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NEW QUESTION: 1

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: ([SHOW ANSWER](#))

Section: Questions Set G

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 explains 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: 2

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: 3

The serial sevens test is often used to determine delirium and dementia. This test aids in assessing which of the following?

- A. Abstract thinking
- B. Ability to focus and concentrate thoughts
- C. Judgment
- D. Memory

Answer: ([SHOW ANSWER](#))

Explanation

(A) This answer is incorrect. The test measures the abilities to concentrate and calculate. The use of proverbs is the most common way to test abstraction. (B) This answer is correct. The serial sevens test is a common test of calculation ability. It is difficult for the demented or delirious client to perform. (C) This answer is incorrect. The test for judgment should predict whether the individual will behave in a socially accepted manner. (D) This answer is incorrect. In testing memory, the nurse would attempt to get the client either to recall recent events or to think about past events.

NEW QUESTION: 4

A male client received a heart-lung transplant 1 month ago at a local transplant center. While visiting the nursing center to have his blood pressure taken, he complains of recent weakness and fatigue. He also tells the nurse that he is considering stopping his cyclosporine because it is expensive and is causing his face to become round. He fears he will catch viruses and be more susceptible to infections. The nurse responds to this last statement by explaining that cyclosporine:

- A. Is given to prevent rejection and makes him less susceptible to infection than other oral corticosteroids
- B. Is available at discount pharmacies for a reduced price
- C. Is usually not necessary after the first year following transplantation
- D. May initially cause weakness, dizziness, and fatigue, but these side effects will gradually resolve themselves

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

Explanation/Reference:

Explanation:

(A) Cyclosporine is the immunosuppressive drug of choice. It provides immunosuppression but does not lower the white blood cell count; therefore, the client is less susceptible to infection. (B) Cyclosporine is available at discount pharmacies. The cost may be absorbed by health insurance, or Medicare, if the client is eligible. However, this statement does not address the entire problem verbalized by the client. (C) Immunosuppressive agents will be taken for the client's entire life because rejection can occur at any time.

(D) These side effects do not necessarily resolve in time; however, the client may adapt.

NEW QUESTION: 5

The cardiac client who exhibits the symptoms of disorientation, lethargy, and seizures may be exhibiting a toxic reaction to:

A. Digoxin (Lanoxin)

B. Lidocaine (Xylocaine)

C. Quinidine gluconate or sulfate (Quinaglute, Quinidex)

D. Nitroglycerin IV (Tridil)

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

(A) Side effects of digoxin include headache, hypotension, AV block, blurred vision, and yellow-green halos. (B) Side effects of lidocaine include heart block, headache, dizziness, confusion, tremor, lethargy, and convulsions. (C) Side effects of quinidine include heart block, hepatotoxicity, thrombocytopenia, and respiratory depression. (D) Side effects of nitroglycerin include postural hypotension, headache, dizziness, and flushing.

NEW QUESTION: 6

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: 7

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/Reference:

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: 8

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)

(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: 9

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)

(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: 10

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/Reference:

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: 11

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)

(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: 12

The nurse is teaching a child's parents how to protect the child from lead poisoning. The nurse knows that a common source of lead poisoning in children is:

- A.** Dandelion leaves
- B.** Pencils
- C.** Old paint
- D.** Stuffing from toy animals

Answer: C (LEAVE A REPLY)

(A) Dandelion leaves are not a source of lead. (B) Pencils are not a source of lead poisoning. (C) Chewing on objects painted before 1960 is a common source of lead poisoning in children. Gasoline is another source. (D) Stuffed animals are not a source of lead.

NEW QUESTION: 13

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)

(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: 14

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: ([SHOW ANSWER](#))

Explanation

(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: 15

A gravida 2 para 1 client is hospitalized with severe preeclampsia. While she receives magnesium sulfate (MgSO₄) therapy, the nurse knows it is safe to repeat the dosage if:

A. Deep tendon reflexes are absent

B. Urine output is 20 mL/hr

C. MgSO₄ serum levels are >15 mg/dL

D. Respirations are >16 breaths/min

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

Explanation/Reference:

Explanation:

(A) MgSO₄ is a central nervous system depressant. Loss of reflexes is often the first sign of developing toxicity. (B) Urinary output at <25 mL/hr or 100 mL in 4 hours may result in the accumulation of toxic levels of magnesium. (C) The therapeutic serum range for MgSO₄ is 6-8 mg/dL. Higher levels indicate toxicity.

(D) Respirations of >16 breaths/min indicate that toxic levels of magnesium have not been reached.

Medication administration would be safe.

NEW QUESTION: 16

A 14-year-old teenager is demonstrating behavior indicative of an obsessive-compulsive disorder. She is obsessed with her appearance. She will not leave her room until her hair, clothes, and makeup are perfect. She always dresses immaculately. Recently, she expressed disgust over her appearance after she gained 5 lb. After observing a marked weight loss over a 2-week period, her mother suspects that she is experiencing bulimia. She eats everything on her plate, then runs to the bathroom. In interviewing the teenager, she discusses in great detail all of the events leading to her bulimia, but not her feelings. What defense mechanism is she using?

A. Dissociation

B. Intellectualization

C. Rationalization

D. Displacement

Answer: B (LEAVE A REPLY)

Explanation

(A) Dissociation is separating a group of mental processes from consciousness or identity, such as multiple personalities. That is not evident in this situation. (B) Intellectualization is excessive use of reasoning, logic, or words usually without experiencing associated feelings. This is the defense mechanism that this client is using.

(C) Rationalization is giving a socially acceptable reason for behavior rather than the actual reason. She is discussing events, not reasons. (D) Displacement is a shift of emotion associated with an anxiety-producing person, object, or situation to a less threatening object.

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NEW QUESTION: 17

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)

(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: 18

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: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(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: 19

The most important reason to closely assess circumferential burns at least every hour is that they may result in:

A. Hypovolemia

B. Renal damage

C. Ventricular arrhythmias

D. Loss of peripheral pulses

Answer: D (LEAVE A REPLY)

(A) Hypovolemia could be a result of fluid loss from thermal injury, but not as a result of the circumferential injury. (B) Renal damage is typically seen because of prolonged hypovolemia or myoglobinuria. (C) Electrical injuries and electrolyte changes typically cause arrhythmias in the burn client. (D) Full-thickness circumferential burns are nonelastic and result in an internal tourniquet effect that compromises distal blood flow when the area involved is an extremity. Circumferential full-thickness torso burns compromise respiratory motion and, when extreme, cardiac return.

NEW QUESTION: 20

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: (SHOW ANSWER)

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: 21

A couple is planning the conception of their first child.

The wife, whose normal menstrual cycle is 34 days in length, correctly identifies the time that she is most likