viable baby girl at 39 weeks 3 years ago; the second pregnancy produced a viable baby boy at 36 weeks 2 years ago. Both children are living and well. Using the gravida and para system to record the client's obstetrical history, the nurse should record:

A. Gravida 3 para 1

B. Gravida 3 para 2

C. Gravida 2 para 1

D. Gravida 2 para 2

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) This answer is an incorrect application of gravida and para. The client has had two prior deliveries of more than 20 weeks' gestation; therefore, para equals 2, not 1. (B) This answer is the correct application of gravida and para. The client is currently pregnant for the third time (G = 3), regardless of the length of the pregnancy, and has had two prior pregnancies with birth after the 20th week (P = 2), whether infant was alive or dead. (C) This answer is an incorrect application of gravida and para. The client is currently pregnant for the third time (G = 3, not 2); prior pregnancies lasted longer than 20 weeks (therefore, P = 2, not 1). (D) This is an incorrect application of gravida and para. Client is currently pregnant for third time (G = 3, not 2).

NEW QUESTION: 491

A client presented herself to the mental health center, describing the following symptoms: a weight loss of 20 lb in the past 2 months, difficulty concentrating, repeated absences from work due to "fatigue," and not wanting to get dressed in the morning. She leaves her recorded message on her telephone and has lost interest in answering the phone or doorbell. The nurse's assessment of her behavior would most likely be:

A. Deep depression

B. Psychotic depression

C. Severe anxiety

D. Severe depression

Answer: D (LEAVE A REPLY)

Explanation

(A) A client in deep depression would have been brought to the mental health center and would not be physically able to seek help for herself. (B) She is not manifesting psychotic symptoms in her behaviors. (C) The client's symptoms are more indicative of depression than anxiety. (D) Although the client was able to bring herself to the mental health center, the extent of her weight loss and the interference of symptoms with activities of daily living indicate that she is severely depressed.

NEW QUESTION: 492

Which type of insulin can be administered by a continuous IV drip?

A. Humulin N

B. NPH insulin

C. Regular insulin

D. Lente insulin

Answer: C (LEAVE A REPLY)

Section: Questions Set C

Explanation:

(A) Humulin N cannot be administered IV. (B) NPH insulin cannot be administered IV. (C) Regular insulin is the only insulin that can be administered IV. (D) Lente insulin cannot be administered IV.

NEW QUESTION: 493

Before giving methergine postpartum, the nurse should assess the client for:

A. Decreased amount of lochial flow

B. Elevated blood pressure

C. Flushing

D. Afterpains

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Methergine is given to contract the uterus and to control postpartal hemorrhage; therefore, lochial flow should decrease. (B) Methergine may elevate the blood pressure. A client with an elevated blood pressure should not receive methergine, but she could be given oxytocin if necessary. (C) Flushing is not a side effect of methergine. (D) Afterpains are increased with methergine usage. The client should be informed that this is a normal response.

NEW QUESTION: 494

A 6-month-old infant has developmental delays. His weight falls below the 5th percentile when plotted on a growth chart. A diagnosis of failure to thrive is made. What behaviors might indicate the possibility of maternal deprivation?

- A. Responsive to touch, wants to be held
- B. Uncomforted by touch, refuses bottle
- C. Maintains eye-to-eye contact
- D. Finicky eater, easily pacified, cuddly

Answer: B ([LEAVE A REPLY](#))

(A) Normal infant attachment behaviors include responding to touch and wanting to be held. (B) Maternal deprivation behaviors include poor feeding, stiffening and refusal to eat, and inconsistencies in responsiveness. (C) Attachment behavior includes maintaining eye contact. (D) Maternal deprivation behaviors include displeasure with touch and physical contact.

NEW QUESTION: 495

A 9-month-old infant is being examined in the general pediatric clinic for a routine well-child checkup. His immunizations are up to date, and his mother reports that he has had no significant illnesses or injuries.

Which of the following signs would lead the nurse to believe that he has had a cerebral injury?

- A. Hyperextension of the neck with evidence of pain on flexion
- B. Holding the head to one side and pointing the chin toward the other side
- C. Holding the head erect and in the midline when in a vertical position
- D. Significant head lag when raised to a sitting position

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) This position is indicative of a possible meningeal irritation or infection such as meningitis. (B) This position is seen most frequently in infants who have had an injury to the sternocleidomastoid muscle. (C) Most infants aged 4 months and older are able to maintain this position. (D) Infants older than 6 months of age should not have significant head lag. This is a sign of cerebral injury and should be referred for further evaluation.

NEW QUESTION: 496

A male client seeks counseling after his wife of 19 years threatened to divorce him. For most of their marriage, he has physically and verbally abused her. When asked about his behavior in the process of the nursing assessment, the client states, "I was mean to my wife because she insists on cooking meals and wearing clothes that I do not like." This defense mechanism is an example of:

- A. Repression
- B. Regression

C. Reaction formation

D. Rationalization

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Repression is blocking a desire from conscious expression. The client is conscious of his desires. (B) Regression is returning to an earlier form of expression, which is not demonstrated here. (C) Reaction formation is acting out the opposite of true feelings. The client felt anger concerning his wife's cooking and acted out his feelings. (D)

Rationalization is unconsciously falsifying an experience by giving a "rational" explanation. The client is attempting to justify his behavior by giving an explanation.

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NEW QUESTION: 497

Assessment of a client reveals a 30% loss of preillness weight, lanugo, and cessation of menses for 3 months.

Her vital signs are BP 90/50, P 96 bpm, respirations 30, and temperature 97 F. She admits to the nurse that she has induced vomiting 3 times this morning, but she had to continue exercising to lose "just 5 more lb." Her symptoms are consistent with:

A. Pregnancy

B. Bulimia

C. Gastritis

D. Anorexia nervosa

Answer: D (LEAVE A REPLY)

Explanation

(A) Presenting behaviors collectively are inconsistent with depression. (B) A preillness weight loss of 30%, lanugo, and cessation of menses are inconsistent with bulimia. (C) Symptoms and vital signs do not indicate the presence of infection. (D) All symptoms and vital signs are consistent with anorexia nervosa.

NEW QUESTION: 498

On a mother's 2nd postpartum day after having a vaginal delivery, the RN is preparing to assess her perineum and anus as part of her daily assessment. The best position for the client to be placed in for this assessment is:

- A. Sims'
- B. Fowler's
- C. Prone
- D. Any position that the RN chooses

Answer: (SHOW ANSWER)

Explanation

(A) The Sims' position is the best position for assessment of the perineum and anus. The top leg is placed over the bottom leg, and the RN raises the upper buttocks to fully expose the perineum and anus. (B) Fowler's position is a sitting position, and the perineum and anus would not be exposed. (C) The prone position would have the mother on her back, and her perineum and anus would not be exposed. (D) The position of choice should always be the Sims'.

NEW QUESTION: 499

A 45-year-old client diagnosed with major depression is scheduled for electroconvulsive therapy (ECT) in the morning. Which of the following medications are routinely administered either before or during ECT?

- A. Thioridazine (Mellaril), lithium, and benztropine
- B. Atropine, sodium brevitol, and succinylcholine chloride (Anectine)
- C. Sodium, potassium, and magnesium
- D. Carbamazepine (Tegretol), haloperidol, and trihexyphenidyl (Artane)

Answer: B (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) Thioridazine (an antipsychotic drug), lithium (an antimanic drug), and benztropine (an antiparkinsonism agent) are generally administered to treat schizophrenic and bipolar disorders. (B) Atropine (a cholinergic blocker), sodium brevitol (a shortacting anesthetic), and succinylcholine (a neuromuscular blocker) are administered either before or during ECT to counteract bradycardia and to provide anesthesia and total muscle relaxation. (C) These are electrolyte substances administered to correct fluid and electrolyte imbalances in the body. (D) Carbamazepine (an anticonvulsant), haloperidol (an antipsychotic), and trihexyphenidyl (an antiparkinsonism agent) are usually administered in psychiatric settings to control problems associated with psychotic behavior.

NEW QUESTION: 500

The nurse is caring for a 3-month-old girl with meningitis. She has a positive Kernig's sign. The nurse expects her to react to discomfort if she:

- A. Dorsiflexes her ankle

- B. Flexes her spine
- C. Plantiflexes her wrist
- D. Turns her head to the side

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Discomfort with ankle dorsiflexion is not expected with meningitis. (B) Spinal flexion, flexing the neck or the hips with legs extended, causes discomfort if the meninges are irritated. (C) Discomfort with wrist flexion is not expected with meningitis. (D) Rotating the cervical spine may cause discomfort with meningitis, but pain with flexion is more indicative of meningeal irritation.

NEW QUESTION: 501

A client has been in labor for 10 hours. Her contractions have become hypoactive and slowed in duration. The fetus is at 0 station, cervix is dilated 8 cm and effaced 90%. The physician orders an oxytocin (Pitocin) infusion to be started at once. The RN begins the oxytocin infusion. It is important that the RN discontinue the infusion if which one of the following occur?

- A. The client's contractions are <2 minutes apart.
- B. Duration of the contractions are 60 seconds.
- C. The uterus relaxes between contractions.
- D. The client complains that she is tired.

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) It is very important that there is a resting phase or relaxation period between the contractions. During this period, the uterus, placenta, and umbilical vessels re-establish blood flow. No resting phase between contractions can lead to fetal bradycardia, fetal hypoxia, and acidosis. It can also result in a tetanic contraction, which can cause uterine rupture. (B) The goal of the oxytocin infusion is to help establish a contraction pattern lasting 45-60 seconds occurring every 2 minutes and a uterine tonus of 60-70 mm Hg. (C) This choice is correct. The uterus has time to recover from the contraction. (D) The client's tiring is no indication to stop the infusion. She will be tired even without the infusion.

NEW QUESTION: 502

A 23-year-old male client is admitted to the chemical dependency unit with a medical diagnosis of alcoholism. He reports that the last time he drank was 3 days ago, and that now he is starting to "feel kind of shaky." Based on the information given above, nursing care goals for this client will initially focus on:

- A. Self-concept problems
- B. Interpersonal issues
- C. Ineffective coping skills

D. Physiological stabilization

Answer: D (LEAVE A REPLY)

(A) Self-concept and self-esteem problems may emerge during the client's treatment, but these are not immediate concerns. (B) Interpersonal issues may become evident during the course of the client's treatment, but these are also not immediate areas of concern. (C) Improving individual coping skills is generally a primary focus in the treatment and nursing care of persons with substance abuse problems. However, this is still not the immediate concern in this client situation. (D) Correction of fluid and electrolyte status and vitamin deficiencies, as well as prevention of delirium, is the immediate concern in the care of this client.

NEW QUESTION: 503

An obstructing stone in the renal pelvis or upper ureter causes:

- A.** Radiating pain into the urethra with labia pain experienced in females or testicular pain in males
- B.** Urinary frequency and dysuria
- C.** Severe flank and abdominal pain with nausea, vomiting, diaphoresis, and pallor
- D.** Dull, aching, back pain

Answer: (SHOW ANSWER)

(A) Radiating pain in the urethra in both sexes, extending into the labia in females and into the testicle or penis in the male, indicates a stone in the middle or lower segment of the ureter. (B) Urinary frequency and dysuria are caused by a stone in the terminal segment of the ureter within the bladder wall. (C) An obstructing stone in the renal pelvis or upper ureter causes severe flank and abdominal pain with nausea, vomiting, diaphoresis, and pallor. (D) Dull and aching pain may indicate early stages of hydronephrosis. Also, a stone in the renal pelvis or upper ureter causes severe flank and abdominal pain.

NEW QUESTION: 504

A 35-year-old client has returned to her room following surgery on her right femur. She has an IV of D5 in one-half normal saline infusing at 125 mL/hr and is receiving morphine sulfate 10-15 mg IM q4h prn for pain.

She last voided 5 1/2 hours ago when she was given her preoperative medication. In monitoring and promoting return of urinary function after surgery, the nurse would:

- A.** Provide food and fluids at the client's request
- B.** Maintain IV, increasing the rate hourly until the client voids
- C.** Report to the surgeon if the client is unable to void within 8 hours of surgery
- D.** Hold morphine sulfate injections for pain until the client voids, explaining to her that morphine sulfate can cause urinary retention

Answer: (SHOW ANSWER)

Explanation

(A) Provision of food and fluid promotes bowel elimination. Nutritional needs postoperatively are determined by the physician, not the client. (B) Increasing IV fluids postoperatively will not cause a client to void. Any change in rate of administration of IV fluids should be determined by the physician. (C) The postoperative client with normal kidney function who cannot void 8 hours after surgery is retaining urine. The client may need catheterization or medication. The physician must provide orders for both as necessary. (D) Although morphine sulfate can cause urinary retention, withholding pain medication will not ensure that the client will void. The client with uncontrolled pain will probably not be able to void.

NEW QUESTION: 505

A 55-year-old man has recently been diagnosed with hypertension. His physician orders a low-sodium diet for him. When he asks, "What does salt have to do with high blood pressure?" the nurse's initial response would be:

- A. "The reason is not known why hypertension is associated with a high-salt diet."
- B. "Large amounts of salt in your diet can cause you to retain fluid, which increases your blood pressure."
- C. "Salt affects your blood vessels and causes your blood pressure to be high."
- D. "Salt is needed to maintain blood pressure, but too much causes hypertension."

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

- (A) This response is untrue. (B) Decreasing salt intake reduces fluid retention and decreases blood pressure.
- (C) Salt does not have an effect on the blood vessels themselves, but on fluid retention, which accompanies salt intake. (D) This response is untrue.

NEW QUESTION: 506

A 24-hours' postpartum client complains of discomfort at the episiotomy site. On assessment, the nurse notes the episiotomy is without signs of infection. To relieve the discomfort, the nurse should first:

- A. Assist her with a sitz bath
- B. Administer the prescribed medication for pain
- C. Teach her Kegel exercises
- D. Apply an ice pack

Answer: ([SHOW ANSWER](#))

Explanation

- (A) Warm, moist heat will promote circulation and provide comfort. A sitz bath should be tried before medication is given. (B) Pain medication can be given when other comfort measures such as a sitz bath and topical applications are ineffective. (C) Kegel exercises facilitate sitting by decreasing tension on the episiotomy. They will not be effective for pain

control or sustained comfort level. (D) Ice packs are appropriate to apply in the first 12 hours postdelivery to produce vasoconstriction and to reduce edema to the area.

NEW QUESTION: 507

The nurse is teaching a 10-year-old insulin-dependent diabetic how to administer insulin. Which one of the following steps must be taught for insulin administration?

- A. Never use abdominal site for a rotation site.
- B. Pinch the skin up to form a subcutaneous pocket.
- C. Avoid applying pressure after injection.
- D. Change needles after injection.

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set B

Explanation:

(A) Sites for injection need to be rotated, including abdominal sites, to enhance insulin absorption. (B) The pinch technique is the most effective method for obtaining skin tightness to allow easy entrance of the needle to subcutaneous tissues. (C) Massaging the site of injection facilitates absorption of the insulin. (D) Changing the needle will break the sterility of the system. It has become acceptable practice to reuse disposable needles and syringes for 3-7 days.

NEW QUESTION: 508

A client is being discharged from the hospital today. The discharge teaching for care of her colostomy included which of the following basic principles for protecting the skin around her stoma:

- A. Taping a pouch that is leaking
- B. Cutting the skin barrier 1/2 inches larger than the stoma
- C. Changing the pouch only when leakage occurs
- D. Using a skin sealant under pouch adhesives

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) When a pouch seal leaks, the pouch should be immediately changed, not taped. Stool held against the skin can quickly result in severe irritation. (B) The skin barrier should be cut only slightly larger than the stoma (one-half inch). (C) The client should be taught to change pouches whenever possible before leakage occurs.

(D) When skin sealant is used under the tape, the outermost layer of the epidermis remains intact. When no skin sealant is used, this layer is removed when the tape is removed.

NEW QUESTION: 509

A female client at 10 weeks' gestation complains to her physician of slight vaginal bleeding and mild cramps.

On examination, her physician determines that her cervix is closed. The client is exhibiting signs of:

- A. An inevitable abortion
- B. A threatened abortion
- C. An incomplete abortion
- D. A missed abortion

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) An inevitable abortion includes the signs of cervical dilation and effacement as well as pain and bleeding.

(B) A threatened abortion is a condition in which intrauterine bleeding occurs early in pregnancy, the cervix remains undilated, and the uterine contents are not necessarily expelled. (C) An incomplete abortion occurs when some portions of the products of conception are expelled from the uterus. (D) A missed abortion occurs when the embryo dies in utero and is retained in the uterus.

NEW QUESTION: 510

A gravida 2 para 1 client delivered a full-term newborn 12 hours ago. The nurse finds her uterus to be boggy, high, and deviated to the right. The most appropriate nursing action is to:

- A. Notify the physician
- B. Place the client on a pad count
- C. Massage the uterus and re-evaluate in 30 minutes
- D. Have the client void and then re-evaluate the fundus

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) The nurse should initiate actions to remove the most frequent cause of uterine displacement, which involves emptying the bladder. Notifying the physician is an inappropriate nursing action. (B) The pad count gives an estimate of blood loss, which is likely to increase with a boggy uterus; but this action does not remove the most frequent cause of uterine displacement, which is a full bladder. (C) Massage may firm the uterus temporarily, but if a full bladder is not emptied, the uterus will remain displaced and is likely to relax again. (D) The most common cause of uterine displacement is a full bladder.

NEW QUESTION: 511

A 54-year-old client is admitted to the hospital with a possible gastric ulcer. He is a heavy smoker. When discussing his smoking habits with him, the nurse should advise him to:

- A. Smoke low-tar, filtered cigarettes
- B. Smoke cigars instead
- C. Smoke only right after meals

D. Chew gum instead

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A, B, D) Cigarettes, cigars, and chewing gum would stimulate gastric acid secretion. (C) Smoking on a full stomach minimizes effect of nicotine on gastric acid.

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NEW QUESTION: 512

The client has been in active labor for the last 12 hours. During the last 3 hours, labor has been augmented with oxytocin because of hypoactive uterine contractions. Her physician assesses her cervix as 95% effaced, 8 cm dilated, and the fetus is at 0 station. Her oral temperature is 100.2F at this time. The physician orders that she be prepared for a cesarean delivery. In preparing the client for the cesarean delivery, which one of the following physician's orders should the RN question?

- A. Administer meperidine (Demerol) 100 mg IM 1 hour prior to the delivery.
- B. Discontinue the oxytocin infusion.
- C. Insert an indwelling Foley catheter prior to delivery.
- D. Prepare abdominal area from below the nipples to below the symphysis pubis area.

Answer: A (LEAVE A REPLY)

(A) Meperidine is a narcotic analgesic medication that crosses the placental barrier and reaches the fetus, causing respiratory depression in the fetus. A narcotic medication should never be included in the preoperative order for a cesarean delivery. (B) Oxytocin infusion would be discontinued if client is being prepared for a cesarean delivery because the medication would not be needed. (C) The bladder is always emptied prior to and during the surgical intervention to prevent the urinary bladder from accidentally being incised while the uterine incision is made. (D) The abdominal area is always prepared to rid the area of hair before the abdominal incision is made. Abdominal hair cannot be sterilized and could become a source for postoperative incisional infection.

NEW QUESTION: 513

A primigravida with a blood type A negative is at 28 weeks' gestation. Today her physician has ordered a RhoGAM injection. Which statement by the client demonstrates that more teaching is needed related to this therapy?

- A. "I'm getting this shot so that my baby won't develop antibodies against my blood, right?"
- B. "I understand that if my baby is Rh positive I'll be getting another one of these injections."
- C. "This shot should help to protect me in future pregnancies if this baby is Rh positive, like my husband."
- D. "This shot will prevent me from becoming sensitized to Rh-positive blood."

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) RhoGAM is given to Rh-negative mothers to prevent the maternal Rh immune response to fetal Rh- positive antigens. (B) If the infant is Rh positive, the mother will receive another dose postdelivery to prevent maternal sensitization. (C) Prevention of maternal sensitization will protect future pregnancies because the mother's blood will be free of antibodies against her fetus. (D) RhoGAM prevents maternal sensitization to Rh-positive blood.

NEW QUESTION: 514

A cardinal symptom of the schizophrenic client is hallucinations. A nurse identifies this as a problem in the category of:

- A. Impaired communication
- B. Sensory-perceptual alterations
- C. Altered thought processes
- D. Impaired social interaction

Answer: ([SHOW ANSWER](#))

(A) Impaired communication refers to decreased ability or inability to use or understand language in an interaction. (B) In sensory-perceptual alterations an individual has distorted, impaired, or exaggerated responses to incoming stimuli (i.e., a hallucination, which is a false sensory perception that is not associated with real external stimuli). (C) An altered thought processes problem statement is used when an individual experiences a disruption in cognitive operations and activities (i.e., delusions, loose associations, ideas of reference). (D) In impaired social interaction, the individual participates too little or too much in social interactions.

NEW QUESTION: 515

An 8-week-old infant has been diagnosed with gastroesophageal reflux. The nurse is teaching the infant's mother to care for the infant at home. Which one of the following statements by the nurse is appropriate regarding the infant's home care?

- A. "Lay the infant flat on her left side after feeding."

- B. "Feed the infant every 4 hours with half-strength formula."
- C. "Antacids need to be given an hour before feeding."
- D. "Play activities should be carried out before instead of after feedings."

Answer: D (LEAVE A REPLY)

(A)

Elevating the child's head to a 30-degree angle is the recommended position for gastroesophageal reflux. The supine position predisposes the child to aspiration. (B) Small, frequent feedings with thickened formula are recommended to minimize vomiting. (C) Antacids should be given at the same time as the feeding to improve their buffering action.

(D)

The infant should be kept still after feedings to reduce the risk of vomiting and aspiration. Vigorous activities should be carried out before feedings.

NEW QUESTION: 516

A male client has experienced low back pain for several years. He is the primary support of his wife and six children. Although he would qualify for disability, he plans to continue his employment as long as possible. His back pain has increased recently, and he is unable to control it with non-steroidal anti-inflammatory agents. He refuses surgery and cannot take narcotics and remain alert enough to concentrate at work. His physician has suggested application of a transcutaneous electrical nerve stimulation (TENS) unit. Which of the following is an appropriate rationale for using a TENS unit for relief of pain?

- A. TENS units have an ultrasonic effect that relaxes muscles, decreases joint stiffness, and increases range of motion.
- B. TENS units produce endogenous opioids that affect the central nervous system with analgesic potency comparable to morphine.
- C. TENS units work on the gate-control theory of pain; biostimulation therapy of large fibers block painful stimuli.
- D. TENS units prevent muscle spasms, decrease the potential for further injury, and minimize pressure on joints.

Answer: C (LEAVE A REPLY)

(A) TENS units do not have this effect, but whirlpool therapy does. (B) TENS units do not produce endogenous opioids, only the body can do that. (C) TENS units do work based on the gatecontrol theory of pain control. (D) TENS units do not have this effect, but possibly changing the client's position would.

NEW QUESTION: 517

An 8-year-old boy has been diagnosed with hemophilia. Which of the following diagnostic blood studies is characteristically abnormal in this disorder?

- A. Partial thromboplastin time
- B. Platelet count
- C. Complete blood count

D. Bleeding time

Answer: A ([LEAVE A REPLY](#))

(A) Partial thromboplastin time measures activity of thromboplastin, which depends on the intrinsic clotting factors deficient in children who are hemophiliacs. (B) Platelet counts are normal in hemophilia. (C) Hemophilia does not affect the complete blood count. (D) Bleeding times are normal in hemophiliacs. They measure the time interval for the bleeding from small superficial wounds to cease.

NEW QUESTION: 518

A client is experiencing visual problems at school. She has complained of difficulty seeing the blackboard and squinting. She no longer likes to participate in physical activities such as softball. The client has displayed possible classic symptoms of which refractive error?

A. Astigmatism

B. Hyperopia

C. Myopia

D. Amblyopia

Answer: ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) Visual images are blurred and distorted. (B) Symptoms are headaches, burning eyes, fatigue, squinting, and difficulty reading. (C) These symptoms are classic for myopia. (D) Amblyopia is not a refractive error. It is a loss of vision in one or both eyes.

NEW QUESTION: 519

The nurse would be sure to instruct a client on the signs and symptoms of an eye infection and hemorrhage.

These signs and symptoms would include:

A. Blurred vision and dizziness

B. Eye pain and itching

C. Feeling of eye pressure and headache

D. Eye discharge and hemoptysis

Answer: ([SHOW ANSWER](#))

Section: Questions Set B

Explanation:

(A) Although blurred vision may occur, dizziness would not be associated with an infection or hemorrhage. (B) Eye pain is a symptom of hemorrhage within the eye, and itching is associated with infection. (C) Nausea and headache would not be usual symptoms of eye hemorrhage or infection. (D) Some eye discharge might be anticipated if an infection is present; hemoptysis would not.

NEW QUESTION: 520

At her monthly prenatal visit, a client reports experiencing heartburn. Which nursing measure should be included in her plan of care to help alleviate it?

- A. Restrict fluid intake.
- B. Use Alka-Seltzer as necessary.
- C. Eat small, frequent bland meals.
- D. Lie down after eating.

Answer: ([SHOW ANSWER](#))

(A) At least eight glasses of fluid per day are encouraged to help dilute stomach contents, thereby decreasing irritation. (B) Alka Seltzer contains aspirin, which is irritating to gastric mucosa, and therefore should be avoided. (C) Small, frequent bland meals help to decrease gastric pressure and to prevent reflux. (D) Lying down after meals may cause gastric reflux and prevents optimal gastric emptying.

NEW QUESTION: 521

A physician's order reads: Administer KCl 10% oral solution 1.5 mL. The KCl bottle reads 20 mEq/15 mL.

What dosage should the nurse administer to the infant?

- A. 1 mEq
- B. 1.13 mEq
- C. 2 mEq
- D. Not enough information to calculate

Answer: ([SHOW ANSWER](#))

Explanation

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) $1.33 \text{ mEq} = 1 \text{ mL}$, then $1.5 \text{ mL} \times 1.99$, or 2 mEq. (D) Information is adequate for calculation.

NEW QUESTION: 522

A burn victim's immunization history is assessed by the nurse. Which immunization is of priority concern?

- A. Oral poliovirus vaccine
- B. Inactivated poliovirus vaccine
- C. Tetanus toxoid
- D. Hepatitis B vaccine

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Oral poliovirus vaccine is given to prevent polio. Polio is transmitted by direct contact with an infected person. (B) Inactivated poliovirus vaccine is given to adults and immunosuppressed individuals. Polio is transmitted by direct contact with an infected person. (C) Tetanus toxoid prevents tetanus. Tetanus is transmitted through contaminated

wounds. (D) Hepatitis B vaccine prevents hepatitis B infection. Hepatitis B is transmitted through contact with infected blood or body fluids.

NEW QUESTION: 523

Which of the following should the nurse anticipate receiving as an as-needed order for a postoperative carotid endarterectomy client?

- A. Nifedipine 10 mg SL for B/P 140/90
- B. Furosemide 20 mg/PO for decreased urine output
- C. Magnesium salicylate to decrease inflammation
- D. Nitroglycerin gr 1/150 for chest pain

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set G

Explanation:

(A) It is important to maintain a normal to slightly lower pressure to prevent the graft from blowing and excessive pressure to surgical vascular areas. (B, C, D) None of these drugs is related to managing the problem at hand. Also, none of the problems for which these drugs would be indicated is expected with this type of surgery, except if there is a prior history.

NEW QUESTION: 524

The physician orders fluoxetine (Prozac) for a depressed client. Which of the following should the nurse remember about fluoxetine?

- A. Because fluoxetine is a tricyclic antidepressant, it may precipitate a hypertensive crisis.
- B. The therapeutic effect of the drug occurs 2-4 weeks after treatment is begun.
- C. Foods such as aged cheese, yogurt, soy sauce, and bananas should not be eaten with this drug.
- D. Fluoxetine may be administered safely in combination with monoamine oxidase (MAO) inhibitors.

Answer: ([SHOW ANSWER](#))

Section: Questions Set A

Explanation:

(A) Fluoxetine is not a tricyclic antidepressant. It is an atypical antidepressant. (B) This statement is true. (C) These foods are high in tyramine and should be avoided when the client is taking MAO inhibitors. Fluoxetine is not an MAO inhibitor. (D) Fatal reactions have been reported in clients receiving fluoxetine in combination with MAO inhibitors.

NEW QUESTION: 525

A client is started on prednisone 2.5 mg po bid. Which of the following instructions should be included in her discharge teaching specific to this medication?

- A. Increase your oral intake of fluids to at least 4000 mL every day.
- B. Avoid contact with people who have contagious illnesses.

C. Brush your teeth at least 4 times a day with a firm toothbrush.

D. Immediately stop taking the prednisone if you feel depressed.

Answer: ([SHOW ANSWER](#))

Explanation

(A) Fluid retention is a side effect of prednisone. The nurse should teach clients to weigh themselves daily and to observe for signs of edema. If these signs of fluid retention occur, they should notify the physician. (B) Prednisone, a glucocorticoid, suppresses the normal immune response making the client more susceptible to infections. (C) An increase in bleeding tendencies is a side effect of prednisone therapy. The nurse should teach clients to use preventive measures (i.e., electric razors and soft toothbrushes). (D) Depression and personality changes are side effects of prednisone therapy. Prednisone should never be discontinued abruptly.

NEW QUESTION: 526

A client with severe PIH receiving MgSO₄ is placed in a quiet, darkened room. The nurse bases this action on the following understanding:

A. The client is restless.

B. The elevated blood pressure causes photophobia.

C. Noise or bright lights may precipitate a convulsion.

D. External stimuli are annoying to the client with PIH.

Answer: ([SHOW ANSWER](#))

(A)

The client may be anxious and hyperresponsive to stimuli but not necessarily restless.

(B)

This is not a physiological response to an elevated blood pressure in PIH. (C) The nurse must know the nursing measures that decrease the potential for convulsions. A quiet, darkened room decreases stimuli and promotes rest. (D) External stimuli might induce a convulsion but are not annoying to the client with PIH.

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NEW QUESTION: 527

A male client receives 10 U of regular human insulin SC at 9:00 AM. The nurse would expect peak action from this injection to occur at:

- A. 9:30 AM
- B. 10:30 AM
- C. 12 noon
- D. 4:00 PM

Answer: ([SHOW ANSWER](#))

Section: Questions Set A

Explanation:

(A) This is too early for peak action to occur. (B) This is too early for peak action to occur. (C) Regular insulin peak action occurs 2-4 hours after administration. (D) This is too late for peak action to occur.

NEW QUESTION: 528

A 16-year-old diabetic girl has been selected as a cheerleader at her school. She asks the nurse whether she should increase her insulin when she is planning to attend cheerleading practice sessions lasting from 8 to 11 AM. The most appropriate answer would be:

- A. "You should ask your doctor about this."
- B. "Yes, increase your insulin by 1 U for each hour of practice because exercise causes the body to need more insulin."
- C. "No, do not increase your insulin. Exercise will not affect your insulin needs."
- D. "No, do not increase your insulin, but eating a snack prior to practice exercise will make insulin more effective and move more glucose into the cells."

Answer: ([SHOW ANSWER](#))

Explanation

(A) A nurse can give this information to a client. (B) Exercise makes insulin more efficient in moving more glucose into the cells. No more insulin is needed. (C) Exercise makes insulin more efficient unless the diabetes is poorly controlled. (D) Exercise makes insulin more efficient in moving more glucose into the cells.

NEW QUESTION: 529

Which type of insulin can be administered by a continuous IV drip?

- A. Humulin N
- B. NPH insulin
- C. Regular insulin
- D. Lente insulin

Answer: C ([LEAVE A REPLY](#))

(A) Humulin N cannot be administered IV. (B) NPH insulin cannot be administered IV. (C) Regular insulin is the only insulin that can be administered IV. (D) Lente insulin cannot be administered IV.

NEW QUESTION: 530

A mother brings a 6-month-old infant and a 4-year-old child to the nursing clinic for routine examination and screening. Which of these plans by the nurse would be most successful?

- A. Examine the 4 year old first.
- B. Provide time for play and becoming acquainted.
- C. Have the mother leave the room with one child, and examine the other child privately.
- D. Examine painful areas first to get them "over with."

Answer: B ([LEAVE A REPLY](#))

(A)

The 6 month old should be examined first. If several children will be examined, begin with the most cooperative and less anxious child to provide modeling. (B) Providing time for play and getting acquainted minimizes stress and anxiety associated with assessment of body parts. (C) Children generally cooperate best when their mother remains with them.

(D)

Painful areas are best examined last and will permit maximum accuracy of assessment.

NEW QUESTION: 531

The physician prescribes phenytoin (Dilantin) for a client with seizure disorders. Phenytoin can only be mixed with which of the following solutions?

- A. Ringer's lactate
- B. D5 in water
- C. D5 with Ringer's lactate
- D. Normal saline

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Phenytoin will precipitate if mixed with Ringer's lactate and should not be administered. (B, C) Phenytoin will precipitate if mixed with D5 in Ringer's lactate and should not be administered. (D) Phenytoin is compatible only with normal saline and should be mixed only with normal saline for administration.

NEW QUESTION: 532

Assessment of a newborn for Apgar scoring includes observation for:

- A. Pupil response
- B. Respiratory rate
- C. Heart rate
- D. Babinski's reflex

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Pupil response should be assessed but is not part of Apgar scoring. (B) Respiratory effort is an essential part of Apgar scoring, not respiratory rate. (C) Heart rate is the most

critical component of Apgar scoring. (D) Assessment of Babinski's reflex is not a component of Apgar scoring.

NEW QUESTION: 533

The child with iron poisoning is given IV deferoxamine mesylate (Desferal). Following administration, the child suffers hypotension, facial flushing, and urticaria. The initial nursing intervention would be to:

- A. Discontinue the IV
- B. Stop the medication, and begin a normal saline infusion
- C. Take all vital signs, and report to the physician
- D. Assess urinary output, and if it is 30 mL an hour, maintain current treatment

Answer: ([SHOW ANSWER](#))

(A)

The IV line should not be discontinued because other IV medications will be needed.

(B)

Stop the medication and begin a normal saline infusion. The child is exhibiting signs of an allergic reaction and could go into shock if the medication is not stopped. The line should be kept opened for other medication. (C) Taking vital signs and reporting to the physician is not an adequate intervention because the IV medication continues to flow. (D) Assessing urinary output and, if it is 30 mL an hour, maintaining current treatment is an inappropriate intervention owing to the child's obvious allergic reaction.

NEW QUESTION: 534

When planning care for a 9-year-old client, the nurse uses which of the most effective means of helping siblings cope with their feelings about a brother who is terminally ill?

- A. Open discussion and understanding
- B. Play-acting out feelings in different roles
- C. Storytelling
- D. Drawing pictures

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation:

(A) When dealing with grief, siblings are usually most comfortable initially with open discussion. (B) Assuming different roles allows children to act out their feelings without fear of reprisals and to gain insight and control.

(C) This method may be helpful, but having the child take an active part through role playing is more effective.

(D) This technique may be helpful, but being an active participant through role playing is more effective.

NEW QUESTION: 535

A 10-month-old infant's mother says that he takes fresh whole milk eagerly, but that when she offered him baby foods at 6 months of age, he pushed them out of his mouth. Because he has gained weight appropriately, she has quit trying to get him to eat other foods. The nurse's response is based on the knowledge that:

A. Milk intake should be limited to no more than four 8-oz bottles per day and should be followed by iron-enriched cereal or other solid foods or juices

B. Milk is an excellent food and will meet his nutritional needs adequately until he is ready to eat solid foods

C. It is acceptable to continue to give him whole milk and to delay giving solid foods as long as he takes a vitamin supplement daily

D. He should be started on iron-enriched cereal, meat, vegetables, fruits, and juices prior to bottle feeds. Milk intake should be limited to 1 qt/day

Answer: ([SHOW ANSWER](#))

(A) If the infant is given the bottle first, he will be less likely to be hungry enough to eat the solid foods. (B) Milk is deficient in iron, vitamin C, zinc, and fluoride. It does not provide an adequate diet. (C) The vitamin supplement will help, but the infant needs an iron supplement. (D) Giving the solid food when the infant is hungriest will increase the likelihood that he will eat. The more solid food he takes, the less milk he will desire.

NEW QUESTION: 536

On morning rounds, the nurse found a manic-depressive client who is taking lithium in a confused mental state, vomiting, twitching, and exhibiting a coarse hand tremor. Which one of the following nursing actions is essential at this time?

A. Administer her next dosage of lithium, and then call the physician.

B. Withhold her lithium, and report her symptoms to the physician.

C. Place her on NPO to decrease the excretion of lithium from her body, and call the physician.

D. Contact the lab and request a lithium level in 30 minutes, and call the physician.

Answer: ([SHOW ANSWER](#))

(A) The client has lithium toxicity, and the nurse must withhold further dosages. (B) Because of her level of toxicity, further lithium could cause coma and death. The nurse needs further orders from the physician to stabilize the client's lithium level. (C) Ensuring adequate intake of sodium chloride will promote excretion of lithium and will assist in managing the client's lithium toxicity. (D) A lithium blood level must be drawn immediately to determine the seriousness of the toxicity and to provide the physician with data for medical orders.

NEW QUESTION: 537

A 42-year-old male client has been treated at an alcoholic rehabilitation center for physiological alcohol dependence. The nurse will be able to determine that he is preparing

for discharge and is effectively coping with his problem when he shares with her the following information:

- A.** "I know that I will not ever be able to socially drink alcohol again and will need the support of the AA group."
- B.** "I know that I can only drink one or two drinks at social gatherings in the future, but at least I don't have to continue AA."
- C.** "I really wasn't addicted to alcohol when I came here, I just needed some help dealing with my divorce."
- D.** "It really wasn't my fault that I had to come here. If my wife hadn't left, I wouldn't have needed those drinks."

Answer: ([SHOW ANSWER](#))

Section: Questions Set F

Explanation

Explanation:

(A) The client has insight into the severity of his alcohol addiction and has chosen one of the most effective treatment strategies to support him - Alcoholics Anonymous. (B) The client is still using denial and is not dealing with his alcohol addiction. (C) The client is exhibiting denial about his alcohol addiction and projecting blame on his divorce. (D) The client is projecting blame onto his wife for being in the hospital while still denying his alcohol addiction.

NEW QUESTION: 538

The nurse is teaching a 10-year-old insulin-dependent diabetic how to administer insulin. Which one of the following steps must be taught for insulin administration?

- A.** Never use abdominal site for a rotation site.
- B.** Pinch the skin up to form a subcutaneous pocket.
- C.** Avoid applying pressure after injection.
- D.** Change needles after injection.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Sites for injection need to be rotated, including abdominal sites, to enhance insulin absorption. (B) The pinch technique is the most effective method for obtaining skin tightness to allow easy entrance of the needle to subcutaneous tissues. (C) Massaging the site of injection facilitates absorption of the insulin. (D) Changing the needle will break the sterility of the system. It has become acceptable practice to reuse disposable needles and syringes for 3-7 days.

NEW QUESTION: 539

The pediatric nurse charts that the parents of a 4-yearold child are very anxious. Which observation would indicate to the nurse unhealthy coping by these parents:

- A. Discussing their needs with the nursing staff
- B. Discussing their needs with other family members
- C. Seeking support from their minister
- D. Refusing to participate in the child's care

Answer: D (LEAVE A REPLY)

Explanation

(A, B, C) These methods are healthy ways of dealing with anxiety. (D) Participation minimizes feelings of helplessness and powerlessness. It is important that parents have accurate information and that they seek support from sources available to them.

NEW QUESTION: 540

A client is pregnant with her second child. Her last menstrual period began on January 15. Her expected date of delivery would be:

- A. October 8
- B. October 15
- C. October 22
- D. October 29

Answer: C (LEAVE A REPLY)

(A) Incorrect application of Nagele's rule: correctly subtracted 3 months but subtracted 7 days rather than added. (B) Incorrect application of Nagele's rule: correctly subtracted 3 months but did not add 7 days. (C) Correct application of Nagele's rule: correctly subtracted 3 months and added 7 days. (D) Incorrect application of Nagele's rule: correctly subtracted 3 months but added 14 days instead of 7 days.

NEW QUESTION: 541

A child is to receive atropine 0.15 mg (1/400 g) as part of his preoperative medication. A vial containing atropine 0.4 mg (1/150 g)/mL is on hand. How much atropine should be given?

- A. 0.06 mL
- B. 0.38 mL
- C. 2.7 mL
- D. Information given insufficient to determine the amount of atropine to be administered

Answer: B (LEAVE A REPLY)

Explanation

(A, C) Information was incorrectly placed in the formula, resulting in an incorrect answer. (B) The answer is correct.

$$0.4 \text{ mg} = 1 \text{ mL}; 0.15 \text{ mg } x = \text{mL}$$

$$0.4 x = 0.15$$

$$x = 0.15/0.4$$

$$x = 0.375 \text{ or } 0.38 \text{ mL}$$

(D) Sufficient information is provided to determine the amount of atropine to administer. The amount of atropine available and the amount of atropine ordered is required to determine the amount of atropine to be given.

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NEW QUESTION: 542

A baby is circumcised. Immediate postoperative care should include:

- A. Applying a loose diaper
- B. Keeping the baby NPO for 4 hours to avoid vomiting
- C. Changing the dressing frequently using dry, sterile gauze
- D. Taking the baby to his mother for cuddling

Answer: D (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) A pressure diaper should be applied to discourage hemorrhage. (B) The baby can be fed by his mother soon after the procedure, once it is assessed that he is not in any distress and is stable. (C) Dressing changes should not be dry. Dry dressing will stick. (D) Cuddling after the procedure will hopefully quiet the baby.

Feeding is also important if his feeding was withheld prior to the procedure or it is time for a feeding.

NEW QUESTION: 543

A 27-year-old healthy primigravida is brought to the labor and birthing room by her husband at 32 weeks' gestation. She experienced a sudden onset of painless vaginal bleeding. Following an ultrasound examination, the diagnosis of bleeding secondary to complete placenta previa is made. Expected assessment findings concerning the abdomen would include:

- A. A rigid, boardlike abdomen
- B. Uterine atony
- C. A soft relaxed abdomen
- D. Hypertonicity of the uterus

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) A rigid, boardlike abdomen is an assessment finding indicative of placenta abruptio. (B) A cause of postbirth hemorrhage is uterine atony. With placenta previa, uterine tone is within normal range. (C) The placenta is located directly over the cervical os in complete previa. Blood will escape through the os, resulting in the uterus and abdomen remaining soft and relaxed. (D) In placenta abruptio, hypertonicity of the uterus is caused by the entrapment of blood between the placenta and uterine wall, a retroplacental bleed. This does not exist in placenta previa.

NEW QUESTION: 544

At 16 weeks' gestation, a pregnant client is admitted to the maternity unit to have a McDonald procedure (cerclage) done. She tells the RN who is admitting her to the unit that her physician had explained what this procedure was, but that she did not understand. The RN explains to the client that the purpose for this procedure is to:

- A. Reinforce an incompetent cervix
- B. Repair the amniotic sac
- C. Evaluate cephalopelvic disproportion
- D. Dilate the cervix

Answer: A (LEAVE A REPLY)

(A) The treatment most commonly uses the Shirodkar-Barter procedure (McDonald procedure) or cerclage to enforce the weakened cervix by encircling it with a suture at the level of the internal os. (B) There is no known procedure that is used to repair the amniotic sac. (C) Cephalopelvic disproportion is evaluated later in pregnancy. It is not related to this procedure. (D) No procedure is done to dilate the cervix at 16 weeks' gestation unless the pregnancy is to be terminated.

NEW QUESTION: 545

A 23-year-old male client is admitted to the chemical dependency unit with a medical diagnosis of alcoholism. He reports that the last time he drank was 3 days ago, and that now he is starting to "feel kind of shaky." Based on the information given above, nursing care goals for this client will initially focus on:

- A. Self-concept problems
- B. Interpersonal issues
- C. Ineffective coping skills
- D. Physiological stabilization

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Self-concept and self-esteem problems may emerge during the client's treatment, but these are not immediate concerns. (B) Interpersonal issues may become evident during the course of the client's treatment, but these are also not immediate areas of concern. (C)

Improving individual coping skills is generally a primary focus in the treatment and nursing care of persons with substance abuse problems.

However, this is still not the immediate concern in this client situation. (D) Correction of fluid and electrolyte status and vitamin deficiencies, as well as prevention of delirium, is the immediate concern in the care of this client.

NEW QUESTION: 546

An 80-year-old widow is living with her son and daughter-in-law. The home health nurse has been making weekly visits to draw blood for a prothrombin time test. The client is taking 5 mg of coumadin per day. She appears more debilitated, and bruises are noted on her face. Elder abuse is suspected. Which of the following are signs of persons who are at risk for abusing an elderly person?

- A. A family member who is having marital problems and is regularly abusing alcohol
- B. A person with adequate communication and coping skills who is employed by the family
- C. A friend of the family who wants to help but is minimally competent
- D. A lifelong friend of the client who is often confused

Answer: (SHOW ANSWER)

Explanation

(A) This answer is correct. Two risk factors are identified in this answer. (B) This answer is incorrect. Persons at risk tend to lack communication skills and effective coping patterns. (C) This answer is incorrect. Persons at risk are usually family members or those reluctant to provide care. (D) This answer is incorrect. This individual has a vested interest in providing care.

NEW QUESTION: 547

A 16-year-old student has a long history of bronchial asthma and has experienced several severe asthmatic attacks during the school year. The school nurse is required to administer 0.2 mL of 1/1000 solution of epinephrine SC during an asthma attack. How does the school nurse evaluate the effectiveness of this intervention?

- A. Increased pulse rate
- B. Increased expectorate of secretions
- C. Decreased inspiratory difficulty
- D. Increased respiratory rate

Answer: C (LEAVE A REPLY)

Explanation

(A) A side effect of epinephrine is fatal ventricular fibrillation owing to its effects on cardiac stimulation. (B) Medications used to treat asthma are designed to decrease bronchospasm, not to increase expectorate of secretions. (C) Epinephrine decreased inspiratory difficulty by stimulating α_1 , α_2 , and β -receptors causing sympathomimetic stimulation (e.g., bronchodilation). (D) The person with asthma fights to inspire sufficient air thus increasing respiratory rate.

NEW QUESTION: 548

The parents of a 2-year-old child are ready to begin toilet training activities with him. His parents feel he is ready to train because he is now 2 years old. What would the nurse identify as readiness in this child?

- A. Patience by the child when wearing soiled diapers
- B. Communicating the urge to defecate or urinate
- C. The child awakening wet from his naps
- D. The age at which the child's siblings were trained

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Children experience impatience with soiled diapers when readiness for training is apparent. They often desire to be changed immediately. (B) A child must be able to use verbal or nonverbal skills to communicate needs. (C) A readiness indicator would be awaking dry from naps. (D) The age at which a sibling was toilet trained has no implications for training this child.

NEW QUESTION: 549

Chorioamnionitis is a maternal infection that is usually associated with:

- A. Prolonged rupture of membranes
- B. Postterm deliveries
- C. Maternal pyelonephritis
- D. Maternal dehydration

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Chorioamnionitis is an inflammation of the chorion and amnion that is generally associated with premature or prolonged rupture of membranes. (B) Postterm deliveries have not been shown to increase the risk of chorioamnionitis unless there has been prolonged rupture of membranes. (C) Pyelonephritis is a kidney infection that develops in 20%-40% of untreated maternal UTIs. (D) Maternal dehydration, though of great concern, is not related to chorioamnionitis.

NEW QUESTION: 550

When assessing a female child for Turner's syndrome, the nurse observes for which of the following symptoms?

- A. Tall stature
- B. Amenorrhea
- C. Secondary sex characteristics
- D. Gynecomastia

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) This syndrome is caused by absence of one of the X chromosomes. These children are short in stature. (B) Amenorrhea is a symptom of Turner's syndrome, which appears at puberty. (C) Sexual infantilism is characteristic of this syndrome. (D) Gynecomastia is a symptom in Klinefelter's syndrome.

NEW QUESTION: 551

A client who is gravida 1 para 1 vaginally delivered a 7-lb girl. She received a midline episiotomy at delivery. When assessing the level of her uterus immediately following delivery, the nurse would expect the fundus to be located:

- A.** At the umbilicus
- B.** At the symphysis pubis
- C.** Midway between the umbilicus and the xiphoid process
- D.** Midway between the umbilicus and the symphysis pubis

Answer: D (LEAVE A REPLY)

(A) Within 12 hours of delivery, the fundus of the uterus rises to, or slightly above or below, the umbilicus. Fundal height generally decreases 1 fingerbreadth, or 1 cm/day. (B) The uterus descends into the pelvic cavity at approximately 10-12 postpartal days and can no longer be palpated abdominally. (C) Within 12 hours of delivery, the fundus of the uterus rises to, or slightly above or below, the umbilicus. Fundal height generally decreases 1 fingerbreadth, or 1 cm/day. An enlarged uterus may indicate subinvolution or postpartal hemorrhage. (D) Immediately following delivery, the uterus lies midline, about midway between the umbilicus and the symphysis pubis.

NEW QUESTION: 552

A client is having episodes of hyperventilation related to her surgery that is scheduled tomorrow. Appropriate nursing actions to help control hyperventilating include:

- A.** Administering diazepam (Valium) 10-15 mg po q4h and q1h prn for hyperventilating episode
- B.** Keeping the temperature in the client's room at a high level to reduce respiratory stimulation
- C.** Having the client hold her breath or breathe into a paper bag when hyperventilation episodes occur
- D.** Using distraction to help control the client's hyperventilation episodes

Answer: C (LEAVE A REPLY)

Explanation

(A) An adult diazepam dosage for treatment of anxiety is 2-10 mg PO 2-4 times daily. The order as written would place a client at risk for overdose. (B) A high room temperature could increase hyperventilating episodes by stimulating the respiratory system. (C) Breath holding and breathing into a paper bag may be useful in controlling hyperventilation. Both

measures increase CO₂ retention. (D) Distraction will not prevent or control hyperventilation caused by anxiety or fear.

NEW QUESTION: 553

As a nurse works with an adolescent with cystic fibrosis, the nurse begins to notice that he appears depressed and talks about suicide and feelings of worthlessness. This is an important factor to consider in planning for his care because:

- A.** It may be a bid for attention and an indication that more diversionary activity should be planned for him
- B.** No threat of suicide should be ignored or challenged in any way
- C.** He needs to be observed carefully for signs that his depression has been relieved
- D.** He needs to be confronted with his feelings and forced to work through them

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Threats of suicide should always be taken seriously. (B) This client has a life-threatening chronic illness. He may be concerned about dying or he may actually be contemplating suicide. (C) Sometimes clients who have made the decision to commit suicide appear to be less depressed. (D) Forcing him to look at his feelings may cause him to build a defense against the depression with behavioral or psychosomatic disturbances.

NEW QUESTION: 554

On admission to the inpatient unit, a 34-year-old client is able to follow simple directions, but with great difficulty.

He is worried about how he can keep clean in such a public place and repeatedly dusts his bureau, straightens his bed, and adjusts the clothes in his closet. The client is experiencing a severe level of anxiety. Which response by the nurse would be most therapeutic in initially attempting to reduce his anxiety?

- A.** "You will not be allowed to remain in your room if you continue to bother things."
- B.** "I can see how uncomfortable you are, but I would like you to walk with me so I can show you around the unit."
- C.** "Tell me why your room needs to be so clean."
- D.** "I've inspected this room and it is perfectly clean."

Answer: B (LEAVE A REPLY)

Explanation

(A) This statement is punitive. (B) Acknowledging the anxiety and channeling it into some positive activity is therapeutic. (C) The client cannot say "why"; this statement puts the client on the defensive. (D) A rational approach, especially a judgmental one, is nontherapeutic.

NEW QUESTION: 555

A 60-year-old male client was hospitalized 3 days ago with the diagnosis of acute anterior wall myocardial infarction. Today he has been complaining of increasing weakness and shortness of breath. Crackles in both lung bases are audible on auscultation. He is developing:

- A. An extension of his myocardial infarction
- B. Pneumonia
- C. Pulmonary edema
- D. Pulmonary emboli

Answer: C (LEAVE A REPLY)

Explanation

(A) Extensions of his myocardial infarction would be chest pain unrelieved with nitroglycerin, cardiac enzyme elevations, and electrocardiographic changes. (B) Persons with pneumonia may complain of weakness and shortness of breath and have crackles in their lung bases. However, they would also have sputum production and leukocytosis. (C) Persons who have had myocardial infarctions (especially anterior wall) are at risk of developing left ventricular heart failure, which is a major cause of pulmonary edema. Pulmonary edema is manifest by shortness of breath, weakness, and crackles on auscultation of the lung fields. (D) Pulmonary emboli may be accompanied by shortness of breath, weakness, and crackles. However, the pulmonary hypertension that accompanies pulmonary emboli results in signs of increased systemic venous pressure as well.

NEW QUESTION: 556

A 17-year-old client has a T-4 spinal cord injury. At present, he is learning to catheterize himself. When he says, "This is too much trouble. I would rather just have a Foley." An appropriate response for the RN teaching him would be:

- A. "I know. It is a lot to learn. In the long run, though, you will be able to reduce infections if you do an intermittent catheterization program."
- B. "It is not too much trouble. This is the best way to manage urination."
- C. "OK. I'll ask your physician if we can replace the Foley."
- D. "You need to learn this because your doctor ordered it."

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This response acknowledges the client's feelings, gives him factual information, and acknowledges that the final decision is his. (B) This response is judgmental and discourages the client from expressing his feelings about the procedure. (C) Catheterization is a procedure that takes time to learn, but which, for the spinal cord-injured client, can significantly reduce the incidence of urinary tract infections. A young client with a T-4 injury has the hand function to learn this procedure fairly easily. (D) The final decision about bladder elimination management ultimately rests with the client and not the physician.

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NEW QUESTION: 557

After 3 weeks of treatment, a severely depressed client suddenly begins to feel better and starts interacting appropriately with other clients and staff. The nurse knows that this client has an increased risk for:

- A. Suicide
- B. Exacerbation of depressive symptoms
- C. Violence toward others
- D. Psychotic behavior

Answer: (SHOW ANSWER)

Section: Questions Set A

Explanation:

(A) When the severely depressed client suddenly begins to feel better, it often indicates that the client has made the decision to kill himself or herself and has developed a plan to do so. (B) Improvement in behavior is not indicative of an exacerbation of depressive symptoms. (C) The depressed client has a tendency for self- violence, not violence toward others. (D) Depressive behavior is not always accompanied by psychotic behavior.

NEW QUESTION: 558

A 35-year-old client is admitted to the hospital with diabetic ketoacidosis. Results of arterial blood gases are pH 7.2, PaO₂ 90, PaCO₂ 45, and HCO₃ 16. The nursing assessment of arterial blood gases indicate the presence of:

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

Answer: D (LEAVE A REPLY)

Section: Questions Set C

Explanation:

(A) Respiratory alkalosis is determined by elevated pH and low PaCO₂. (B) Respiratory acidosis is determined by low pH and elevated PaCO₂. (C) Metabolic alkalosis is

determined by elevated pH and HCO₃. (D) Metabolic acidosis is determined by low pH and HCO₃.

NEW QUESTION: 559

Three weeks following discharge, a male client is readmitted to the psychiatric unit for depression. His wife stated that he had threatened to kill himself with a handgun. As the nurse admits him to the unit, he says, "I wish I were dead because I am worthless to everyone; I guess I am just no good." Which response by the nurse is most appropriate at this time?

- A. "I don't think you are worthless. I'm glad to see you, and we will help you."
- B. "Don't you think this is a sign of your illness?"
- C. "I know with your wife and new baby that you do have a lot to live for."
- D. "You've been feeling sad and alone for some time now?"

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

- (A) This response does not acknowledge the client's feelings.
- (B) This is a closed question and does not encourage communication.
- (C) This response negates the client's feelings and does not require a response from the client.
- (D) This acknowledges the client's implied thoughts and feelings and encourages a response.

NEW QUESTION: 560

The nurse would teach a male client ways to minimize the risk of infection after eye surgery. Which of the following indicates the client needs further teaching?

- A. "I will wash my hands before instilling eye medications."
- B. "I will wear sunglasses when going outside."
- C. "I will wear an eye patch for the first 3 postoperative days."
- D. "I will maintain the sterility of the eye medications."

Answer: C (LEAVE A REPLY)

Explanation

- (A) Hand washing would be an important action designed to prevent transmission of pathogens from the hands to the eye.
- (B) Wearing sunglasses when going outside will prevent airborne pathogens from entering the eye.
- (C) Eye patches are most frequently ordered to be worn while the client sleeps or naps, not constantly for this length of time.
- (D) Eye medications are sterile; clients need to be taught how to maintain this sterility.

NEW QUESTION: 561

After a 10-year-old child with insulin-dependent diabetes mellitus receives her dinner tray, she tells the nurse that she hates broccoli and wants some corn on the cob. The nurse's appropriate response is:

- A. "No vegetable exchanges are allowed."
- B. "Corn and other starchy vegetables are considered to be bread exchanges."
- C. "Yes, you may exchange any vegetable for any other vegetable."
- D. "Yes, but only one-half ear is allowed."

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Sites for injection need to be rotated, including abdominal sites, to enhance insulin absorption. (B) The pinch technique is the most effective method for obtaining skin tightness to allow easy entrance of the needle to subcutaneous tissues. (C) Massaging the site of injection facilitates absorption of the insulin. (D) Changing the needle will break the sterility of the system. It has become acceptable practice to reuse disposable needles and syringes for 3-7 days.

NEW QUESTION: 562

A client who is a breast-feeding mother develops mastitis. The clinical signs and symptoms of mastitis include:

- A. Marked engorgement, elevated temperature, chills, and breast pain with an area that is red and hardened
- B. Marked engorgement and breast pain
- C. Elevated temperature and general malaise
- D. Cracked nipple with complaints of soreness

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Mastitis is a bacterial inflammation of the breast tissue found primarily in breast-feeding mothers. The bacteria usually enter the breast through a cracked nipple, or the infection results from stasis of milk behind a blocked duct. (B) With breast engorgement during breast-feeding, there may be marked breast pain. This is not necessarily a sign of infection. (C) Women may become ill during breast-feeding with other bacterial or viral infections that are not related to mastitis. (D) Improper care of the nipples or improper positioning of the infant during breastfeeding may result in cracked or sore nipples.

NEW QUESTION: 563

A female client has experienced varying degrees of depression throughout her life. Now that she is postmenopausal, her depression has increased. She is unable to motivate herself to clean her house or even to get out of bed and get dressed in the morning. The

client was begun on fluoxetine (Prozac) therapy. When educating her about fluoxetine, what might the nurse caution her about?

- A.** A daily dose of fluoxetine may be taken in the morning or evening.
- B.** Fluoxetine is not sedating; therefore, restrictions on driving and other hazardous activities are not necessary.
- C.** Rashes or pruritus usually occur early in the therapy and are treatable without discontinuing the medication.
- D.** It is safe to take over-the-counter or other prescription medications with fluoxetine.

Answer: (SHOW ANSWER)

Section: Questions Set E

Explanation:

(A) A daily dose of fluoxetine should be taken in the morning. Afternoon doses may cause nervousness and insomnia. (B) Although fluoxetine is less sedating than other antidepressants, it may still cause dizziness or drowsiness in some clients. The nurse should caution clients to avoid driving or hazardous activities until the central nervous system effects of the drug are demonstrated. (C) Rashes or pruritus do commonly occur early in therapy and respond to antihistamines or topical corticosteroids. (D) Advise the client not to take over-the-counter or other prescription drugs without consulting with the physician. Fluoxetine does interact with other common drugs such as monoamine oxidase inhibitors, diazepam, insulin, oral antidiabetic agents, tricyclic antidepressants, and tryptophan.

NEW QUESTION: 564

Assessment of parturient reveals the following: cervical dilation 6 cm and station 22; no progress in the last 4 hours. Uterine contractions decreasing in frequency and intensity. Marked molding of the presenting fetal head is described. The physician orders, "Begin oxytocin induction at 1 mU/min." The nurse should:

- A.** Begin the oxytocin induction as ordered
- B.** Increase the dosage by 2 mU/min increments at 15-minute intervals
- C.** Maintain the dosage when duration of contractions is 40-60 seconds and frequency is at 21 □ 2-4 minute intervals
- D.** Question the order

Answer: D (LEAVE A REPLY)

Section: Questions Set B

Explanation:

(A) Oxytocin stimulates labor but should not be used until CPD (cephalopelvic disproportion) is ruled out in a dysfunctional labor. (B) This answer is the correct protocol for oxytocin administration, but the medication should not be used until CPD is ruled out. (C) This answer is the correct manner to interpret effective stimulation, but oxytocin should not be used until CPD is ruled out. (D) This answer is the appropriate nursing action

because the scenario presents dysfunctional labor pattern that may be caused by CPD. Oxytocin administration is contraindicated in CPD.

NEW QUESTION: 565

A 5-year-old child cries continually in her bed. Her parents have been unsuccessful in assisting her in expressing her feelings. Which activity should the nurse provide the child to assist her in expressing her feelings?

- A. Books with colorful pictures
- B. Music
- C. Riding toys
- D. Puppets

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Books increase cognition, assist with fine motor skills, and augment language development. (B) Music provides auditory stimulation and large-muscle activity. (C) Riding toys provide large-muscle activity. (D) Puppets allow expression of feelings and fears that otherwise could not be directly communicated.

NEW QUESTION: 566

A 42-year-old client presents with a diagnosis of paranoid schizophrenia. She has become increasingly restless and verbally argumentative, and her speech has become pressured. She is exhibiting signs of:

- A. Depression
- B. Agitation
- C. Psychotic ideation
- D. Anhedonia

Answer: B (LEAVE A REPLY)

(A) Signs of depression would include withdrawal, sadness, morbid thoughts, insomnia, early awakening, etc. (B) These clinical features are classic signs of agitation. (C) Psychotic ideation includes delusional thoughts, bizarre behavior, disorganized thinking, etc. (D) Anhedonia is the inability to experience pleasure.

NEW QUESTION: 567

A client is placed on lithium therapy for her manicdepressive illness. When monitoring the client, the nurse assesses the laboratory blood values. Toxicity may occur with lithium therapy when the blood level is above:

- A. 1.0 mEq/L
- B. 2.2 mEq/L
- C. 0.03 mEq/L
- D. 1.5 mEq/L

Answer: D (LEAVE A REPLY)

(A) This value is a low blood level. (B) This value is a toxic blood level. (C) This value is a low blood level. (D) This value is the level at which most clients are maintained, and toxicity may occur if the level increases. The client should be monitored closely for symptoms, because some clients become toxic even at this level.

NEW QUESTION: 568

Hematotympanum and otorrhea are associated with which of the following head injuries?

- A. Basilar skull fracture
- B. Subdural hematoma
- C. Epidural hematoma
- D. Frontal lobe fracture

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Basilar skull fractures are fractures of the base of the skull. Blood behind the eardrum or blood or cerebrospinal fluid (CSF) leaking from the ear are indicative of a dural laceration. Basilar skull fractures are the only type with these symptoms. (B, C, D) These do not typically cause dural lacerations and CSF leakage.

NEW QUESTION: 569

A client has ascites, which is caused by:

- A. Decreased plasma proteins
- B. Electrolyte imbalance
- C. Decreased renal function
- D. Portal hypertension

Answer: A (LEAVE A REPLY)

(A) A decrease in plasma proteins causes a decrease in intravascular osmotic pressure resulting in leakage of fluid into peritoneal cavity. (B) Fluid and electrolyte imbalance may occur as a result of the ascites. (C) Ascites is a result of hepatic malfunction, not renal malfunction. (D) Portal hypertension causes esophageal varices, not ascites.

NEW QUESTION: 570

When interviewing parents who are suspected of child abuse, the nurse would use which of the following interview techniques?

- A. Be direct, honest, and attentive.
- B. Approach them in the emergency room as soon as you suspect abuse to "clear the air" right away.
- C. Ask the parents what they could have done differently to prevent this from happening to the child.
- D. After the interview, call child protective services.

Answer: A (LEAVE A REPLY)

Explanation

(A) The nurse must be honest, direct, professional, and attentive in her interview to gain the parent's trust. (B) The nurse should approach the parents in private, away from the child. (C) Asking them to relive and evaluate the situation may be looked at as placing blame on the parents for the child's "accident." At this point, the parents may get defensive and stop communicating. (D) Although you may call child protective services, the nurse should inform the parents of their responsibility to do this and explain the process to them.

NEW QUESTION: 571

A female client was recently diagnosed with gastric cancer. She entered the hospital and had a total gastrectomy with esophagojejunostomy. Her postoperative recovery was uneventful. On conducting discharge teaching, the nurse discusses changes in bodily function and lifestyle changes with the client. In order to prevent pernicious anemia, the nurse stresses that the client must:

- A.** Receive monthly blood transfusions
- B.** Increase the amount of iron in her diet
- C.** Eat small quantities several times daily until she is able to tolerate food in moderate portions
- D.** Understand the need for Vitamin B12 replacement therapy

Answer: D (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) Monthly blood transfusions are not indicated postgastrectomy. (B) Increasing iron in the client's diet may cause irritation and will not alleviate pernicious anemia. (C) It may be necessary that the client eat small meals several times per day, but this measure has no relevance to prevention of pernicious anemia. (D) Pernicious anemia is caused by lack of Vitamin B12, and replacement therapy will be necessary because the client's stomach has been removed.

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NEW QUESTION: 572

When teaching a sex education class, the nurse identifies the most common STDs in the United States as:

- A. Chlamydia
- B. Herpes genitalis
- C. Syphilis
- D. Gonorrhea

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Chlamydia trachomatis infection is the most common STD in the United States. The Centers for Disease Control and Prevention recommend screening of all high-risk women, such as adolescents and women with multiple sex partners. (B) Herpes simplex genitalia is estimated to be found in 5-20 million people in the United States and is rising in occurrence yearly. (C) Syphilis is a chronic infection caused by *Treponema pallidum*. Over the last several years the number of people infected has begun to increase. (D) Gonorrhea is a bacterial infection caused by the organism *Neisseria gonorrhoeae*. Although gonorrhea is common, chlamydia is still the most common STD.

NEW QUESTION: 573

A female client has married recently. A month ago she visited her physician with complaints of burning on urination. She was given a prescription for trimethoprim-sulfamethoxazole (Bactrim) DS bid for 10 days. She was admitted through the emergency room on Saturday evening complaining of flank pain. Her temperature was 104°F. A preliminary urinalysis revealed 31 bacteria along with red and white blood cells in the urine. A preliminary diagnosis of pyelonephritis was made. During a nursing admission assessment, which statement by the client demonstrates a possible cause for pyelonephritis?

- A. "I have not been drinking six to eight glasses of water each day as the nurse had instructed."
- B. "I'm afraid I may have something wrong with my bladder because I have been getting bladder infections frequently since I've been married."
- C. "I took the Bactrim for 6 or 7 days. The burning stopped, so I saved the rest of the medication for the next time."
- D. "I recently had the flu, which could be settling in my kidneys now."

Answer: ([SHOW ANSWER](#))

Explanation

(A) Although it is important that the client drink adequate fluids while treating a bladder infection with trimethoprim-sulfamethoxazole, the failure to do so will not cause pyelonephritis. (B) A stricture or abnormality may cause the progression of bladder infection to urinary tract infection, but this is rare. There is no indication in this situation that this has occurred. (C) The most common cause of pyelonephritis is improper treatment of

bladder infections. The client typically feels better after several days, discontinues the medication, and saves the remainder for the next occurrence of a bladder infection. For this reason, it is imperative to provide client education related to completion of the prescribed medication. (D) There is no evidence that infection in another body system could cause pyelonephritis.

NEW QUESTION: 574

A client with cirrhosis of the liver becomes comatose and is started on neomycin 300 mg q6h via nasogastric tube. The rationale for this therapy is to:

- A.** Prevent systemic infection
- B.** Promote diuresis
- C.** Decrease ammonia formation
- D.** Acidify the small bowel

Answer: C ([LEAVE A REPLY](#))

Explanation

(A) Neomycin is an antibiotic, but this is not the Rationale for administering it to a client in hepatic coma. (B) Diuretics and salt-free albumin are used to promote diuresis in clients with cirrhosis of the liver. (C) Neomycin destroys the bacteria in the intestines. It is the bacteria in the bowel that break down protein into ammonia. (D) Lactulose is administered to create an acid environment in the bowel. Ammonia leaves the blood and migrates to this acidic environment where it is trapped and excreted.

NEW QUESTION: 575

A 9-month-old infant was diagnosed with nonorganic failure to thrive. During her hospitalization, primary nurses were assigned to initiate all infant feedings. The infant's parents question why they cannot feed their own child.

Which of the following responses would be most appropriate by the nurse?

- A.** By assigning the same nurses to the child, the nurses can begin to learn the infant's cues and feeding behaviors.
- B.** The same nurses will prevent parental fatigue and frustration.
- C.** The same nurses will prevent infant fatigue and frustration.
- D.** Primary nurses will ensure privacy.

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set D

Explanation:

(A) Consistent primary care nurses can better interpret infant cues and note feeding behaviors. (B) In nonorganic failure to thrive the parent-infant dyad has already experienced difficulties in the relationship. These parents may already feel dissatisfied and frustrated. The primary nurse would be unable to prevent this. (C) Assigning a primary nurse does not ensure that infant fatigue and frustration will not occur or can be prevented. (D) Providing privacy does not ensure a change in feeding behavior.

NEW QUESTION: 576

A client tells the nurse that she has had a history of urinary tract infections. The nurse would do further health teaching if she verbalizes she will:

- A.** Drink at least 8 oz of cranberry juice daily
- B.** Maintain a fluid intake of at least 2000 mL daily
- C.** Wash her hands before and after voiding
- D.** Limit her fluid intake after 6 PM so that there is not a great deal of urine in her bladder while she sleeps

Answer: D ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Cranberry juice helps to maintain urine acidity, thereby retarding bacterial growth. (B) A generous fluid intake will help to irrigate the bladder and to prevent bacterial growth within the bladder. (C) Hand washing is an effective means of preventing pathogen transmission. (D) Restricting fluid intake would contribute to urinary stasis, which in turn would contribute to bacterial growth.

NEW QUESTION: 577

A 9-month-old infant was diagnosed with nonorganic failure to thrive. During her hospitalization, primary nurses were assigned to initiate all infant feedings. The infant's parents question why they cannot feed their own child. Which of the following responses would be most appropriate by the nurse?

- A.** By assigning the same nurses to the child, the nurses can begin to learn the infant's cues and feeding behaviors.
- B.** The same nurses will prevent parental fatigue and frustration.
- C.** The same nurses will prevent infant fatigue and frustration.
- D.** Primary nurses will ensure privacy.

Answer: ([SHOW ANSWER](#))

Explanation

(A) Consistent primary care nurses can better interpret infant cues and note feeding behaviors. (B) In nonorganic failure to thrive the parent-infant dyad has already experienced difficulties in the relationship.

These parents may already feel dissatisfied and frustrated. The primary nurse would be unable to prevent this.

(C) Assigning a primary nurse does not ensure that infant fatigue and frustration will not occur or can be prevented. (D) Providing privacy does not ensure a change in feeding behavior.

NEW QUESTION: 578

A seventh grader lost consciousness after being hit in the head with a basketball. In the emergency room his vital signs are stable, and he demonstrates no neurologic deficit. He will not be admitted to the hospital. It is most important that you advise his mother to:

- A.** Encourage him to drink plenty of fluids
- B.** Expect him to have nausea with vomiting
- C.** Keep him awake for the next 12 hours
- D.** Wake him up every 1-2 hours during the night

Answer: D (LEAVE A REPLY)

Explanation

(A) Fluid intake should be normal. Fluid intake may be restricted when there is a risk for increased ICP in a hospitalized client. (B) Nausea is possible, but vomiting without nausea is more likely with increased ICP.

Neither one should be expected, but the mother should know to notify the physician or hospital if they occur.

(C) The child does not need to be kept awake. It is important that he can be aroused from sleep. (D) If the child cannot be awakened from sleep after head injury, it is an indication of serious increase in ICP. The mother should call an ambulance right away.

NEW QUESTION: 579

A 23-year-old female client is brought to the emergency room by her roommate for repeatedly making superficial cuts on her wrists and experiencing wide mood swings. She is very angry and hostile. Her medical diagnosis is adjustment disorder versus borderline personality disorder. The client comments to the nurse, "Nobody in here seems to really care about the clients. I thought nurses cared about people!" The client is exhibiting the ego defense mechanism:

- A.** Reaction formation
- B.** Rationalization
- C.** Splitting
- D.** Sublimation

Answer: C (LEAVE A REPLY)

Explanation

(A) Reaction formation is the development and demonstration of attitudes and/or behaviors opposite to what an individual actually feels. The client's comment does reveal her anger and hostility. (B) Rationalization, another ego defense mechanism, is offering a socially acceptable or seemingly logical explanation to justify one's feelings, behaviors, or motives. The client's comment does not reflect rationalization. (C) Splitting, the viewing of people or situations as either all good or all bad, is frequently used by persons experiencing a disruption in self-concept. This ego defense mechanism is reflective of the individual's inability to integrate the positive and negative aspects of self. (D) Sublimation, the channeling of socially unacceptable impulses and behaviors into more acceptable patterns

of behavior, is another ego defense mechanism. The client's comment reveals that she is not engaging in sublimation.

NEW QUESTION: 580

A client's membranes have just ruptured spontaneously. Which of the following nursing actions should take priority?

- A. Assess quantity of fluid.
- B. Assess color and odor of fluid.
- C. Document on fetal monitor strip and chart.
- D. Assess fetal heart rate (FHR).

Answer: D (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) Assessing the quantity of amniotic fluid is important as an indication of maternal fetal well-being, but it does not take priority over assessment of FHR. (B) Greenish-brown discoloration of amniotic fluid indicates presence of meconium. Foul odor may indicate presence of infection. Both of these are important assessment data, but they do not take priority over possible lifethreatening compression of the umbilical cord. (C) Documentation is important, but it does not take priority over the possible life-threatening compression of the umbilical cord. (D) If changes in the FHR are noted, the nurse should check for umbilical cord prolapse. This intervention has priority over the other actions. The danger of a prolapsed cord is increased once membranes have ruptured, especially if the presenting part of the fetus does not fit firmly against the cervix.

NEW QUESTION: 581

A schizophrenic is admitted to the psychiatric unit. What affect would the nurse expect to observe?

- A. Anger
- B. Apathy and flatness
- C. Smiling
- D. Hostility

Answer: B (LEAVE A REPLY)

Explanation

(A) Anger is an emotion that is not necessarily present in schizophrenia. (B) Lack of response to or involvement with environment and distancing are characteristic of schizophrenia. (C) Euphoria is more characteristic of manic-depressive disorder (bipolar disorder). (D) Hostility is an emotion that is not necessarily present in schizophrenia.

NEW QUESTION: 582

A female client with major depression stated that "life is hopeless and not worth living." The nurse should place highest priority on which of the following questions?

- A. "How has your appetite been recently?"
- B. "Have you thought about hurting yourself?"
- C. "How is your relationship with your husband?"
- D. "How has your depression affected your daily living activities?"

Answer: [\(SHOW ANSWER\)](#)

Explanation/Reference:

Explanation:

(A) Although eating habits are important to assess, they are less important than suicidal intent. (B) Maintenance of the client's life is the priority; assessment of suicidal intent is imperative. (C) Relationships and support systems are an important part of assessment, but they are less important than suicidal intent.

(D) Daily living activities will give additional information about the level of depression, and are less significant than suicidal intent, although this information may give additional information about the actual plan for a suicidal attempt.

NEW QUESTION: 583

A pregnant woman at 36 weeks' gestation is followed for PIH and develops proteinuria. To increase protein in her diet, which of the following foods will provide the greatest amount of protein when added to her intake of 100 mL of milk?

- A. Fifty milliliters light cream and 2 tbsp corn syrup
- B. Thirty grams powdered skim milk and 1 egg
- C. One small scoop (90 g) vanilla ice cream and 1 tbsp chocolate syrup
- D. One package vitamin-fortified gelatin drink

Answer: B [\(LEAVE A REPLY\)](#)

Explanation

(A) This choice would provide more unwanted fat and sugar than protein. (B) Skim milk would add protein.

Eggs are good sources of protein while low in fat and calories. (C) The benefit of protein from ice cream would be outweighed by the fat content. Chocolate syrup has caffeine, which is contraindicated or limited in pregnancy. (D) Although most animal proteins are higher in protein than plant proteins, gelatin is not. It loses protein during the processing for food consumption.

NEW QUESTION: 584

Discharge teaching was effective if the parents of a child with atopic dermatitis could state the importance of:

- A. Showering 3-4 times a day
- B. Maintaining a high-humidified environment
- C. Wrapping hands in soft cotton gloves
- D. Furry, soft stuffed animals for play

Answer: (SHOW ANSWER)

(A) Maintaining a low-humidified environment. (B) Avoiding furry, soft stuffed animals for play, which may increase symptoms of allergy. (C) Avoiding showering, which irritates the dermatitis, and encouraging bathing 4 times a day in colloid bath for temporary relief. (D) Wrapping hands in soft cotton gloves to prevent skin damage during scratching.

NEW QUESTION: 585

In working with mental health clients who are prescribed medication that must be taken on a routine basis, it is important for education to begin when the drug therapy is initiated.

One of the first steps in the teaching process is to:

- A. Explain the side effects of the medication
- B. Discuss the danger of overmedication
- C. Distribute written material to supplement verbal instructions
- D. Explore the client's perception regarding medication therapy

Answer: D (LEAVE A REPLY)

Explanation

(A, B, C) The nurse must first obtain information regarding the client's perception of the medication regimen.

(D) The first step in the teaching process is to determine the client's perception.

NEW QUESTION: 586

The physician has ordered that ampicillin 250 mg IV be given over 30 minutes. The medication is diluted as recommended in 10 mL in the volume control chamber of a set that has a tubing of 12 mL. Which nursing measure is most accurate considering these facts?

- A. Infuse volume at 44 mL/hr.
- B. Infuse volume at 22 mL/hr.
- C. Infuse volume at 10 mL/hr.
- D. Infuse volume at 30 mL/hr.

Answer: (SHOW ANSWER)

(A) The volume to be infused should be diluted medication volume added to the volume control chamber (10 mL) plus the tubing volume (12 mL). The general formula for calculating IV medications for children is: $\text{Rate} = \frac{\text{Volume to Be Infused} \times \text{Administration Set Drop Factor}}{\text{Desired Time to Infuse in Minutes}}$ $\text{Rate} = \frac{(10 + 12) \times 60}{30} = 44 \text{ mL/hr.}$ (B, C, D) These values are incorrect.

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NEW QUESTION: 587

In teaching the client about proper umbilical cord care, the nurse recommends that:

- A. Petrolatum be placed around the cord after the sponge bath
- B. A belly binder be applied to prevent umbilical hernia
- C. The area be cleansed at diaper changes with alcohol and inspected for redness or drainage
- D. The cord clamp be left on until the cord stump separates

Answer: (SHOW ANSWER)

(A) Petrolatum does not allow the cord to dry and will encourage infection. (B) Belly binders do not facilitate drying of the cord and will encourage abdominal relaxation. (C) Frequent applications of alcohol will facilitate drying and discourage infection. (D) The cord clamp can be removed in 24 hours. Leaving it on is cumbersome and could pull on the cord unnecessarily.

NEW QUESTION: 588

During his hospitalization, a 3-year-old child has become unusually aggressive in his play activities. His parents report this change in behavior to the primary nurse. How could the nurse explain the child's change in behavior?

- A. Deep-seated feelings of hostility
- B. A lack of interest in socializing
- C. Usual behavior for this child
- D. A coping response

Answer: D (LEAVE A REPLY)

Explanation

(A) Unusually aggressive behavior does not indicate a deepseated problem. (B) A lack of social interest results in poor participation in play activities with peers. Aggression would not be an expected behavior. (C) The aggressive behavior was newly developed and not a routine behavior. (D) Play provides the child with opportunities for coping and adaptation. Aggression during the play activities would indicate a coping response.

NEW QUESTION: 589

To ensure proper client education, the nurse should teach the client taking SL nitroglycerin to expect which of the following responses with administration?

- A. Stinging, burning when placed under the tongue
- B. Temporary blurring of vision
- C. Generalized urticaria with prolonged use
- D. Urinary frequency

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Stinging or burning when nitroglycerin is placed under the tongue is to be expected. This effect indicates that the medication is potent and effective for use. Failure to have this response means that the client needs to get a new bottle of nitroglycerin. (B, C, D) The other responses are not expected in this situation and are not even side effects.

NEW QUESTION: 590

A 35-weeks-pregnant client is undergoing a nonstress test (NST). During the 20-minute examination, the nurse notes three fetal movements accompanied by accelerations of the fetal heart rate, each 15 bpm, lasting 15 seconds. The nurse interprets this test to be:

- A. Nonreactive
- B. Reactive
- C. Positive
- D. Negative

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) In a nonreactive NST, the criteria for reactivity are not met. (B) A reactive NST shows at least two accelerations of FHR with fetal movements, each 15 bpm, lasting 15 seconds or more, over 20 minutes.

(C, D) This term is used to interpret a contraction stress test (CST), or oxytocin challenge test, not an NST.

NEW QUESTION: 591

Which of the following findings would necessitate discontinuing an IV potassium infusion in an adult with ketoacidosis?

- A. Urine output 22 mL/hr for 2 hours
- B. Serum potassium level of 3.7
- C. Small T wave of ECG
- D. Serum glucose level of 180

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation

Explanation:

(A) Adequate renal flow of 30 mL/hr is a necessity with potassium infusions because potassium is excreted renally. (B) Because potassium level will decrease during correction of diabetic ketoacidosis, potassium will be infused even if plasma levels of potassium are normal. (C) A small T wave is normal and desired on the electrocardiogram. A tall, peaked

T-wave could indicate over infusion of potassium and hyperkalemia. (D) Glucose levels of <200 are desirable.

NEW QUESTION: 592

An infant with a congenital heart defect is being discharged with an order for the administration of digoxin elixir every 12 hours. The parents need to be taught when administering digoxin to the infant that:

- A. If the infant vomits within 30 minutes of the digoxin administration, repeat the dose
- B. They need to mix it with formula so the infant swallows it easily
- C. If the infant vomits two or more consecutive doses or becomes listless or anorexic, notify the physician
- D. If a dose of digoxin is skipped for more than 6 hours, a new timetable for administration must be developed

Answer: C (LEAVE A REPLY)

Explanation

(A) Occasionally the child may vomit. They should not repeat the dose because the amount of digoxin that was absorbed is unknown, and serum levels of digoxin that are too high are more dangerous than those that are temporarily too low. (B) To ensure that the entire dose of digoxin is received, never mix it with food or formula. (C) Vomiting, anorexia, and listlessness are all signs of digoxin toxicity and should be reported to the physician immediately. (D) If a dose is forgotten for more than 6 hours, the nurse should advise the parents to skip that dose and to continue the next dose as scheduled.

NEW QUESTION: 593

A child is to receive atropine 0.15 mg (1/400 g) as part of his preoperative medication. A vial containing atropine 0.4 mg (1/150 g)/mL is on hand. How much atropine should be given?

- A. 0.06 mL
- B. 0.38 mL
- C. 2.7 mL
- D. Information given insufficient to determine the amount of atropine to be administered

Answer: B (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A, C) Information was incorrectly placed in the formula, resulting in an incorrect answer. (B) The answer is correct.

$$0.4 \text{ mg} = 1 \text{ mL}; 0.15 \text{ mg } x = \text{mL}$$

$$0.4 x = 0.15$$

$$x = 0.15/0.4$$

$$x = 0.375 \text{ or } 0.38 \text{ mL}$$

(D) Sufficient information is provided to determine the amount of atropine to administer. The amount of atropine available and the amount of atropine ordered is required to determine the amount of atropine to be given.

NEW QUESTION: 594

When assessing a child with diabetes insipidus, the nurse should be aware of the cardinal signs of:

- A. Anemia and vomiting
- B. Polyuria and polydipsia
- C. Irritability relieved by feeding formula
- D. Hypothermia and azotemia

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Anemia and vomiting are not cardinal signs of diabetes insipidus. (B) Polyuria and polydipsia are the cardinal signs of diabetes insipidus. (C) Irritability relieved by feeding water, not formula, is a common sign, but not the cardinal sign, of diabetes insipidus. (D) Hypothermia and azotemia are signs, but not cardinal signs, of diabetes insipidus.

NEW QUESTION: 595

At 30 weeks' gestation, a client is admitted to the unit in premature labor. Her contractions are every 5 minutes and last 60 seconds, her cervix is closed, and the suture placed around her cervix during her 16th week of gestation, when she had the MacDonald procedure, can still be felt by the physician. The amniotic sac is still intact. She is very concerned about delivering prematurely. She asks the RN, "What is the greatest risk to my baby if it is born prematurely?" The RN's answer should be:

- A. Hyperglycemia
- B. Hypoglycemia
- C. Lack of development of the intestines
- D. Lack of development of the lungs

Answer: D (LEAVE A REPLY)

Explanation

(A) Any infant would be at risk for hyperglycemia because the infant's liver is missing the islets of Langerhans, which secrete insulin to break down glucose for cellular use. Prematurity is not an added risk for hyperglycemia. (B) Both premature and mature infants can be at risk for hypoglycemia if their mother had gestational diabetes during pregnancy or entered the pregnancy with diabetes mellitus. These infants are exposed to high levels of maternal glucose while in utero, which causes the islets of Langerhans in the infant's liver to produce insulin. After birth when the umbilical cord is severed, the generous amount of maternal blood glucose is eliminated; however, there is continued islet cell hyperactivity in the infant's liver, which can lead to excessive insulin levels and depleted

blood glucose. (C) Mature infants are born with an immature GI system. The nervous control of the stomach is incomplete at birth, salivary glands are immature at birth, and the intestinal tract is sterile. This is not the greatest risk to the premature infant. (D) Infants born before 37 weeks' gestation are at greatest risk for an insufficient amount of surfactant in the alveoli system of the lungs.

Surfactant helps to prevent lung collapse and ensures stability of the respiratory system so that the infant can maintain his own respirations once the umbilical cord is severed at birth.

NEW QUESTION: 596

Plans for the care of a client with an ulcer caused by emotional problems need to take into consideration that:

- A.** His priority needs are limited to medical management
- B.** There is no real psychological basis for his illness
- C.** The disorder is a threat to his physical well-being
- D.** He is unable to participate in planning his care

Answer: ([SHOW ANSWER](#))

Explanation

(A) There may be a medical emergency that takes top priority; however, the basis of the problem is emotional.

(B) The problem is a physical manifestation of an emotional conflict. (C) The bleeding ulcer can be life threatening. (D) For lifestyle change to occur, the client must participate in the planning of his care so that he is committed to changes that will have positive results.

NEW QUESTION: 597

A 68-year-old client developed acute respiratory distress syndrome while hospitalized for pneumonia. After a

respiratory arrest, an endotracheal tube was inserted. Several days later, numerous attempts to wean him from mechanical ventilation were ineffective, and a tracheostomy was created. For the first 24 hours following tracheostomy, it is important to minimize bleeding around the insertion site. The nurse can accomplish this by:

- A.** Deflating the cuff for 10 minutes every other hour instead of 5 minutes every hour
- B.** Avoiding manipulation of the tracheostomy including cuff deflation
- C.** Reporting any signs of crepitus immediately to the physician
- D.** Changing tracheostomy dressing only as necessary using one-half strength hydrogen peroxide to cleanse the site

Answer: **B** ([LEAVE A REPLY](#))

(A) The tracheal cuff should not be deflated within the first 24 hours following surgery. (B) To minimize bleeding, any manipulation, including cuff deflation, should be avoided. (C) Small amounts of crepitus are expected to occur; however, large amounts or expansion of the area of crepitus should be reported to the physician. (D) The tracheostomy site may be changed as often as necessary, but site care should be done with normal saline.

NEW QUESTION: 598

A 22-year-old client is 16 weeks pregnant. She and her husband are expecting their first baby. The client tells the nurse that her last normal menstrual period was February 16, with 3 days of spotting on February 17, 18, and 19. The nurse calculates her expected date of delivery to be:

- A. November 23rd
- B. December 26th
- C. September 14th
- D. December 9th

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Naele's rule is as follows: add 7 days to the 1st day of the last menstrual period, subtract 3 months, and then add 1 year. (B) Naele's rule presumes that the woman has a 28-day menstrual cycle, with conception occurring on the 14th day of the cycle. Slight vaginal spotting may occur in early gestation for unknown reasons but is insignificant in the calculation of Naele's rule. (C) Naele's rule presumes that the woman has a 28-day menstrual cycle, with conception occurring on the 14th day of the cycle. Slight vaginal spotting may occur in early gestation for unknown reasons but is insignificant in the calculation of Naele's rule. (D) Naele's rule presumes that the woman has a 28-day menstrual cycle, with conception occurring on the 14th day of the cycle. Slight vaginal spotting may occur in early gestation for unknown reasons but is insignificant in the calculation of Naele's rule.

NEW QUESTION: 599

An 18-month-old child has been playing in the garage. His mother brings him to a nurse's home complaining of his mouth being sore. His lips and mouth are soapy and white, with small ulcerated areas beginning to form.

The child begins to vomit. His pulse is rapid and weak. The nurse suspects that the child has:

- A. Inhaled gasoline fumes
- B. Ingested a caustic alkali
- C. Eaten construction chalk
- D. Lead poisoning

Answer: ([SHOW ANSWER](#))

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Explanation:

(A, C, D) These agents would not cause ulcerations on mouth and lips. (B) Strong alkali or acids will cause burns and ulcerations on the mucous membranes.

NEW QUESTION: 600

A female client has been recently diagnosed as bipolar. She has taken lithium for the past several weeks to control mania. What must be included in client education regarding lithium toxicity?

- A.** Maintain a normal diet; however, limit salt intake to no more than 3 g/day.
- B.** Take lithium between meals to increase absorption.
- C.** Withhold lithium if experiencing diarrhea, vomiting, or diaphoresis.
- D.** For pain or fever, avoid aspirin or acetaminophen (Tylenol). Nonsteroidal anti-inflammatory drugs are preferred.

Answer: C (LEAVE A REPLY)

Explanation

(A) The client should maintain a normal diet including normal salt intake. A low-sodium diet can cause lithium retention, leading to toxicity. (B) Lithium must be taken with meals because it is irritating to the gastric mucosa. (C) Diarrhea, vomiting, or diaphoresis can cause dehydration, which will increase lithium blood levels. If these symptoms occur, the nurse should instruct the client to withhold lithium. (D) Lithium is not to be taken with over-the-counter drugs without specific instruction. Some drugs raise lithium levels, whereas others lower lithium levels.

NEW QUESTION: 601

A client states to his nurse that "I was told by the doctor not to take one of my drugs because it seems to have caused decreasing blood cells." Based on this information, which drug might the nurse expect to be discontinued?

- A.** Prednisone
- B.** Timolol maleate (Blocadren)
- C.** Garamycin (Gentamicin)
- D.** Phenytoin (Dilantin)

Answer: D (LEAVE A REPLY)

(A) Prednisone is not linked with hematological side effects. (B) Timolol, a -adrenergic blocker is metabolized by the liver. It has not been linked to blood dyscrasia. (C) Gentamicin is ototoxic and nephrotoxic. (D) Phenytoin usage has been linked to blood dyscrasias such as aplastic anemia. The drug most commonly linked to aplastic anemia is chloramphenicol (Chlormycetin).

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NEW QUESTION: 602

A female client who has chronic obstructive pulmonary disease (COPD) has presented in the emergency department with cough productive of yellow sputum and increasing shortness of breath. On room air, her blood gases are as follows: pH 7.30 mm Hg, PCO₂ 60 mm Hg, PO₂ 55 mm Hg, HCO₃ 32 mEq/L. These arterial blood gases reflect:

- A. Compensated respiratory acidosis
- B. Normal blood gases
- C. Uncompensated metabolic acidosis
- D. Uncompensated respiratory acidosis

Answer: D (LEAVE A REPLY)

Explanation

(A) In compensated respiratory acidosis, the pH level is normal, the PCO₂ level is elevated, and the HCO₃ level is elevated. The client's primary alteration is an inability to remove CO₂ from the lungs, so over time, the kidneys increase reabsorption of HCO₃ to buffer the CO₂. (B) Normal ranges for arterial blood gases for adults and children are as follows: pH 7.35-7.45, PO₂ 80-100 mm Hg, PCO₂ 35-45 mm Hg, HCO₃ 21-28 mEq/L. (C) In uncompensated metabolic acidosis the pH level is decreased, the PCO₂ level is normal, and the HCO₃ level is decreased. The client's primary alteration is an inability to remove excess acid via the kidneys.

The lungs are unable to clear the increased acid. (D) In uncompensated respiratory acidosis, the pH level is decreased, the PCO₂ level is increased, and the HCO₃ level is normal. In a person with long-standing COPD, the HCO₃ level will rise gradually over time to compensate for the gradually increasing PCO₂, and the person's pH level will be normal. When a person with COPD becomes acutely ill, the kidneys do not have time to increase the reabsorption of HCO₃, so the person's pH level will reflect acidosis even though the HCO₃ is elevated.

NEW QUESTION: 603

On admission to the postpartal unit, the nurse's assessment identifies the client's fundus to be soft, 2 fingerbreadths above the umbilicus, and deviated to the right. This is most likely an indication of:

- A. Normal involution
- B. A full bladder
- C. An infection pain
- D. A hemorrhage

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Immediately after expulsion of the placenta, the fundus should be in the midline and remain firm. (B) A boggy displaced uterus in the immediate postpartum period is a sign of urinary distention. Because uterine ligaments are stretched, a full bladder can displace the uterus. (C) Symptoms of infection may include unusual uterine discomfort, temperature elevation, and foul-smelling lochia. The stem of this question does not address any of these factors. (D) While excessive bleeding is associated with a soft, boggy uterus, the stem of this question includes displacement of the uterus, which is more commonly associated with bladder distention.

NEW QUESTION: 604

Based on your knowledge of genetic inheritance, which of these statements is true for autosomal recessive genetic disorders?

- A.** Heterozygotes are affected.
- B.** The disorder is always carried on the X chromosome.
- C.** Only females are affected.
- D.** Two affected parents always have affected children.

Answer: D ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) The term heterozygote refers to an individual with one normal and one mutant allele at a given locus on a pair of homologous chromosomes. An individual who is heterozygous for the abnormal gene does not manifest obvious symptoms. (B) Disorders carried on either the X or Y sex chromosome are referred to as sex-linked recessive. (C) Either sex may be affected by autosomal recessive genetic disorders because the responsible allele can be on any one of the 46 chromosomes. (D) If both parents are affected by the disorder and are not just carriers, then all their children would manifest the same disorder.

NEW QUESTION: 605

A 42-year-old client presents with a diagnosis of paranoid schizophrenia. She has become increasingly restless and verbally argumentative, and her speech has become pressured. She is exhibiting signs of:

- A.** Depression
- B.** Agitation
- C.** Psychotic ideation
- D.** Anhedonia

Answer: ([SHOW ANSWER](#))

Explanation

(A) Signs of depression would include withdrawal, sadness, morbid thoughts, insomnia, early awakening, etc.

(B) These clinical features are classic signs of agitation. (C) Psychotic ideation includes delusional thoughts, bizarre behavior, disorganized thinking, etc. (D) Anhedonia is the inability to experience pleasure.

NEW QUESTION: 606

A 52-year-old client is scheduled for a small-bowel resection in the morning. In conjunction with other preoperative preparation, the nurse is teaching her diaphragmatic breathing exercises. She will teach the client to:

- A.** Inhale slowly and deeply through the nose until the lungs are fully expanded, hold the breath a couple of seconds, and then exhale slowly through the mouth. Repeat 2-3 more times to complete the series every 1-2 hours while awake
- B.** Purse the lips and take quick, short breaths approximately 18-20 times/min
- C.** Take a large gulp of air into the mouth, hold it for 10-15 seconds, and then expel it through the nose. Repeat 4-5 times to complete the series
- D.** Inhale as deeply as possible and then immediately exhale as deeply as possible at a rate of approximately 20-24 times/min

Answer: (SHOW ANSWER)

(A) This is the correct method of teaching diaphragmatic breathing, which allows full lung expansion to increase oxygenation, prevent atelectasis, and move secretions up and out of the lungs to decrease risk of pneumonia. (B) Quick, short breaths do not allow for full lung expansion and movement of secretions up and out of the lungs. Quick, short breaths may lead to O₂ depletion, hyperventilation, and hypoxia. (C) Expelling breaths through the nose does not allow for full lung expansion and the use of diaphragmatic muscles to assist in moving secretions up and out of the lungs. (D) Inhaling and exhaling at a rate of 20-24 times/min does not allow time for full lung expansion to increase oxygenation. This would most likely lead to O₂ depletion and hypoxia.

NEW QUESTION: 607

A 38-year-old female client with a history of chronic schizophrenia, paranoid type, is currently an outpatient at the local mental health and mental retardation clinic. The client comes in once a week for medication evaluation and/or refills. She self-administers haloperidol 5 mg twice a day and benztropine 1 mg once a day.

During a recent clinic visit, she says to the nurse, "I can't stay still at night. I toss and turn and can't fall asleep." The nurse suspects that she may be experiencing:

- A.** Akathisia
- B.** Akinesia
- C.** Dystonia
- D.** Opisthotonos

Answer: (SHOW ANSWER)

Section: Questions Set G

Explanation:

(A) Akathisia, or motor restlessness, is a reversible EPS frequently associated with the administration of antipsychotic drugs such as haloperidol. (B) Akinesia, or muscular or motor retardation, is an example of reversible EPS frequently associated with the administration of major tranquilizers such as haloperidol. (C) Acute dystonic reactions, bizarre and severe muscle contractions usually of the tongue, face, neck or extraocular muscles, are examples of EPS. (D) Opisthotonos, a severe type of whole-body dystonic reaction in which the head and heels are bent backward while the body is bowed forward, is an example of EPS.

NEW QUESTION: 608

A 40-year-old client has been admitted to the hospital with severe substernal chest pain radiating down his left arm. The nurse caring for the client establishes the following priority nursing diagnosis-Alteration in comfort, pain related to:

- A.** Increased excretion of lactic acid due to myocardial hypoxia
- B.** Increased blood flow through the coronary arteries
- C.** Decreased stimulation of the sympathetic nervous system
- D.** Decreased secretion of catecholamines secondary to anxiety

Answer: A (LEAVE A REPLY)

Explanation

(A) Anaerobic metabolism results because the decreased blood supply to the myocardium causes a release of lactic acid. Lactic acid is an irritant to the myocardial neural receptors, producing chest pain. (B) Chest pain is caused by a decrease in the O₂ supply to the myocardial cells. Treatment modalities for chest pain are aimed toward increasing the blood flow through coronary arteries. (C) Chest pain causes an increase in the stimulation of the sympathetic nervous system. This stimulation increases the heart rate and blood pressure, causing an increase in myocardial workload aggravating the chest pain. (D) Chest pain and anxiety cause increased secretion of catecholamines by stimulating the sympathetic nervous system. This stimulation increases chest pain by increasing the workload of the heart.

NEW QUESTION: 609

The 4th of July holiday comes while a client is in the hospital being treated for schizophrenia. She is taking chlorpromazine and has improved to the point of being allowed to go with a group to the park for a picnic. The side effect of chlorpromazine that the nurse needs to keep in mind during this outing is:

- A.** Hypotension
- B.** Photosensitivity
- C.** Excessive appetite
- D.** Dryness of the mouth

Answer: B (LEAVE A REPLY)

Explanation

(A) A decrease in blood pressure sometimes occurs with chlorpromazine. It would not be a factor influenced by a picnic in the park. (B) Protection from the sun is important in clients taking phenothiazines because they burn easily and severely. (C) An appetite increase sometimes occurs with chlorpromazine. It would not be affected by a picnic. (D) Dryness of the mouth may occur at any time and is not affected by the picnic outing.

NEW QUESTION: 610

Loss of appetite for a child with leukemia is a major recurrent problem. The plan of care should be designed to:

- A.** Reinforce attempts to eat
- B.** Help the child gain weight
- C.** Increase his appetite
- D.** Make mealtimes pleasant

Answer: A ([LEAVE A REPLY](#))

(A)

Ignoring refusals to eat and rewarding eating attempts are the most successful means of increasing intake. (B) This goal is not specific enough or related to the loss of appetite.

(C)

This goal is not possible at this time based on his illness. (D) This goal is helpful, but alone will not address his loss of appetite.

NEW QUESTION: 611

A client has just received an epidural block. She is laboring on her right side. The nurse notes that her blood pressure has dropped from 132/68 to 78/42 mm Hg. The nurse's first action would be to:

- A.** Call the physician immediately and give dopamine IM
- B.** Turn her on her left side and recheck her blood pressure in 5 minutes
- C.** Administer oxytocin (Pitocin) immediately and increase the rate of IV fluids
- D.** Increase the rate of IV fluids and start O2 by mask

Answer: D ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Nursing measures to support fetal oxygenation and promote maternal blood pressure would precede calling the physician. (B) Systolic pressures below 100 mm Hg or a reduction in the systolic pressure of >30% necessitate treatment. Assessing the blood pressure in 5 minutes may allow for further fetal and/or maternal compromise. Turning the client on her left side will promote uteroplacental perfusion and is appropriate. (C) Oxytocin (Pitocin) increases the strength of uterine contractions and may cause maternal hypotension; thus it is an inappropriate drug for use in this clinical situation. IV fluids would be increased to expand the circulating blood volume and promote increased blood pressure. (D) Turning the mother to her left lateral side promotes uteroplacental perfusion.

IV fluids are administered to increase the circulating blood volume, and O2 is administered to promote fetal oxygenation and decrease the nausea accompanying the hypotension.

NEW QUESTION: 612

A child sustains a supracondylar fracture of the femur. When assessing for vascular injury, the nurse should be alert for the signs of ischemia, which include:

- A.** Bleeding, bruising, and hemorrhage
- B.** Increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase
- C.** Pain, pallor, pulselessness, paresthesia, and paralysis
- D.** Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Bleeding, bruising, and hemorrhage may occur due to injury but are not classic signs of ischemia. (B) An increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase is related to the disruption of muscle integrity. (C) Classic signs of ischemia related to vascular injury secondary to long bone fractures include the five "P's": pain, pallor, pulselessness, paresthesia, and paralysis. (D) Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus are common clinical manifestations of a fracture but not ischemia.

NEW QUESTION: 613

A 70-year-old client is almost finished receiving her second unit of packed red blood cells. The client, who weighs 80 lb, has started complaining of being short of breath and now has crackles in the bases of her lungs. After slowing or stopping the transfusion, the most appropriate initial nursing action would be to:

- A.** Raise the client's head and place her feet in a dependent position
- B.** Notify the physician
- C.** Place the client on 2 liters of O2 via nasal cannula
- D.** Administer furosemide (Lasix) 20 mg IV push

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Raising the client's head and placing her feet in a dependent position is an independent nursing action that can be taken to decrease venous return and to reduce pulmonary congestion. (B) Notifying the physician is an appropriate action that should be taken after the client is positioned to maximize her respiratory status. (C) Placing the client on O2 may be done with a physician's order or according to an institution's standing orders;

however, other actions should be taken first. (D) Furosemide 20 mg IV push is an appropriate medication for the client, but it must be ordered by her physician.

NEW QUESTION: 614

A 32-year-old female client is being treated for Guillain- Barre syndrome. She complains of gradually increasing muscle weakness over the past several days. She has noticed an increased difficulty in ambulating and fell yesterday. When conducting a nursing assessment, which finding would indicate a need for immediate further evaluation?

- A. Complaints of a headache
- B. Loss of superficial and deep tendon reflexes
- C. Complaints of shortness of breath
- D. Facial paralysis

Answer: C (LEAVE A REPLY)

(A) Headaches are not associated with Guillain-Barre syndrome. (B) Loss of superficial and deep tendon reflexes is expected with this diagnosis. (C) Complaints of shortness of breath must be further evaluated. Forty percent of all clients have some detectable respiratory weakness and should be prepared for a possible tracheostomy. Pneumonia is also a common complication of this syndrome. (D) Facial paralysis is expected and is not considered abnormal.

NEW QUESTION: 615

A 47-year-old male client is admitted for colon surgery. Intravenous antibiotics are begun 2 hours prior to surgery. He has no known infection. The rationale for giving antibiotics prior to surgery is to:

- A. Provide cathartic action within the colon
- B. Reduce the risk of wound infection from anaerobic bacteria
- C. Relieve the client's concern regarding possible infection
- D. Reduce the risk of intraoperative fever

Answer: B (LEAVE A REPLY)

Explanation

(A) Cathartic drugs promote evacuation of intestinal contents. (B) The client undergoing intestinal surgery is at increased risk for infection from large numbers of anaerobic bacteria that inhabit the intestines.

Administering antibiotics prophylactically can reduce the client's risk for infection. (C) Antibiotics are indicated in the treatment of infections and have no effect on emotions. (D) Antipyretics are useful in the treatment of elevated temperatures. Antibiotics would have an effect on infection, which causes temperature elevation, but would not directly affect such an elevation.

NEW QUESTION: 616

In assessing the nature of the stool of a client who has cystic fibrosis, what would the nurse expect to see?

- A. Clay-colored stools
- B. Steatorrhea stools
- C. Dark brown stools
- D. Blood-tinged stools

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Clay-colored stools indicate dysfunction of the liver or biliary tract. (B) In the early stages of cystic fibrosis, fat absorption is primarily affected resulting in fat, foul, frothy, bulky stools. (C) Dark brown stools indicate normal passage through the colon. (D) Blood-tinged stools indicate dysfunction of the gastrointestinal (GI) tract.

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NEW QUESTION: 617

A female client is started on warfarin (Coumadin) 5 mg po bid. To adequately evaluate the effectiveness of the warfarin therapy, the nurse must know that this medication:

- A. Dissolves any clots already formed in the arteries
- B. Prevents the conversion of prothrombin to thrombin
- C. Interferes with the synthesis of vitamin K-dependent clotting factors
- D. Stimulates the manufacturing of platelets

Answer: C (LEAVE A REPLY)

(A) Thrombolytic agents (e.g., streptokinase) directly activate plasminogen, dissolving fibrin deposits, which in turn dissolves clots that have already formed. (B) Heparin prevents the formation of clots by potentiating the effects of antithrombin III and the conversion of prothrombin to thrombin. (C) Warfarin prevents the formation of clots by interfering with the hepatic synthesis of the vitamin K-dependent clotting factors. (D) Platelets initiate the coagulation of blood by adhering to each other and the site of injury to form platelet plugs.

NEW QUESTION: 618

A child has a nursing diagnosis of fluid volume excess related to compromised regulatory mechanisms.

Which of the following nursing interventions is the most accurate measure to include in his care?

- A. Weigh the child twice daily on the same scale.
- B. Monitor intake and output.
- C. Check urine specific gravity of each voiding.
- D. Observe for edema.

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Although all of these interventions are important aspects of care, weight is the most sensitive indicator of fluid balance. (B) Although monitoring intake and output is important, weight is a more accurate indicator of fluid status. (C) Urine specific gravity does not necessarily indicate fluid volume excess. (D) Edema may not be apparent, yet the client may have fluid volume excess.

NEW QUESTION: 619

A parent told the public health nurse that her 6-year-old son has been taking tetracycline for a chronic skin condition. The parent asked if this could cause any problems for the child. What should the nurse explain to the parent?

- A. Giving tetracycline to a child younger than 8 years may cause permanent staining of his teeth.
- B. If you give tetracycline with milk, it may be absorbed readily.
- C. The medication should be given to adults, not children.
- D. Secondary infections of chronic skin disorders do not respond to antibiotics.

Answer: A (LEAVE A REPLY)

(A) Tetracycline should be avoided during tooth development because it interferes with enamel formation and dental pigmentation. (B) Milk interferes with the absorption of tetracyclines. (C) Children older than 9 years or past the tooth development stage may be given tetracycline. (D) Secondary infections of chronic skin disorders may respond to antibiotics such as penicillin or tetracyclines.

NEW QUESTION: 620

A client is a depressed, 48-year-old salesman. A serious concern for the nurse working with depressed clients is the potential of suicide. The time that suicide is most likely to occur is:

- A. In the acutely depressed state
- B. When the depression starts to lift
- C. In the denial phase
- D. During a manic episode

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The client may be too disorganized in the acute phase to make a workable plan. (B) When the depression starts to lift, the client is able to make a workable plan. (C) There usually is not a significant denial phase related to depression. Suicide occurs in a state of despair and hopelessness. (D) Suicide is uncommon in the manic state. In this state, clients do not feel hopeless, but euphoric and overly confident.

NEW QUESTION: 621

When giving discharge instructions to a 24-year-old client who had a short-arm cast applied for a fractured right ulna, the nurse recognizes the importance of telling him that the drying time for a plaster of Paris cast is approximately:

- A.** 30 minutes
- B.** 1-4 hours
- C.** 12-24 hours
- D.** 24-72 hours

Answer: ([SHOW ANSWER](#))

Explanation

(A) Synthetic cast materials harden in 3-15 minutes. Weight bearing is permitted in 15-30 minutes. Drying time for plaster of Paris is about 24-72 hours. (B, C) Plaster of Paris cast materials are heavier than synthetic materials and require a drying time of 24-72 hours. Synthetic materials dry within 30 minutes. (D) Plaster of Paris cast materials are heavier than synthetic materials and require a longer period to set and dry. Even though setting time (hardening) is only 3-15 minutes, the drying time for plaster of Paris is 24-72 hours. This depends on the size and thickness of the cast, exposure to air, and humidity in the air.

NEW QUESTION: 622

Which of the following nursing care goals has the highest priority for a child with epiglottitis?

- A.** Sleep or lie quietly 10 hr/day.
- B.** Consume foods from all four food groups.
- C.** Be afebrile throughout her hospital stay.
- D.** Participate in play activities 4 hr/day.

Answer: **A** ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Of these four goals, maintenance of a calm, quiet atmosphere to reduce anxiety and to allow for rest is the most important. (B) Although nutrition is important, the child needs fluids to maintain fluid and electrolyte balance more than solid foods. In addition, the child may not be able to swallow solid foods owing to epiglottic swelling. (C) This goal is unrealistic because fever is a common symptom of the infection associated with epiglottitis.

(D) If overexerted, the child will need more O₂ and energy than available, and these requirements may exacerbate the condition.

NEW QUESTION: 623

A premature infant needs supplemental O₂ therapy. A nursing intervention that reduces the risk of retrolental fibroplasia is to:

- A. Maintain O₂ at <40%
- B. Maintain O₂ at >40%
- C. Give moist O₂ at >40%
- D. Maintain on 100% O₂

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Retrolental fibroplasia is the result of prolonged exposure to high levels of O₂ in premature infants.

Complications are hemorrhage and retinal detachment. (B, C, D) O₂ concentration is too high.

NEW QUESTION: 624

A female client at 30 weeks' gestation is brought into the emergency department after falling down a flight of stairs. On examination, the physician notes a rigid, boardlike abdomen; FHR in the 160s; and stable vital signs. Considering possible abdominal trauma, which obstetric emergency must be anticipated?

- A. Abruptio placentae
- B. Ectopic pregnancy
- C. Massive uterine rupture
- D. Placenta previa

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Abruptio placentae, the complete or partial separation of the placenta from the uterine wall, can be caused by external trauma. When hemorrhage is concealed, one sign is a rapid increase in uterine size with rigidity. (B) Ectopic pregnancy occurs when the embryo implants itself outside the uterine cavity. (C) Massive uterine rupture occurs during labor when the uterine contents are extruded through the uterine wall. It is usually due to weakness from a pre-existing uterine scar and trauma from instruments or an obstetrical intervention. (D) Placenta previa is the condition in which the placenta is implanted in the lower uterine segment and either completely or partially covers the cervical os.

NEW QUESTION: 625

Assessment of a client reveals a 30% loss of preillness weight, lanugo, and cessation of menses for 3 months.

Her vital signs are BP 90/50, P 96 bpm, respirations 30, and temperature 97 oF. She admits to the nurse that she has induced vomiting 3 times this morning, but she had to continue exercising to lose "just 5 more lb." Her symptoms are consistent with:

- A. Pregnancy
- B. Bulimia
- C. Gastritis
- D. Anorexia nervosa

Answer: D ([LEAVE A REPLY](#))

Section: Questions Set F

Explanation:

(A) Presenting behaviors collectively are inconsistent with depression. (B) A preillness weight loss of 30%, lanugo, and cessation of menses are inconsistent with bulimia. (C) Symptoms and vital signs do not indicate the presence of infection. (D) All symptoms and vital signs are consistent with anorexia nervosa.

NEW QUESTION: 626

A 23-year-old college student seeks medical attention at the college infirmary for complaints of severe fatigue. Her skin is pale, and she reports exertional dyspnea. She is admitted to the hospital with possible aplastic anemia. Laboratory values reflect anemia, and the client is prepared for a bone marrow biopsy. She refuses to sign the biopsy consent and states, "Can't you just get the doctor to give me a transfusion and let me go. This weekend begins spring break, and I have plans to go to Florida." At this time the nurse's greatest concern is that:

- A. The client may contract an infection as a result of being exposed to large crowds at spring break
- B. The client does not grasp the full impact of her illness
- C. The client may require transfusion before leaving for spring break
- D. The causative agent be identified and treatment begun

Answer: ([SHOW ANSWER](#))

(A)

The client could contract an infection, but at this point it is not the most pertinent issue.

(B)

The client's statement indicates that she does not grasp the full impact of her illness. Further client education must be given, along with allowing her to express her feelings regarding her illness. (C) The client may require a transfusion, but this is a temporary measure because the causative agent has not been identified. Her feelings regarding her illness must be addressed in order for care to continue. (D) A bone marrow is done first to make a definitive diagnosis; then treatment may begin.

NEW QUESTION: 627

A 52-year-old client is scheduled for a small-bowel resection in the morning. In conjunction with other preoperative preparation, the nurse is teaching her diaphragmatic breathing exercises. She will teach the client to:

A. Inhale slowly and deeply through the nose until the lungs are fully expanded, hold the breath a couple of seconds, and then exhale slowly through the mouth. Repeat 2-3 more times to complete the series every

1-2 hours while awake

B. Purse the lips and take quick, short breaths approximately 18-20 times/min

C. Take a large gulp of air into the mouth, hold it for 10-15 seconds, and then expel it through the nose.

Repeat 4-5 times to complete the series

D. Inhale as deeply as possible and then immediately exhale as deeply as possible at a rate of approximately 20-24 times/min

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) This is the correct method of teaching diaphragmatic breathing, which allows full lung expansion to increase oxygenation, prevent atelectasis, and move secretions up and out of the lungs to decrease risk of pneumonia. (B) Quick, short breaths do not allow for full lung expansion and movement of secretions up and out of the lungs. Quick, short breaths may lead to O₂ depletion, hyperventilation, and hypoxia. (C) Expelling breaths through the nose does not allow for full lung expansion and the use of diaphragmatic muscles to assist in moving secretions up and out of the lungs. (D) Inhaling and exhaling at a rate of 20-24 times/min does not allow time for full lung expansion to increase oxygenation. This would most likely lead to O₂ depletion and hypoxia.

NEW QUESTION: 628

A 64-year-old client is admitted to the hospital with benign prostatic hypertrophy (BPH). He has a history of adult-onset diabetes and hypertension and is scheduled to undergo a resection of the prostate. When recording his health history, the nurse asks about his chief complaint. The most serious symptom that may accompany BPH is:

A. Acute urinary retention

B. Hesitancy in starting urination

C. Increased frequency of urination

D. Decreased force of the urinary stream

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) Acute urinary retention requires urgent medical attention. If measures such as a warm tub bath or warm tea do not occur after 6 hours, the client should go to the ED for catheterization. (B, C, D) This choice is a symptom of BPH, but it is not serious or life threatening.

NEW QUESTION: 629

The following nursing diagnosis is written for a comatose client with cirrhosis of the liver and secondary splenomegaly - High risk for injury: Increased susceptibility to bleeding related to:

- A. Increased absorption of vitamin K
- B. Thrombocytopenia due to hypersplenism
- C. Diminished function of the Kupffer cells
- D. Increased synthesis of the clotting factors

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set G

Explanation

Explanation:

(A) There is a decreased absorption of vitamin K with cirrhosis of the liver. This decrease impairs blood coagulation and the formation of prothrombin. (B) Thrombocytopenia, an increased destruction of platelets, occurs secondary to hypersplenism. (C) A diminished function of the Kupffer cells occurs with cirrhosis of the liver, causing the client to become more susceptible to infections. (D) A decrease in the synthesis of fibrinogen and clotting factors VII, IX, and X occurs with cirrhosis of the liver and increases the susceptibility to bleeding.

NEW QUESTION: 630

The nurse notes multiple bruises on the arms and legs of a newly admitted client with lupus. The client states, "I get them whenever I bump into anything." The nurse would expect to note a decrease in which of the following laboratory tests?

- A. Number of platelets
- B. WBC count
- C. Hemoglobin level
- D. Number of lymphocytes

Answer: A ([LEAVE A REPLY](#))

(A) Thrombocytopenia, a decrease in platelets, occurs in lupus and causes a decrease in blood coagulation and thrombus formation. (B) Clients with lupus will have a decrease in the WBC count decreasing their resistance to infection. (C) Clients with lupus may have a decrease in the hemoglobin level causing anemia. (D) Leukopenia, a decrease in white blood cells, is seen in lupus and decreases resistance to infection.

NEW QUESTION: 631

A client is experiencing muscle weakness and lethargy. His serum K⁺ is 3.2. What other symptoms might he exhibit?

- A. Tetany
- B. Dysrhythmias
- C. Numbness of extremities

D. Headache

Answer: B (LEAVE A REPLY)

Section: Questions Set B

Explanation:

(A) Tetany is seen with low calcium. (B) Low potassium causes dysrhythmias because potassium is responsible for cardiac muscle activity. (C) Numbness of extremities is seen with high potassium. (D) Headache is not associated with potassium excess or deficiency.

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NEW QUESTION: 632

Which of the following ECG changes would be seen as a positive myocardial stress test response?

- A. Hyperacute T wave
- B. Prolongation of the PR interval
- C. ST-segment depression
- D. Pathological Q wave

Answer: (SHOW ANSWER)

(A) Hyperacute T waves occur with hyperkalemia. (B) Prolongation of the P R interval occurs with first-degree AV block. (C) Horizontal ST-segment depression of >1 mm during exercise is definitely a positive criterion on the exercise ECG test. (D) Pathological Q waves occur with MI.

NEW QUESTION: 633

At 38 weeks' gestation, a client is in active labor. She is using her Lamaze breathing techniques. The RN is coaching her breathing and encouraging her to relax and work with her contractions. Which one of the following complaints by the client will alert the RN that she is beginning to hyperventilate with her breathing?

- A. "I am cold."
- B. "I have a backache."
- C. "I feel dizzy."
- D. "I am nauseous."

Answer: C (LEAVE A REPLY)

Explanation

(A) Cold is not a symptom of hyperventilation. This could be due to the temperature of the room. (B) Backache is not a symptom of hyperventilation. This is probably due to the gravid uterus and its effect on the back muscles, or it may be due to the client's position in bed. (C) Dizziness is the first symptom of hyperventilation. It occurs because the body is eliminating too much CO₂. (D) Nausea is not a symptom of hyperventilation. It could be a symptom of pain.

NEW QUESTION: 634

A male client has asthma and his physician has prescribed beclomethasone (Vanceril) 3 puffs tid in addition to his other medications. After taking his beclomethasone, the client should be instructed to:

- A.** Clean his inhaler with warm water and soak it in a 10% bleach solution
- B.** Drink a glass of water
- C.** Sit and rest
- D.** Use his bronchodilator inhaler

Answer: ([SHOW ANSWER](#))

(A) Inhalers should be cleaned once a day. They should be taken apart, washed in warm water, and dried according to manufacturer's instructions. Soaking in bleach is inappropriate. (B) A common side effect of inhaled steroid preparations is oral candidal infection. This can be prevented by drinking a glass of water or gargling after using a steroid inhaler. (C) There is nothing wrong with sitting and resting after using a steroid inhaler, but it is not necessary. (D) If a person is using a steroid inhaler as well as a bronchodilator inhaler, the bronchodilator should always be used first. The reason for this is that the bronchodilator opens up the person's airways so that when the steroid inhaler is used next, there will be better distribution of medication.

NEW QUESTION: 635

A psychiatric nurse is providing an orientation to a new staff nurse. She reminds the nurse that psychiatrists often use categories of medications and that it is important that she recall that some categories of medications have synonyms. Another name used to describe minor tranquilizers is which of the following?

- A.** Antipsychotic medications
- B.** Antidepressant medications
- C.** Antianxiety medications
- D.** Antimania medication

Answer: ([SHOW ANSWER](#))

(A) Antipsychotic medications are also known as major tranquilizers. (B) Antidepressants fall into different categories, such as the tricyclics or the MAO inhibitors. (C) Antianxiety medications are also known as minor tranquilizers. (D) Antimania medications are those such as lithium and lithium carbonate (Lithobid).

NEW QUESTION: 636

A 75-year-old client is hospitalized with pneumonia caused by gram-positive bacteria. Which one of the following best describes a gram-positive bacterial pneumonia?

- A. Klebsiellapneumonia
- B. Pneumococcal pneumonia
- C. Legionella pneumophilapneumonia
- D. Escherichia colipneumonia

Answer: B ([LEAVE A REPLY](#))

Explanation

(A) Klebsiellapneumonia is caused by gram-negative bacteria. (B) Pneumococcal pneumonia is caused by gram-positive bacteria. (C) Legionella pneumophilapneumonia is a nonbacterial pneumonia. (D) E. colipneumonia is caused by gram-negative bacteria.

NEW QUESTION: 637

A 54-year-old client is admitted to the hospital with a possible gastric ulcer. He is a heavy smoker. When discussing his smoking habits with him, the nurse should advise him to:

- A. Smoke low-tar, filtered cigarettes
- B. Smoke cigars instead
- C. Smoke only right after meals
- D. Chew gum instead

Answer: C ([LEAVE A REPLY](#))

(A, B, D) Cigarettes, cigars, and chewing gum would stimulate gastric acid secretion. (C) Smoking on a full stomach minimizes effect of nicotine on gastric acid.

NEW QUESTION: 638

Which of the following medications requires close observation for bronchospasm in the client with chronic obstructive pulmonary disease or asthma?

- A. Verapamil (Isoptin)
- B. Amrinone (Inocor)
- C. Epinephrine (Adrenalin)
- D. Propranolol (Inderal)

Answer: ([SHOW ANSWER](#))

Explanation

(A) Verapamil has the respiratory side effect of nasal or chest congestion, dyspnea, shortness of breath (SOB), and wheezing. (B) Amrinone has the effect of increased contractility and dilation of the vascular smooth muscle. It has no noted respiratory side effects. (C) Epinephrine has the effect of bronchodilation through stimulation. (D) Propranolol, esmolol, and labetalol are all - blocking agents, which can increase airway resistance and cause bronchospasms.

NEW QUESTION: 639

An IDDM client's condition stabilizes. He begins to receive a daily injection of NPH insulin at 6:30 AM. The nurse can most likely expect a hypoglycemic reaction to occur that same day at:

- A. 8:30 AM-10:30 AM
- B. 2:30 PM-4:30 PM
- C. 7:30 PM-9:30 PM
- D. 10:30 PM-11:30 PM

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) This time describes the time of onset of NPH insulin's action, rather than its peak effect. (B) NPH insulin, an intermediate-acting insulin, usually begins to lower serum glucose levels about 2 hours after administration. The action of NPH insulin peaks 8-14 hours after administration. It has a 20-30 hour duration. (C) The time stated is not the time of peak action for NPH insulin administered at 6:30 AM. (D) The time stated is not the time of peak action for NPH insulin administered at 6:30 AM.

NEW QUESTION: 640

A client had a hemicolectomy performed 2 days ago. Today, when the nurse assesses the incision, a small part of the abdominal viscera is seen protruding through the incision. This complication of wound healing is known as:

- A. Excoriation
- B. Dehiscence
- C. Decortication
- D. Evisceration

Answer: (D) ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) Excoriation is abrasion of the epidermis or of the coating of any organ of the body by trauma, chemicals, burns, or other causes. (B) Dehiscence is a partial or complete separation of the wound edges with no protrusion of abdominal tissue. (C) Decortication is removal of the surface layer of an organ or structure. It is a type of surgery, such as removing the fibrinous peel from the visceral pleura in thoracic surgery. (D) Evisceration occurs when the incision separates and the contents of the cavity spill out.

NEW QUESTION: 641

After the fetal activity test (nonstress test) is completed, the RN is looking at the test results on the monitor strip. The RN observes that the fetal heart accelerated 5 beats/min with each fetal movement. The accelerations lasted ≥ 15 seconds and occurred 3 times during the 20-minute test. The RN knows that these test results will be interpreted as:

- A. A reactive test
- B. A nonreactive test
- C. An unsatisfactory test
- D. A negative test

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) A nonstress test that shows at least two accelerations of the fetal heart rate of 15 bpm with fetal activity, lasting ≥ 15 seconds over a 20-minute period. (B) Reactive criteria are not met. The accelerations of the fetal heart rate are not at least 15 bpm and do not last 15 seconds. This could mean fetal well-being is compromised. Usually a contraction stress test is ordered if the nonstress test results are negative. (C) An unsatisfactory test means the data cannot be interpreted, or there was inadequate fetal activity. If this happens, usually the test is ordered to be done at a later date. (D) A negative test is a term used to describe the results of a contraction stress test.

NEW QUESTION: 642

A 40-year-old client is admitted to the coronary care unit with chest pain and shortness of breath. The physician diagnosed an anterior wall myocardial infarction.

What tests should the nurse anticipate?

- A. Reticulocyte count, creatinine phosphokinase (CPK)
- B. Aspartate transaminase, alanine transaminase
- C. Sedimentation rate, WBC count
- D. Lactic dehydrogenase, CPK

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Reticulocyte count measures the number of immature erythrocytes. CPK is an enzyme released from injured myocardial tissue. (B) Aspartate transaminase is an enzyme released from injured myocardial tissue. Alanine transaminase is an enzyme released for general tissue destruction, which is specific for liver injury. (C) Sedimentation rate is a nonspecific test for inflammation. (D) Lactic dehydrogenase and CPK are enzymes released from injured myocardial tissue.

NEW QUESTION: 643

A client was not using his seat belt when involved in a car accident. He fractured ribs 5, 6, and 7 on the left and developed a left pneumothorax. Assessment findings include:

- A. Crackles and paradoxical chest wall movement
- B. Decreased breath sounds on the left and chest pain with movement
- C. Rhonchi and frothy sputum
- D. Wheezing and dry cough

Answer: B (LEAVE A REPLY)

(A) Crackles are caused by air moving through moisture in the small airways and occur with pulmonary edema. Paradoxical chest wall movement occurs with flail chest when a segment of the thorax moves outward on inspiration and inward on expiration. (B) Decreased breath sounds occur when a lung is collapsed or partially collapsed. Chest pain with movement occurs with rib fractures. (C) Rhonchi are caused by air moving through large fluid-filled airways. Frothy sputum may occur with pulmonary edema. (D) Wheezing is caused by fluid in large airways already narrowed by mucus or bronchospasm. Dry cough could indicate a cardiac problem.

NEW QUESTION: 644

A client presents to the emergency room with cyanosis, coughing, tachypnea, and tachycardia. She has a history of asthma. Arterial blood gas values are pH 7.28, PaO₂ 54, PaCO₂ 60, and HCO₃ 24. The nursing assessment of arterial blood gases indicate the presence of:

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

Answer: B (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) Respiratory alkalosis is determined by elevated pH and low PaCO₂. (B) Respiratory acidosis is determined by low pH and elevated PaCO₂. (C) Metabolic alkalosis is determined by elevated pH and HCO₃. (D) Metabolic acidosis is determined by low pH and HCO₃.

NEW QUESTION: 645

A chronic alcoholic client's condition deteriorates, and he begins to exhibit signs of hepatic coma. Which of the following is an early sign of impending hepatic coma?

- A. Hiccups
- B. Anorexia
- C. Mental confusion
- D. Feter hepaticus

Answer: C (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) Hiccups are not a sign of impending hepatic coma. (B) Anorexia is not a sign of impending hepatic coma. (C) One of the earliest symptoms of hepatic coma is mental confusion. Asterixis, a flapping tremor of the hand, may also be seen. (D) This sign is associated with the later stages of

hepatic coma. Fetor hepaticus, a characteristic odor on the breath that smells like acetone, may sometimes be noted when the liver fails.

NEW QUESTION: 646

Which of the following blood values would require further nursing action in a newborn who is 4 hours old?

- A. Hemoglobin 17.2 g/dL
- B. Platelets 250,000/mm³
- C. Serum glucose 30 mg/dL
- D. White blood cells 18,000/mm³

Answer: (SHOW ANSWER)

Explanation

(A) The normal range for hemoglobin in the newborn is 17-19 g/dL; 17.2 g/dL is within normal limits. (B) A normal value range for platelets in the newborn is 150,000-400,000 mm³; 250,000/mm³ is within normal range. (C) A serum glucose of 30 mg/dL in the first 72 hours of life is indicative of hypoglycemia and warrants further intervention. (D) On the day of birth, a white blood cell count of 18,000-40,000/mm³ is normal in the newborn.

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NEW QUESTION: 647

A client is pregnant with her second child. Her last menstrual period began on January 15. Her expected date of delivery would be:

- A. October 8
- B. October 15
- C. October 22
- D. October 29

Answer: (SHOW ANSWER)

Section: Questions Set B

Explanation:

(A) Incorrect application of Naegele's rule: correctly subtracted 3 months but subtracted 7 days rather than added. (B) Incorrect application of Naegele's rule: correctly subtracted 3 months but did not add 7 days. (C) Correct application of Naegele's rule: correctly

subtracted 3 months and added 7 days. (D) Incorrect application of Naegele's rule: correctly subtracted 3 months but added 14 days instead of 7 days.

NEW QUESTION: 648

A 4-year-old boy is brought to the emergency room with bruises on his head, face, arms, and legs. His mother states that he fell down some steps. The nurse suspects that he may have been physically abused. In accordance with the law, the nurse must:

- A. Tell the physician her concerns
- B. Report her suspicions to the authorities
- C. Talk to the child's father
- D. Confront the child's mother

Answer: B (LEAVE A REPLY)

(A) Although the nurse probably would talk to the physician about these concerns, the nurse is not required by law to do so. (B) All healthcare workers are required by the Federal Child Abuse Prevention and Treatment Act of 1974 to report suspected and actual cases of child abuse and/or neglect. (C) Talking to the child's father may or may not help the child, and the nurse is not required by law to do so. (D) Confrontation may not be indicated; the nurse is not required by law to confront the child's mother with these suspicions.

NEW QUESTION: 649

After a 10-year-old child with insulin-dependent diabetes mellitus receives her dinner tray, she tells the nurse that she hates broccoli and wants some corn on the cob. The nurse's appropriate response is:

- A. "No vegetable exchanges are allowed."
- B. "Corn and other starchy vegetables are considered to be bread exchanges."
- C. "Yes, you may exchange any vegetable for any other vegetable."
- D. "Yes, but only one-half ear is allowed."

Answer: B (LEAVE A REPLY)

(A) Sites for injection need to be rotated, including abdominal sites, to enhance insulin absorption. (B) The pinch technique is the most effective method for obtaining skin tightness to allow easy entrance of the needle to subcutaneous tissues. (C) Massaging the site of injection facilitates absorption of the insulin. (D) Changing the needle will break the sterility of the system. It has become acceptable practice to reuse disposable needles and syringes for 3-7 days.

NEW QUESTION: 650

A 6-year-old girl is visiting the outpatient clinic because she has a fever and a rash. The doctor diagnoses chickenpox. Her mother asks the nurse how many baby aspirins her daughter can have for fever. The nurse should:

- A. Advise the mother not to give her aspirin

- B.** Ask if the client is allergic to aspirin before giving further information
- C.** Assess the function of the client's cranial nerve VIII
- D.** Check the aspirin bottle label to determine milligrams per tablet

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Aspirin taken during a viral infection has been implicated as a predisposing factor to Reye's syndrome in children and adolescents. Children and adolescents should not be given aspirin. (B) Allergy to aspirin is not related to Reye's syndrome. (C) Tinnitus, caused by damage to the acoustic nerve, occurs with aspirin toxicity, but this is not related to Reye's syndrome. (D) A 6-year-old child should not be given any baby aspirin.

NEW QUESTION: 651

When a client is receiving vasoactive therapy IV, such as dopamine (Intropin), and extravasation occurs, the nurse should be prepared to administer which of the following medications directly into the site?

- A.** Phentolamine (Regitine)
- B.** Epinephrine
- C.** Phenylephrine (Neo-Synephrine)
- D.** Sodium bicarbonate

Answer: **A** ([LEAVE A REPLY](#))

Explanation

(A) Phentolamine is given to counteract the-adrenergic effects that cause ischemia and necrosis of local tissue.

(B) Epinephrine is an endogenous catecholamine that produces vasoconstriction and increases heart rate and contractility. (C) Phenylephrine causes constriction of arterioles of skin, mucous membranes, and viscera, which in turn can cause ischemia and necrosis. (D) Sodium bicarbonate is an alkalinizing agent that is incompatible with dopamine.

NEW QUESTION: 652

A 19-month-old child is admitted to the hospital for surgical repair of patent ductus arteriosus. The child is being given digoxin. Prior to administering the medication, the nurse should:

- A.** Not give the digoxin if the pulse is 60
- B.** Not give the digoxin if the pulse is 100
- C.** Take the apical pulse for a full minute
- D.** Monitor for visual disturbances, a side effect of digoxin

Answer: **C** ([LEAVE A REPLY](#))

Section: Questions Set G

Explanation:

(A) Digoxin should not be given to adults with an apical pulse < 60 bpm. (B) Digoxin should be given to children with an apical pulse > 100 bpm. With a pulse < 100 bpm, the medication should be withheld and the physician notified. (C) Prior to digoxin administration in both children and adults, an apical pulse should be taken for 1 full minute. Aside from the rate per minute, the nurse should note any sudden increase or decrease in heart rate, irregular rhythm, or regularization of a chronic irregular heart rhythm. (D) Early indications of digoxin toxicity, such as visual disturbances, occur rarely as initial signs in children.

NEW QUESTION: 653

A 9-year-old child was in the garage with his father, who was repairing a lawnmower. Some gasoline ignited and caused an explosion. His father was killed, and the child has split-thickness and full-thickness burns over 40% of his upper body, face, neck, and arms. All of the following nursing diagnoses are included on his care plan. Which of these nursing diagnoses should have top priority during the first 24-48 hours postburn?

- A. Pain related to tissue damage from burns
- B. Potential for infection related to contamination of wounds
- C. Fluid volume deficit related to increased capillary permeability
- D. Potential for impaired gas exchange related to edema of respiratory tract

Answer: D (LEAVE A REPLY)

Explanation

(A, B, C) These answers are all correct; however, maintenance of airway is the top priority. (D) Persons burned about the face and neck during an explosion are also likely to suffer burns of the respiratory tract, which can lead to edema and respiratory arrest.

NEW QUESTION: 654

Following a vaginal delivery, the postpartum nurse should observe for:

- A. Dystocia, kraurosis
- B. Chadwick's sign
- C. Fatigue, hemorrhoids
- D. Hemorrhage and infection

Answer: D (LEAVE A REPLY)

Section: Questions Set C

Explanation:

(A) Dystocia is difficult labor. The delivery has occurred. Kraurosis is atrophy and dryness of skin and any mucous membrane (vulva). (B) Chadwick's sign is a bluish color of vaginal mucosa suggestive of pregnancy.

(C) Fatigue is a common symptom in the postpartal period. Hemorrhoids may occur with pregnancy. (D) Hemorrhage and infection are potential complications of vaginal delivery.

Hemorrhage may result from retained placental fragments or soft uterus. Infection may occur from the introduction of organisms into the uterus during the delivery.

NEW QUESTION: 655

A 35-year-old client is receiving psychopharmacological treatment of his major depression with tranylcypromine sulfate (Parnate), a monoamine oxidase (MAO) inhibitor. The nurse teaches the client that while he is taking this type of antidepressant, he needs to restrict his dietary intake of:

- A. Potassium-rich foods
- B. Tryptophan
- C. Tyramine
- D. Saturated fats

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) The client may need to avoid some potassium-rich foods (such as bananas, raisins, etc.). However, this is not because of the potassium content of these foods. (B) Tryptophan is an essential amino acid that is present in high concentrations in animal and fish protein. (C) The client will need to watch his dietary intake of tyramine. Tyramine is a by-product of the conversion of tyrosine to epinephrine. Tyramine is found in a variety of foods and beverages, ranging from aged cheese to caffeine drinks. Ingestion of tyramine-rich foods while taking a MAO inhibitor may lead to an increase in blood pressure and/or a life-threatening hypertensive crisis. (D) To maintain a healthy lifestyle, restriction of dietary saturated fats is advisable.

NEW QUESTION: 656

Children often experience visual impairments. Refractive errors affect the child's visual activity. The main refractive error seen in children is myopia. The nurse explains to the child's parents that myopia may also be described as:

- A. Cataracts
- B. Farsightedness
- C. Nearsightedness
- D. Lazy eye

Answer: C (LEAVE A REPLY)

(A) Cataracts are not considered refractive errors. Cataracts can be described as opacity of the lens. (B) Hyperopia is the term for farsightedness. One can see objects at a distance more clearly than close objects. (C) Myopia is the term for nearsightedness. Objects that are close in distance are more clearly seen. (D) Lazy eye refers to strabismus or misalignment of the eyes.

NEW QUESTION: 657

In caring at home for a child who just ingested a caustic alkali, the nurse would immediately tell the mother to:

- A. Give vinegar, lemon juice, or orange juice
- B. Phone the doctor
- C. Take the child to the emergency room
- D. Induce vomiting

Answer: A ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) The immediate action is to neutralize the action of the chemical before further damage takes place. (B) This action should be done after neutralizing the chemical. (C) This action should be done after neutralizing the chemical. (D) Never induce vomiting with a strong alkali or acid. Additional damage will be done when the child vomits the chemical.

NEW QUESTION: 658

During a client's first postpartum day, the nurse assessed that the fundus was located laterally to the umbilicus.

This may be due to:

- A. Endometritis
- B. Fibroid tumor on the uterus
- C. Displacement due to bowel distention
- D. Urine retention or a distended bladder

Answer: ([SHOW ANSWER](#))

(A, B) Endometritis, urine retention, or bladder distention provide good distractors because they may delay involution but do not usually cause the uterus to be lateral. (C) Bowel distention and constipation are common in the postpartum period but do not displace the uterus laterally. (D) Urine retention or bladder distention commonly displaces the uterus to the right and may delay involution.

NEW QUESTION: 659

A 9-month-old infant visits her pediatrician for a routine visit. A developmental assessment was initiated by the nurse. Which skill would cause the nurse to be concerned about the infant's developmental progression?

- A. She sits briefly alone with assistance.
- B. She creeps and crawls.
- C. She pulls herself to her feet with help.
- D. She stands while holding onto furniture.

Answer: A ([LEAVE A REPLY](#))

Section: Questions Set D

Explanation:

(A) The 9-month-old infant can sit alone for long periods. By the age of 6 months, many infants can pull themselves to a sitting position. (B, C, D) This skill represents normal development.

NEW QUESTION: 660

A female client is exhibiting signs of respiratory distress. Which of the following signs indicate a possible pneumothorax?

- A. Crackles or rales on the affected side
- B. Bradypnea and bradycardia
- C. Shortness of breath and sharp pain on the affected side
- D. Increased breath sounds on the affected side

Answer: ([SHOW ANSWER](#))

(A) With a pneumothorax, air occupies the pleural space. Crackles or rales are heard with increased fluid or secretions and would not be present with air in the space. (B) With a pneumothorax, the client would experience tachypnea and tachycardia to compensate for the decrease in oxygenation. (C) Symptoms of pneumothorax include shortness of breath, sharp pain on the affected side with movement or coughing, asymmetrical chest expansion, and diminished or absent breath sounds on the affected side. (D) With a pneumothorax, breath sounds would be decreased on the affected side (indicates air in the pleural space).

NEW QUESTION: 661

A client is in early labor. Her fetus is in a left occipitoanterior (LOA) position; fetal heart sounds are best auscultated just:

- A. Below the umbilicus toward left side of mother's abdomen
- B. Below the umbilicus toward right side of mother's abdomen
- C. At the umbilicus
- D. Above the umbilicus to the left side of mother's abdomen

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) LOA identifies a fetus whose back is on its mother's left side, whose head is the presenting part, and whose back is toward its mother's anterior. It is easiest to auscultate fetal heart tones (FHTs) through the fetus's back. (B) The identified fetus's back is on its mother's left side, not right side. It is easiest to auscultate FHTs through the fetus's back. (C) In an LOA position, the fetus's head is presenting with the back to the left anterior side of the mother. The umbilicus is too high of a landmark for auscultating the fetus's heart rate through its back. (D) This is the correct auscultation point for a fetus in the left sacroanterior position, where the sacrum is presenting, not LOA.

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NEW QUESTION: 662

In an interview for suspected child abuse, the child's mother openly discusses her feelings. She feels her husband is too aggressive in disciplining their child. The child's father states, "Being a school custodian, I see kids every day that are bad because they did not get enough discipline at home. That will not happen to our child." Based on this remark, the nurse would make the following nursing diagnosis:

- A.** Fear related to retaliation by the father
- B.** Actual injury related to poor impulse control by the father
- C.** Ineffective coping
- D.** Altered family process related to physical abuse

Answer: (SHOW ANSWER)

Explanation

(A) There is no evidence of fear as the child is unable to communicate. (B) There is actual injury, but the parents have not yet admitted causing the child's injuries. (C) This diagnosis is incomplete. There is no specific ineffective coping behavior identified in this nursing diagnosis. (D) Altered family process best describes the family dynamics in this situation. The parents have admitted severe disciplinary action.

NEW QUESTION: 663

A female client at 36 weeks' gestation is experiencing preterm labor. Her physician has prescribed two doses of betamethasone 12 mg IM q24h. The nurse explains that she is receiving this drug to:

- A.** Treat fetal respiratory distress syndrome
- B.** Prevent uterine infection
- C.** Promote fetal lung maturation
- D.** Increase uteroplacental circulation

Answer: C (LEAVE A REPLY)

(A) Respiratory distress syndrome occurs in the newborn, not the fetus. It may be treated postnatally with surfactant therapy. (B) Betamethasone is a corticosteroid, not an anti-infective drug; therefore, its use would not prevent uterine infection. (C) Betamethasone binds with glucocorticoid receptors in alveolar cells to increase production of surfactant, thus increasing lung maturity in the preterm fetus. (D) Betamethasone does not affect uteroplacental circulatory exchange.

NEW QUESTION: 664

The day following his admission, the nurse sits down by a male client on the sofa in the dayroom. He was admitted for depression and thoughts of suicide. He looks at the nurse and says, "My life is so bad no one can do anything to help me." The most helpful initial response by the nurse would be:

- A. "It concerns me that you feel so badly when you have so many positive things in your life."
- B. "It will take a few weeks for you to feel better, so you need to be patient."
- C. "You are telling me that you are feeling hopeless at this point?"
- D. "Let's play cards with some of the other clients to get your mind off your problems for now."

Answer: [\(SHOW ANSWER\)](#)

(A) This response does not acknowledge the client's feelings and may increase his feelings of guilt. (B) This response denotes false reassurance. (C) This response acknowledges the client's feelings and invites a response. (D) This response changes the subject and does not allow the client to talk about his feelings.

NEW QUESTION: 665

A six-month-old infant is receiving ribavirin for the treatment of respiratory syncytial virus. Ribavirin is administered via which one of the following routes?

- A. Oral
- B. IM
- C. IV
- D. Aerosol

Answer: [D \(LEAVE A REPLY\)](#)

Section: Questions Set B

Explanation:

(A) Ribavirin is not supplied in an oral form. (B) Ribavirin is administered by aerosol in order to decrease the duration of viral shedding within the infected tissue. (C) Ribavirin is not approved for IV use to treat respiratory syncytial virus. (D) Ribavirin is a synthetic antiviral agent supplied as a crystalline powder that is reconstituted with sterile water. A Small Aerosol Particle Generator unit aerosolizes the medication for delivery by oxygen hood, croup tent, or aerosol mask.

NEW QUESTION: 666

Iron dextran (Imferon) is a parenteral iron preparation.

The nurse should know that it:

- A. Is also called intrinsic factor
- B. Must be given in the abdomen
- C. Requires use of the Z-track method

D. Should be given SC

Answer: C (LEAVE A REPLY)

(A) Intrinsic factor is needed to absorb vitamin B12. (B) Iron dextran is given parenterally, but Z-track in a large muscle. (C) A Z-track method of injection is required to prevent staining and irritation of the tissue. (D) An SC injection is not deep enough and may cause subcutaneous fat abscess formation.

NEW QUESTION: 667

A neonate was admitted to the hospital with projectile vomiting. According to the parents, the baby had experienced vomiting episodes after feeding for the last 2 days. A medical diagnosis of hypertrophic pyloric stenosis was made. On assessment, the infant had poor skin turgor, sunken eyeballs, dry skin, and weight loss. Identify the number-one priority nursing diagnosis.

A. Fluid volume deficit

B. Altered nutrition

C. Altered bowel elimination

D. Anxiety

Answer: A (LEAVE A REPLY)

(A) Fluid volume deficit is the major problem. Symptoms of dehydration are evident. The effects of fluid and electrolyte balance may be life threatening. Rehydration can be accomplished effectively through IV fluids and electrolytes. (B) Vomiting may also signal a nutritional problem. However, the nutritional problem would be secondary to fluid and electrolyte disturbances. The infant may also be placed on NPO status. (C) With vomiting, a decrease in the size and number of stools is expected. (D) The infant cannot verbalize feelings of anxiety. Anxiety would not be an appropriate diagnosis.

NEW QUESTION: 668

Painless vaginal bleeding in the last trimester may be caused by:

A. Menstruation

B. Abruptio placentae

C. Placenta previa

D. Polyhydramnios

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Menstruation should not occur during pregnancy. (B) Abruptio placentae is marked by painful vaginal bleeding following a premature placental detachment after 20th week of gestation. (C) A low-lying placenta separates from the uterine wall as the uterus contracts and cervix dilates. This separation causes painless bleeding in the 7th-8th month. (D) Polyhydramnios is excessive amniotic fluid.

NEW QUESTION: 669

A 23-year-old female client is brought to the emergency room by her roommate for repeatedly making superficial cuts on her wrists and experiencing wide mood swings. She is very angry and hostile. Her medical diagnosis is adjustment disorder versus borderline personality disorder. The client comments to the nurse, "Nobody in here seems to really care about the clients. I thought nurses cared about people!" The client is exhibiting the ego defense mechanism:

- A. Reaction formation
- B. Rationalization
- C. Splitting
- D. Sublimation

Answer: C ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) Reaction formation is the development and demonstration of attitudes and/or behaviors opposite to what an individual actually feels. The client's comment does reveal her anger and hostility. (B) Rationalization, another ego defense mechanism, is offering a socially acceptable or seemingly logical explanation to justify one's feelings, behaviors, or motives. The client's comment does not reflect rationalization. (C) Splitting, the viewing of people or situations as either all good or all bad, is frequently used by persons experiencing a disruption in self-concept. This ego defense mechanism is reflective of the individual's inability to integrate the positive and negative aspects of self. (D) Sublimation, the channeling of socially unacceptable impulses and behaviors into more acceptable patterns of behavior, is another ego defense mechanism. The client's comment reveals that she is not engaging in sublimation.

NEW QUESTION: 670

A client was admitted with rib fractures and a pneumothorax, which were sustained as a result of a motor vehicle accident. A chest tube was placed on the left side to reinflate his lung, and he was transferred to a client unit. Twenty-four hours after admission he continues to have bloody sputum, develops increasing hypoxemia, and his chest x-ray shows patchy infiltrates. The nurse analyzes these symptoms as being consistent with:

- A. Pneumonia
- B. Pulmonary contusions
- C. Pulmonary edema
- D. Tension pneumothorax

Answer: B ([LEAVE A REPLY](#))

Section: Questions Set C

Explanation:

(A) Pneumonia may be reflected by patchy infiltrates. In addition, fever, an increasing white blood cell count, and copious sputum production would be present. (B) Blunt chest

trauma causes a bruising process in which interstitial and alveolar edema and hemorrhage occur. This is manifest by gradual deterioration over 24 hours of arterial blood gases and the continued production of bloody sputum. Patchy infiltrates are evident on chest xray 24 hours postinjury. (C) Pulmonary edema usually results from left heart failure. It is manifest by pink, frothy sputum; increasing dyspnea; tachycardia; and crackles on auscultation. (D) Tension pneumothorax is a potential complication for someone with rib fractures and a chest tube. It is manifest by diminished breath sounds on the affected side, rapidly deteriorating arterial blood gases in the presence of an open airway, and shock that is unexplained by other injuries.

NEW QUESTION: 671

The nurse assesses a client on the second postpartum day and finds a dark red discharge on the peripad. The stain appears to be about 5 inches long. Which of the following correctly describes the character and amount of lochia?

- A.** Lochia alba, light
- B.** Lochia serosa, heavy
- C.** Lochia granulosa, heavy
- D.** Lochia rubra, moderate

Answer: D (LEAVE A REPLY)

Section: Questions Set D

Explanation/Reference:

Explanation:

(A) Lochia alba occurs approximately 10 days after birth and is yellow to white. A discharge is classified as light when less than a 4-inch stain exists. (B) Lochia serosa is pink to brown and occurs 3-4 days after delivery. A stain is classified as heavy when a peripad is saturated in 1 hour. (C) Lochia granulosa is not a proper classification. (D) Lochia rubra is red, consisting mainly of blood, debris, and bacteria, and lasts from the time of delivery to 3-4 days afterward. A stain is classified as moderate when less than a 6-inch stain exists.

NEW QUESTION: 672

Which behavior by a female client feeding her newborn demonstrates that she needs more teaching related to safety and infant feeding?

- A.** She uses the bulb syringe to help clear her baby's nose when milk is regurgitated.
- B.** She places her infant on her right side after feeding her.
- C.** She props the bottle in the crib to feed her baby, which allows her to write birth announcements and feed her baby at the same time.
- D.** She burps her baby by placing her in a sitting position, supporting her head and neck and gently massaging her back.

Answer: C (LEAVE A REPLY)

Explanation

(A) This practice is the proper use of the bulb syringe to clear the infant's airway in case of regurgitation. (B) Placing the infant on either side or on the stomach prevents aspiration of regurgitated milk. (C) "Bottle propping" is an unsafe practice because it increases the likelihood of aspiration. (D) This practice is one correct way of burping an infant.

NEW QUESTION: 673

Following the delivery of a healthy newborn, a client has developed thrombophlebitis and is receiving heparin IV. What are the signs and symptoms of a heparin overdose for which the nurse would need to observe during postpartum care of the client?

- A. Dysuria
- B. Epistaxis, hematuria, dysuria
- C. Vertigo, hematuria, ecchymosis
- D. Hematuria, ecchymosis, and epistaxis

Answer: D (LEAVE A REPLY)

(A) Dysuria is not a common symptom of heparin overdose. (B) Although epistaxis and hematuria are common symptoms of heparin overdose, dysuria is not. (C) Vertigo is not a common symptom of heparin overdose. (D) Hematuria, ecchymosis, and epistaxis are the most common signs and symptoms of a heparin overdose. Others are thrombocytopenia, elevated liver enzymes, and local injection site complications.

NEW QUESTION: 674

A client undergoes a transurethral resection, prostate (TURP). He returns from surgery with a three-way continuous Foley irrigation of normal saline in progress. The purpose of this bladder irrigation is to prevent:

- A. Bladder spasms
- B. Clot formation
- C. Scrotal edema
- D. Prostatic infection

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The purpose of bladder irrigation is not to prevent bladder spasms, but to drain the bladder and decrease clot formation and obstruction. (B) A three-way system of bladder irrigation will cleanse the bladder and prevent formation of blood clots. A catheter obstructed by clots or other debris will cause prostatic distention and hemorrhage. (C) Scrotal edema seldom occurs after TURP. Bladder irrigation will not prevent this complication. (D) Prostatic infection seldom occurs after TURP. Bladder irrigation will not prevent this complication.

NEW QUESTION: 675

After 3 weeks of treatment, a severely depressed client suddenly begins to feel better and starts interacting appropriately with other clients and staff. The nurse knows that this client has an increased risk for:

- A. Suicide
- B. Exacerbation of depressive symptoms
- C. Violence toward others
- D. Psychotic behavior

Answer: A (LEAVE A REPLY)

(A) When the severely depressed client suddenly begins to feel better, it often indicates that the client has made the decision to kill himself or herself and has developed a plan to do so. (B) Improvement in behavior is not indicative of an exacerbation of depressive symptoms. (C) The depressed client has a tendency for self-violence, not violence toward others. (D) Depressive behavior is not always accompanied by psychotic behavior.

NEW QUESTION: 676

A 25-year-old client is admitted for a tonsillectomy. She tells the nurse that she has had episodes of muscle cramps, weakness, and unexplained temperature elevation. Many years ago her father died shortly after surgery after developing a high fever. She further tells the nurse that her surgeon is having her take dantrolene sodium (Dantrium) prophylactically prior to her tonsillectomy. Dantrolene sodium is ordered preoperatively to reduce the risk or prevent:

- A. Infection postoperatively
- B. Malignant hyperthermia
- C. Neuroleptic malignant syndrome
- D. Fever postoperatively

Answer: B (LEAVE A REPLY)

(A, D) Dantrolene sodium is a peripheral skeletal muscle relaxant and would have no effect on a postoperative infection. (B) Dantrolene sodium is indicated prophylactically for clients with malignant hyperthermia or with a family history of the disorder. The mortality rate for malignant hyperthermia is high. (C) Neuroleptic malignant syndrome is an exercise-induced muscle pain and spasm and is unrelated to malignant hyperthermia.

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NEW QUESTION: 677

The nurse is caring for a client who has diabetes insipidus. The nurse would describe this client's urine output pattern as:

- A. Anuria
- B. Oliguria
- C. Dysuria
- D. Polyuria

Answer: D ([LEAVE A REPLY](#))

Explanation

(A)Anuria is defined as absence of urine output, which is not indicative of the urinary pattern of diabetes insipidus. (B)Oliguria is defined as <500 mL of urine per day, which is not a urinary output pattern associated with diabetes insipidus. (C)Dysuria is defined as difficult urination. Clients with diabetes insipidus do not have dysuria as a symptom of their disease. (D) Polyuria is a primary symptom of diabetes insipidus. These clients have decreased or absent vasopressin secretion, which causes water loss in the urine and sodium increases.

NEW QUESTION: 678

Which of the following statements relevant to a suicidal client is correct?

- A. The more specific a client's plan, the more likely he or she is to attempt suicide.
- B. A client who is unsuccessful at a first suicide attempt is not likely to make future attempts.
- C. A client who threatens suicide is just seeking attention and is not likely to attempt suicide.
- D. Nurses who care for a client who has attempted suicide should not make any reference to the word "suicide" in order to protect the client's ego.

Answer: A ([LEAVE A REPLY](#))

(A)

This is a high-risk factor for potential suicide. (B) A previous suicide attempt is a definite risk factor for subsequent attempts. (C) Every threat of suicide should be taken seriously.

(D)

The client should be asked directly about his or her intent to do bodily harm. The client is never hurt by direct, respectful questions.

NEW QUESTION: 679

The nurse is caring for a client who has had a tracheostomy for 7 years. The client is started on a fullstrength tube feeding at 75 mL/hr. Prior to starting the tube feeding, the nurse confirms placement of the tube in the stomach. The hospital policy states that all tube feeding must be dyed blue. On suctioning, the nurse notices the sputum to be a blue color. This is indicative of which of the following?

- A. The client aspirated tube feeding.
- B. The nurse has placed the suction catheter in the esophagus.
- C. This is a normal finding.
- D. The feeding is infusing into the trachea.

Answer: A ([LEAVE A REPLY](#))

(A)

Once the feeding tube placement is confirmed in the stomach, aspiration can occur if the client's stomach becomes too full. When suctioning the trachea, if secretions resemble tube feeding, the client has aspirated the feeding. (B) Because the trachea provides direct access to a client's airway, it would not be possible to place the catheter in the esophagus.

(C)

Blue-colored sputum is never considered a normal finding and should be reported and documented. (D) The nurse confirmed placement of the feeding tube in the stomach prior to initiating the tube feeding; therefore, it is highly unlikely that the feeding tube would be located in the trachea.

NEW QUESTION: 680

A 24-year-old graduate student recognizes that he has a phobia. He suffers severe anxiety when he is in darkness. It has altered his lifestyle because he is unable to go to a movie theater, concert, and other events that may require absence of light. The client is seeking assistance because he is no longer able to socialize with friends due to his phobia. The psychologist working with him is using desensitization. He has asked the nursing staff to assist the client in muscle relaxation techniques. What result would indicate client education has been successful?

- A. He enters a movie theater, sits in his chair, and replaces anxiety with relaxation as the theater darkens.
- B. He enters a concert, but as the lights dim, he does not experience anxiety.
- C. He states that he no longer fears dark places.
- D. He takes a part-time job as a photographic assistant. His job necessitates his working in a darkroom.

Answer: (SHOW ANSWER)

Explanation

(A) This situation provides specific evidence that the client is able to integrate muscle relaxation technique into his lifestyle to alleviate anxiety. (B) The client may not experience anxiety at the concert, but there is no evidence regarding the technique that he used to alleviate anxiety. (C) The client may state he no longer experiences anxiety, but there is no evidence demonstrating this. He may be denying anxiety to discontinue therapy prematurely. (D) Does he experience anxiety in the darkroom? He may have taken this job to force himself to deal with the phobia directly.

NEW QUESTION: 681

A client presents to the psychiatric unit crying hysterically. She is diagnosed with severe anxiety disorder. The first nursing action is to:

- A. Demand that she relax
- B. Ask what is the problem
- C. Stand or sit next to her
- D. Give her something to do

Answer: (SHOW ANSWER)

Explanation

(A) This nursing action is too controlling and authoritative. It could increase the client's anxiety level. (B) In her anxiety state, the client cannot rationally identify a problem. (C) This nursing action conveys a message of caring and security. (D) Giving the client a task would increase her anxiety. This would be a late nursing action.

NEW QUESTION: 682

A 9-year-old child was in the garage with his father, who was repairing a lawnmower. Some gasoline ignited and caused an explosion. His father was killed, and the child has split-thickness and full-thickness burns over 40% of his upper body, face, neck, and arms. All of the following nursing diagnoses are included on his care plan. Which of these nursing diagnoses should have top priority during the first 24-48 hours postburn?

- A. Pain related to tissue damage from burns
- B. Potential for infection related to contamination of wounds
- C. Fluid volume deficit related to increased capillary permeability
- D. Potential for impaired gas exchange related to edema of respiratory tract

Answer: D (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A, B, C) These answers are all correct; however, maintenance of airway is the top priority. (D) Persons burned about the face and neck during an explosion are also likely to suffer burns of the respiratory tract, which can lead to edema and respiratory arrest.

NEW QUESTION: 683

When administering phenytoin (Dilantin) to a child, the nurse should be aware that a toxic effect of phenytoin therapy is:

- A. Stephens-Johnson syndrome
- B. Folate deficiency
- C. Leukopenic aplastic anemia
- D. Granulocytosis and nephrosis

Answer: A (LEAVE A REPLY)

Explanation

(A) Stevens-Johnson syndrome is a toxic effect of phenytoin. (B) Folate deficiency is a side effect of phenytoin, but not a toxic effect. (C) Leukopenic aplastic anemia is a toxic effect of carbamazepine (Tegretol).
(D) Granulocytosis and nephrosis are toxic effects of trimethadione (Tridione).

NEW QUESTION: 684

A 35-year-old client is admitted to the hospital with diabetic ketoacidosis. Results of arterial blood gases are pH 7.2, PaO₂ 90, PaCO₂ 45, and HCO₃ 16. The nursing assessment of arterial blood gases indicate the presence of:

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

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Respiratory alkalosis is determined by elevated pH and low PaCO₂. (B) Respiratory acidosis is determined by low pH and elevated PaCO₂. (C) Metabolic alkalosis is determined by elevated pH and HCO₃. (D) Metabolic acidosis is determined by low pH and HCO₃.

NEW QUESTION: 685

A client returns to the cardiovascular intensive care unit following his coronary artery bypass graft. In planning his care, the most important electrolyte the nurse needs to monitor will be:

- A. Chloride
- B. HCO₃
- C. Potassium
- D. Sodium

Answer: C (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(A) Chloride, HCO₃, and sodium will need to be monitored, but monitoring these electrolytes is not as important as potassium monitoring. (B) Chloride, HCO₃, and sodium will need to be monitored, but monitoring these electrolytes is not as important as potassium monitoring. (C) Potassium will need to be closely monitored because of its effects on the heart. Hypokalemia could result in supraventricular tachyarrhythmias. (D) Chloride, HCO₃, and sodium will need to be monitored, but monitoring these electrolytes is not as important as potassium monitoring.

NEW QUESTION: 686

A female client has just died. Her family is requesting that all nursing staff leave the room. The family's religious leader has arrived and is ready to conduct a ceremony for the deceased in the room, requesting that only family members be present. The nurse assigned to the client should perform the appropriate nursing action, which might include:

- A.** Inform the family that it is the hospital's policy not to conduct religious ceremonies in client rooms.
- B.** Refuse to leave the room because the client's body is entrusted in the nurse's care until it can be brought to the morgue.
- C.** Tell the family that they may conduct their ceremony in the client's room; however, the nurse must attend.
- D.** Respect the client's family's wishes.

Answer: D ([LEAVE A REPLY](#))

Explanation

(A) It is rare that a hospital has a specific policy addressing this particular issue. If the statement is true, the nurse should show evidence of the policy to the family and suggest alternatives, such as the hospital chapel.

(B) Refusal to leave the room demonstrates a lack of understanding related to the family's need to grieve in their own manner. (C) The nurse should leave the room and allow the family privacy in their grief. (D) The family's wish to conduct a religious ceremony in the client's room is part of the grief process. The request is based on specific cultural and religious differences dictating social customs.

NEW QUESTION: 687

A 26-year-old client has no children. She has had an abdominal hysterectomy. In the first 24 hours postoperatively, the nurse would be concerned if the client:

- A.** Cries easily and says she is having abdominal pain
- B.** Develops a temperature of 102_F
- C.** Has no bowel sounds
- D.** Has a urine output of 200 mL for 4 hours

Answer: B ([LEAVE A REPLY](#))

Explanation/Reference:

Explanation:

(A) The client may be more tearful than normal due to the stress of the surgery and its implications for her future life. She would be expected to have pain following surgery. (B) A temperature of 102_F indicates an infectious process. This is not a normal sequence to surgery and indicates a need for further assessment.

(C) The client is expected to have no bowel sounds for 24-48 hours after surgery because of the trauma to the bowel. (D) Normal urine output is 30 mL/hr. This represents an output of 50 mL/hr, which is greater than normal.

NEW QUESTION: 688

A 23-year-old borderline client is admitted to an inpatient psychiatric unit following an impulsive act of self-mutilation. A few hours after admission, she requests special privileges, and when these are not granted, she stands up and angrily shouts that the people on the unit do not care, and she storms across the room. The nurse should respond to this behavior by:

- A.** Placing her in seclusion until the behavior is under control
- B.** Walking up to the client and touching her on the arm to get her attention
- C.** Communicating a desire to assist the client to regain control, offering a one-to-one session in a quiet area
- D.** Confronting the client, letting her know the consequences for getting angry and disrupting the unit

Answer: C (LEAVE A REPLY)

Explanation

(A) Threatening a client with punitive action is violating a client's rights and could escalate the client's anger.

(B) Angry clients need respect for personal space, and physical contact may be perceived as a threatening gesture escalating anger. (C) Client lacks sufficient self-control to limit own maladaptive behavior; she may need assistance from staff. (D) Confronting an angry client may escalate her anger to further acting out, and consequences are for acting out anger aggressively, not for getting angry or feeling angry.

NEW QUESTION: 689

A 20-year-old female client delivers a stillborn infant. Following the delivery, an appropriate response by the labor nurse to the question, "Why did this happen to my baby?" is:

- A.** "It's God's will. It was probably for the best. There was something probably wrong with your baby."
- B.** "You're young. You can have other children later."
- C.** "I know your other children will be a great comfort to you."
- D.** "I can see you're upset. Would you like to see and hold your baby?"

Answer: D (LEAVE A REPLY)

Explanation

(A) The mother and the father require support; the nurse should not minimize their grief in this situation. (B) Attachment to this infant occurs during the pregnancy for both the mother and father. Another child cannot replace this child. (C) Attachment to this infant occurs during the pregnancy for both the mother and father.

Siblings will not replace their feelings or minimize their loss of this infant. (D) Holding and viewing the infant decreases denial and may facilitate the grief process. The nurse should prepare family members for how the infant appears ("she is bruised") and provide support.

NEW QUESTION: 690

A 72-year-old client with a new colostomy is being evaluated at the clinic today for constipation. When discussing diet with the client, the nurse recognizes that which one of the following foods most likely caused this problem?

- A. Fried chicken
- B. Eggs
- C. Tapioca
- D. Cabbage

Answer: ([SHOW ANSWER](#))

(A) Fried, greasy food, such as fried chicken, will produce diarrhealike stools in individuals with all types of GI ostomies. (B) Eggs will cause odor-producing stools in individuals with all types of GI ostomies. (C) Tapioca and rice products will cause constipation in individuals with all types of GI ostomies. (D) Cabbage will cause odor-producing and flatus-producing stools in individuals with all types of GI ostomies.

NEW QUESTION: 691

A client takes warfarin (Coumadin) 15 mg po daily. To evaluate the medication's effectiveness, the nurse should monitor the:

- A. prothrombin time (PT)
- B. partial thromboplastin time (PTT)
- C. PTT-C
- D. Fibrin split products

Answer: A ([LEAVE A REPLY](#))

(A) PT evaluates adequacy of extrinsic clotting pathway. Adequacy of warfarin therapy is monitored by PT. (B) PTT evaluates adequacy of intrinsic clotting pathway. Adequacy of heparin therapy is monitored by PTT. (C) There is no such laboratory test. (D) Fibrin split products indicate fibrinolysis. This is a screening test for disseminated intravascular coagulation. Heparin therapy may increase fibrin split products.

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NEW QUESTION: 692

A 66-year-old female client has smoked 2 packs of cigarettes per day for 20 years. Her arterial blood gases on room air are as follows: pH 7.35; PO₂ 70 mm Hg; PCO₂ 55 mm Hg; HCO₃ 32 mEq/L. These blood gases reflect:

- A. Compensated metabolic acidosis
- B. Compensated respiratory acidosis
- C. Compensated respiratory alkalosis
- D. Uncompensated respiratory acidosis

Answer: B ([LEAVE A REPLY](#))

(A) In compensated metabolic acidosis, the pH level is normal, the PCO₂ level is decreased, and the HCO₃ level is decreased. The client's primary alteration is an inability to remove excess acid via the kidneys. The lungs compensate by hyperventilating and decreasing PCO₂. (B) In compensated respiratory acidosis, the pH level is normal, the PCO₂ level is elevated, and the HCO₃ level is elevated. The client's primary alteration is an inability to remove CO₂ from the lungs, so over time, the kidneys increase reabsorption of HCO₃ to buffer the CO₂. (C) In compensated respiratory alkalosis, the pH level is normal, the PCO₂ level is decreased, and the HCO₃ level is decreased. The client's primary alteration is hyperventilation, which decreases PCO₂. The client compensates by increasing the excretion of HCO₃ from the body. (D) In uncompensated respiratory acidosis, the pH level is decreased, the PCO₂ level is increased, and the HCO₃ level is normal. The client's primary alteration is an inability to remove CO₂ from the lungs. The kidneys have not compensated by increasing HCO₃ reabsorption.

NEW QUESTION: 693

The nurse recognizes that a client with the diagnosis of cholecystitis and cholelithiasis would expect to have stools that are:

- A. Clay or gray colored
- B. Watery and loose
- C. Bright-red streaked
- D. Black

Answer: (SHOW ANSWER)

(A) Clients who have obstruction in the biliary tract so that bile is not released into the duodenum experience a change in stools from brown to gray or clay colored. (B) This type of stool can occur with other GI problems, such as bacterial or viral infections, and other disease problems, and is not a common finding with biliary obstructions such as cholecystitis and cholelithiasis. (C) This type of stool is usually associated with a GI or bowel problem, such as lower GI bleeding, rather than with biliary obstructions. (D) This type of stool is usually associated with a GI or bowel problem, such as upper GI bleeding, rather than with biliary obstructions.

NEW QUESTION: 694

Proper positioning for the child who is in Bryant's traction is:

- A. Both hips flexed at a 90-degree angle with the knees extended and the buttocks elevated off the bed
- B. Both legs extended, and the hips are not flexed

C. The affected leg extended with slight hip flexion

D. Both hips and knees maintained at a 90-degree flexion angle, and the back flat on the bed

Answer: A ([LEAVE A REPLY](#))

Explanation

(A) The child's weight supplies the countertraction for Bryant's traction; the buttocks are slightly elevated off the bed, and the hips are flexed at a 90-degree angle. Both legs are suspended by skin traction. (B) The child in Buck's extension traction maintains the legs extended and parallel to the bed. (C) The child in Russell traction maintains hip flexion of the affected leg at the prescribed angle with the leg extended. (D) The child in "90-90" traction maintains both hips and knees at a 90-degree flexion angle and the back is flat on the bed.

NEW QUESTION: 695

A 50-year-old depressed client has recently lost his job. He has been reluctant to leave his hospital room. Nursing care would include:

A. Forcing the client to attend all unit activities

B. Encouraging the client to discuss why he is so sad

C. Monitoring elimination patterns

D. Providing sensory stimulation

Answer: (SHOW ANSWER)

(A) The client should be encouraged to attend the unit activities. The nurse and client should choose a few activities for the client to attend that will be positive experiences for him. (B) The nurse should encourage the client to discuss his feelings and to begin to deal with the depression. (C) Depressed persons often have little appetite and poor fluid intake. Constipation is common. (D) A calm, consistent level of stimuli is most effective. Sensory deprivation and overstimulation should be avoided.

NEW QUESTION: 696

Before completing a nursing diagnosis, the nurse must first:

A. Write goals and objectives

B. Perform an assessment

C. Plan interventions

D. Perform evaluation

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Goals and objectives are based on a nursing assessment and diagnosis. (B) Assessment is the first step of nursing process. (C) Interventions are nursing actions to meet goals and objectives. (D) Evaluation process follows nursing interventions.

NEW QUESTION: 697

A client is having episodes of hyperventilation related to her surgery that is scheduled tomorrow. Appropriate nursing actions to help control hyperventilating include:

- A.** Administering diazepam (Valium) 10-15 mg po q4h and q1h prn for hyperventilating episode
- B.** Keeping the temperature in the client's room at a high level to reduce respiratory stimulation
- C.** Having the client hold her breath or breathe into a paper bag when hyperventilation episodes occur
- D.** Using distraction to help control the client's hyperventilation episodes

Answer: C (LEAVE A REPLY)

(A) An adult diazepam dosage for treatment of anxiety is 2-10 mg PO 2-4 times daily. The order as written would place a client at risk for overdose. (B) A high room temperature could increase hyperventilating episodes by stimulating the respiratory system. (C) Breath holding and breathing into a paper bag may be useful in controlling hyperventilation. Both measures increase CO₂ retention. (D) Distraction will not prevent or control hyperventilation caused by anxiety or fear.

NEW QUESTION: 698

A 26-year-old male client is brought by his wife to the emergency department (ED) unconscious. Blood is drawn for a stat blood count (CBC), fasting blood sugar level, and electrolytes. An indwelling urinary catheter is inserted. He has a history of type 1 diabetes (insulindependent diabetes mellitus [IDDM]). A diagnosis of ketoacidosis is made. Stat lab values reveal a blood sugar level of 520 mg/dL. Which of the following should the nurse expect to administer in the ER?

- A.** D50W by IV push
- B.** NPH insulin SC
- C.** Regular insulin by IV infusion
- D.** Sweetened grape juice by mouth

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This action would further increase the client's blood sugar. (B) NPH insulin is an intermediate-acting insulin, with an average of 4-6 hours before onset of action. The client needs insulin that will act immediately. During a ketoacidotic state, the client is dehydrated, so any insulin administered SC will be poorly absorbed. (C) Regular insulin is the fastest acting-insulin; when given IV, it will immediately act to decrease blood sugar. Regular insulin is given to decrease blood glucose levels by promoting metabolism of glucose, inhibiting lipolysis and formation of ketone bodies. (D) This action would further increase the client's blood sugar.

NEW QUESTION: 699

A client was prescribed a major tranquilizer 2 months ago. One month ago she was placed on benztropine (Cogentin). What would indicate that benztropine therapy is effective?

- A. Smooth, coordinated voluntary movement
- B. Tremors
- C. Rigidity
- D. Muscle weakness

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Benztropine is prescribed to decrease or alleviate extrapyramidal side effects of major tranquilizers.

Smooth, coordinated voluntary movement indicates minimal extrapyramidal side effects.

(B) Tremors are an extrapyramidal side effect. (C) Rigidity is an extrapyramidal side effect.

(D) Muscle weakness is an extrapyramidal side effect.

NEW QUESTION: 700

Two hours after the second injection of haloperidol, a client complains to the nurse of a stiff neck and inability to sit still. He is experiencing symptoms consistent with:

- A. Parkinsonism and dystonia
- B. Dystonia and akathisia
- C. Akathisia and parkinsonism
- D. Neuroleptic malignant syndrome

Answer: B (LEAVE A REPLY)

(A) Stiff neck is consistent with a dystonic reaction, but the client has no symptoms of drooling, shuffling gait, or pill-rolling movements characteristic of parkinsonism. (B) Stiff neck is consistent with a dystonic reaction, and inability to sit still with varying degrees of psychomotor agitation is characteristic of akathisia. (C) The client has symptoms of dystonia but not of parkinsonism. (D) The client has none of the characteristic symptoms of neuroleptic malignant syndrome: hyperpyrexia, generalized muscle rigidity, mutism, obtundation, agitation, sweating, increased blood pressure and pulse.

NEW QUESTION: 701

The nurse is caring for a client who has diabetes insipidus. The nurse would describe this client's urine output pattern as:

- A. Anuria
- B. Oliguria
- C. Dysuria
- D. Polyuria

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

Explanation

(A) Anuria is defined as absence of urine output, which is not indicative of the urinary pattern of diabetes insipidus. (B) Oliguria is defined as <500 mL of urine per day, which is not a urinary output pattern associated with diabetes insipidus. (C) Dysuria is defined as difficult urination. Clients with diabetes insipidus do not have dysuria as a symptom of their disease. (D) Polyuria is a primary symptom of diabetes insipidus. These clients have decreased or absent vasopressin secretion, which causes water loss in the urine and sodium increases.

NEW QUESTION: 702

The physician orders haloperidol 5 mg IM stat for a client and tells the nurse that the dose can be repeated in

1-2 hours if needed. The most likely rationale for this order is:

- A. The client will settle down more quickly if he thinks the staff is medicating him
- B. The medication will sedate the client until the physician arrives
- C. Haloperidol is a minor tranquilizer and will not oversedate the client
- D. Rapid neuroleptization is the most effective approach to care for the violent or potentially violent client

Answer: D (LEAVE A REPLY)

Explanation

(A) If the client could think logically, he would not be paranoid. In fact, he is probably suspicious of the staff, too. Newly admitted clients frequently experience high levels of anxiety, which can contribute to delusions.

(B) The goal of pharmacological intervention is to calm the client and assist with reality-based thinking, not to sedate him. (C) Haloperidol is a neuroleptic and antipsychotic drug, not a minor tranquilizer. (D) Haloperidol is a high-potency neuroleptic and first-line choice for rapid neuroleptization, with low potential for sedation.

NEW QUESTION: 703

A physician's order reads: 0.25 normal saline at 50 mL/hr until discontinued. The nurse is using a microdrip tubing set. How many drops per minute should the nurse administer?

- A. 1 gtt/min
- B. 5 gtt/min
- C. 50 gtt/min
- D. 100 gtt/min

Answer: C (LEAVE A REPLY)

Explanation

(A) This answer is a miscalculation. (B) This answer is a miscalculation. (C) 50 gtt/min. (D) This answer is a miscalculation.

NEW QUESTION: 704

For the past several months, an elderly female client with Alzheimer's disease has experienced paranoia; hallucinations; and aggressive, disruptive behavior. The family is utilizing haloperidol as needed to control her behavior. On nursing assessment, you note that the client demonstrates involuntary movements of the tongue and fingers. This may most likely indicate:

- A.** Tardive dyskinesia, which may be a side effect of antipsychotic medication
- B.** Early symptoms of Parkinson's disease
- C.** A more advanced stage of Alzheimer's disease than previously experienced by the client
- D.** The need to change her medication from haloperidol to another antipsychotic drug to lessen symptoms

Answer: [\(SHOW ANSWER\)](#)

Explanation

(A) Tardive dyskinesia is a common side effect of antipsychotic medications such as haloperidol.

Discontinuing the medication can alleviate symptoms. (B) Although mild tremors are an early sign of Parkinson's disease, haloperidol must be discontinued first and the client further evaluated. (C) These symptoms do not necessarily indicate a more advanced stage of Alzheimer's disease. (D) Most antipsychotic drugs are chemically similar and will produce the same side effects.

NEW QUESTION: 705

One afternoon 3 weeks into his alcohol treatment program, a client says to the nurse, "It's really not all my fault that I have a drinking problem. Alcoholism runs in my family. Both my grandfather and father were heavy drinkers." The nurse's best response would be:

- A.** "That might be a problem. Tell me more about them."
- B.** "Risk factors can often be controlled by self-responsibility."
- C.** "It sounds like you're intellectualizing your drinking problem."
- D.** "Your grandfather and father were both alcoholics?"

Answer: **B** [\(LEAVE A REPLY\)](#)

Section: Questions Set G

Explanation:

(A) Focusing is an effective therapeutic strategy. This response, however, allows the client to "defocus" off the topic of learning how to accept responsibility for his behavior and future growth. (B) The nurse can educate the client about both the "genetic risk" for the development of alcoholism and ways to make long-term healthy lifestyle changes. (C) This response is inappropriately confrontational and condescending to the client. (D) Reflection of content can be an effective verbal therapeutic technique. It is used inappropriately here.

NEW QUESTION: 706

Which of the following nursing actions is essential to prevent drug-resistant tuberculosis?

- A. Monitor liver function.
- B. Monitor renal function.
- C. Assess knowledge of respiratory isolation.
- D. Monitor compliance with drug therapy.

Answer: (SHOW ANSWER)

Explanation

(A) Monitoring liver function will not prevent the development of drug-resistant organisms. (B) Monitoring renal function will not prevent the development of drug-resistant organisms. (C) Knowledge of respiratory isolation will reduce transmission of tuberculosis but will not prevent development of drug-resistant organisms. (D) Noncompliance with prescribed antituberculosis drug regimen is the primary cause of drug-resistant organisms. Noncompliance permits the mutation of organisms.

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NEW QUESTION: 707

Following a fracture of the left femur, a client develops symptoms of osteomyelitis. During the acute phase of osteomyelitis, nursing care is directed toward:

- A. Moving or turning the client's left leg carefully to minimize pain and discomfort
- B. Allowing the client out of bed only in a wheelchair or gurney to minimize weight bearing on the left leg
- C. Providing the client with a high-protein, high-fiber diet to promote healing
- D. Instituting physical therapy to ensure restoration of optimal functioning of the leg

Answer: (SHOW ANSWER)

Explanation

(A) Any movement of his affected limb will cause discomfort to the child. (B) No weight bearing will be allowed until healing is well underway to avoid pathological fractures. (C) The child will be anorexic and may experience vomiting. Diet should be simple and high caloric until appetite returns and symptoms subside. (D) Physical therapy is instituted only after infection subsides.

NEW QUESTION: 708

MgSO₄ is ordered IV following the established protocol for a client with severe PIH. The anticipated effects of this therapy are anticonvulsant and:

- A. Vasoconstrictive
- B. Vasodilative
- C. Hypertensive
- D. Antiemetic

Answer: (SHOW ANSWER)

Explanation

(A) An anticonvulsant effect is the goal of drug therapy for PIH. However, we would not want to increase the vasoconstriction that is already present. This would make the symptoms more severe. (B) An anticonvulsant effect and vasodilation are the desired outcomes when administering this drug. (C) An anticonvulsant effect is the goal of drug therapy for PIH; however, hypertensive drugs would increase the blood pressure even more.

(D) An anticonvulsant effect is the goal of drug therapy for PIH. MgSO₄ is not classified as an antiemetic.

Antiemetics are not indicated for PIH treatment.

NEW QUESTION: 709

A 23-year-old female client is brought to the emergency room by her roommate for repeatedly making superficial cuts on her wrists and experiencing wide mood swings. She is very angry and hostile. Her medical diagnosis is adjustment disorder versus borderline personality disorder. The client comments to the nurse, "Nobody in here seems to really care about the clients. I thought nurses cared about people!" The client is exhibiting the ego defense mechanism:

- A. Reaction formation
- B. Rationalization
- C. Splitting
- D. Sublimation

Answer: C (LEAVE A REPLY)

(A) Reaction formation is the development and demonstration of attitudes and/or behaviors opposite to what an individual actually feels. The client's comment does reveal her anger and hostility. (B) Rationalization, another ego defense mechanism, is offering a socially acceptable or seemingly logical explanation to justify one's feelings, behaviors, or motives. The client's comment does not reflect rationalization. (C) Splitting, the viewing of people or situations as either all good or all bad, is frequently used by persons experiencing a disruption in self-concept. This ego defense mechanism is reflective of the individual's inability to integrate the positive and negative aspects of self. (D) Sublimation, the channeling of socially unacceptable impulses and behaviors into more acceptable patterns of behavior, is another ego defense mechanism. The client's comment reveals that she is not engaging in sublimation.

NEW QUESTION: 710

A client has returned to the unit from the recovery room after having a thyroidectomy. The nurse knows that a major complication after a thyroidectomy is:

- A. Respiratory obstruction
- B. Hypercalcemia
- C. Fistula formation
- D. Myxedema

Answer: A (LEAVE A REPLY)

Explanation

(A) Respiratory obstruction due to edema of the glottis, bilateral laryngeal nerve damage, or tracheal compression from hemorrhage is a major complication after a thyroidectomy. (B) Hypocalcemia accompanied by tetany from accidental removal of one or more parathyroid glands is a major complication, not hypercalcemia. (C) Fistula formation is not a major complication associated with a thyroidectomy. It is a major complication with a laryngectomy. (D) Myxedema is hypothyroidism that occurs in adults and is not a complication of a thyroidectomy. A thyroidectomy client tends to develop thyroid storm, which is excess production of thyroid hormone.

NEW QUESTION: 711

A child with celiac disease is being discharged from the hospital. The mother demonstrates knowledge of nutritional needs of her child when she is able to state the foods which are included in a:

- A. Lactose-restricted diet
- B. Gluten-restricted diet
- C. Phenylalanine-restricted diet
- D. Fat-restricted diet

Answer: B (LEAVE A REPLY)

Explanation

(A) A lactose-restricted diet is prescribed for children with lactose intolerance or diarrhea. (B) A gluten-restricted diet is the diet for children with celiac disease. (C) A phenylalanine-restricted diet is prescribed for children with phenylketonuria. (D) A fat-restricted diet is prescribed for children with disorders of the liver, gallbladder, or pancreas.

NEW QUESTION: 712

A client is admitted to the labor unit. On vaginal examination, the presenting part in a cephalic presentation was at station plus two. Station 12 means that the:

- A. Presenting part is 2 cm above the level of the ischial spines
- B. Biparietal diameter is at the level of the ischial spines
- C. Presenting part is 2 cm below the level of the ischial spines
- D. Biparietal diameter is 5 cm above the ischial spines

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Station is the relationship of the presenting part to an imaginary line drawn between the ischial spines.

If the presenting part is above the ischial spines, the station is negative. (B) When the biparietal diameter is at the level of the ischial spines, the presenting part is generally at a +4 or +5 station. (C) Station is the relationship of the presenting part to an imaginary line drawn between the ischial spines. If the presenting part is below the ischial spines, the station is positive. Thus, 2 cm below the ischial spines is the station +2.

(D) When the biparietal diameter is above the ischial spines by 5 cm, the presenting part is usually engaged or at station 0.

NEW QUESTION: 713

An 80-year-old male client with a history of arteriosclerosis is experiencing severe pain in his left leg that started approximately 20 minutes ago. When performing the admission assessment, the nurse would expect to observe which of the following:

- A. Both lower extremities warm to touch with 2 pedal pulses
- B. Both lower extremities cyanotic when placed in a dependent position
- C. Decreased or absent pedal pulse in the left leg
- D. The left leg warmer to touch than the right leg

Answer: (SHOW ANSWER)

Section: Questions Set G

Explanation:

(A) This statement describes a normal assessment finding of the lower extremities. (B) This assessment finding reflects problems caused by venous insufficiency. (C) Decreased or absent pedal pulses reflect a problem caused by arterial insufficiency. (D) The leg that is experiencing arterial insufficiency would be cool to touch due to the decreased circulation.

NEW QUESTION: 714

A client is in early labor. Her fetus is in a left occipitoanterior (LOA) position; fetal heart sounds are best auscultated just:

- A. Below the umbilicus toward left side of mother's abdomen
- B. Below the umbilicus toward right side of mother's abdomen
- C. At the umbilicus
- D. Above the umbilicus to the left side of mother's abdomen

Answer: A (LEAVE A REPLY)

Explanation

(A) LOA identifies a fetus whose back is on its mother's left side, whose head is the presenting part, and whose back is toward its mother's anterior. It is easiest to auscultate fetal heart tones (FHTs) through the fetus's back. (B) The identified fetus's back is on its

mother's left side, not right side. It is easiest to auscultate FHTs through the fetus's back. (C) In an LOA position, the fetus's head is presenting with the back to the left anterior side of the mother. The umbilicus is too high of a landmark for auscultating the fetus's heart rate through its back. (D) This is the correct auscultation point for a fetus in the left sacroanterior position, where the sacrum is presenting, not LOA.

NEW QUESTION: 715

A 30-year-old client has a history of several recent traumatic experiences. She presents at the physician's office with a complaint of blindness. Physical exam and diagnostic testing reveal no organic cause. The nurse recognizes this as:

- A.** Delusion
- B.** Illusion
- C.** Hallucination
- D.** Conversion

Answer: D (LEAVE A REPLY)

(A) The client's blindness is real. Delusion is a false belief. (B) Illusion is the misrepresentation of a real, external sensory experience. (C) Hallucination is a false sensory perception involving any of the senses. (D) Conversion is the expression of intrapsychic conflict through sensory or motor manifestations.

NEW QUESTION: 716

The nurse assists a client with advanced emphysema to the bathroom. The client becomes extremely short of breath while returning to bed. The nurse should:

- A.** Increase his nasal O₂ to 6 L/min
- B.** Place him in a lateral Sims' position
- C.** Encourage pursed-lip breathing
- D.** Have him breathe into a paper bag

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Giving too high a concentration of O₂ to a client with emphysema may remove his stimulus to breathe.

(B) The client should sit forward with his hands on his knees or an overbed table and with shoulders elevated. (C) Pursed-lip breathing helps the client to blow off CO₂ and to keep air passages open. (D) Covering the face of a client extremely short of breath may cause anxiety and further increase dyspnea.

NEW QUESTION: 717

A 15-year-old client was diagnosed as having cystic fibrosis at 8 months of age. He is in the hospital for a course of IV antibiotic therapy and vigorous chest physiotherapy. He has

a poor appetite. The nurse can best help him to meet the desired outcome of consuming a prescribed number of calories by:

- A.** Including the client in planning sessions to select the type of meal plan and foods for his diet
- B.** Working with the nutritionist to devise a diet with significantly increased calories
- C.** Selecting foods for the client's diet that are high in calories and instituting a strict calorie count
- D.** Constantly providing him with chips, dips, and candies, because the number of calories consumed is more important than the quality of foods

Answer: ([SHOW ANSWER](#))

(A) The adolescent knows what he likes and will be more likely to eat if he has some control over his diet. (B) The nurses and nutritionist can plan an excellent diet, but it will not help the adolescent unless he eats it. (C) Eating is already a chore for this client. Adding a strict calorie count could make it even more burdensome. (D) Fats are particularly difficult for the cystic fibrosis client to digest. He does need a healthful diet, not just more calories.

NEW QUESTION: 718

A client is dilated 8 cm and entering the transition phase of labor. Common behaviors of the laboring woman during transition are:

- A.** Frustration, vague in communication
- B.** Seriousness, some difficulty following directions
- C.** Calmness, follows directions easily
- D.** Excitement, openness to instructions

Answer: **A** ([LEAVE A REPLY](#))

Explanation

(A) During the transition phase, the mother may become frustrated and unclear in her communication owing to severe pain and fear of loss of control. (B) These behaviors are common in the active phase of labor. (C) These behavioral clues are seen in the latent phase of labor. (D) These characteristics are observed in the latent phase of labor.

NEW QUESTION: 719

Which of the following menu choices would indicate that a client with pressure ulcers understands the role diet plays in restoring her albumin levels?

- A.** Broiled fish with rice
- B.** Bran flakes with fresh peaches
- C.** Lasagna with garlic bread
- D.** Cauliflower and lettuce salad

Answer: ([SHOW ANSWER](#))

(A) Broiled fish and rice are both excellent sources of protein. (B) Fresh fruits are not a good source of protein. (C) Foods in the bread group are not high in protein. (D) Most

vegetables are not high in protein; peas and beans are the major vegetables higher in protein.

NEW QUESTION: 720

At 30 weeks' gestation, a client is admitted to the unit in premature labor. Her physician orders that an IV be started with 500 mL D5W mixed with 150 mg of ritodrine stat. The RN prepares the IV solution with the medication. The RN knows that clients receiving the medication ritodrine IV should be observed closely for which one of the following side effects:

- A.** Hypoglycemia
- B.** Hyperkalemia
- C.** Tachycardia
- D.** Increase in hematocrit and hemoglobin

Answer: C (LEAVE A REPLY)

Section: Questions Set C

Explanation:

(A) Ritodrine is a sympathomimetic α_2 -adrenergic agonist that can cause an elevation of blood glucose and plasma insulin in pregnant women. Hyperglycemia can occur in women with abnormal carbohydrate metabolism because of their inability to release more insulin. (B) Hypokalemia can occur resulting from the action of the β -mimetics. It results from a displacement of the extracellular potassium into the intracellular space. (C) Ritodrine causes vasodilation of vessel walls, which can lead to hypotension. The body compensates by increasing heart rate and pulse pressure. (D) There is a lowering of serum iron resulting from the action of β -mimetics to activate hematopoiesis.

NEW QUESTION: 721

A female client has been hospitalized for several months following major abdominal surgery for a ruptured colon. A colostomy was created, and the large abdominal wound was left open and allowed to heal through granulation. She is receiving gentamicin IV for treatment of wound infection. Knowing this drug is ototoxic, the nurse would implement which of the following measures?

- A.** Instruct the client to report any signs of tinnitus, dizziness or difficulty hearing.
- B.** Advise the client to discontinue the drug at the first sign of dizziness.
- C.** Order audiometric testing in order to determine if hearing loss is caused by an ototoxic drug or other cause.
- D.** Instruct the client in Valsalva's maneuver to equalize middle ear pressure and to prevent hearing loss.

Answer: A (LEAVE A REPLY)

Explanation

(A) The first nursing measure is to instruct the client in which drug side effects to report. (B) Discontinuing the drug is not an independent nursing intervention and may compromise

client care. (C) Audiometric testing will detect hearing loss, but it does not indicate a potential cause. (D) Equalizing middle ear pressure will not prevent hearing loss.

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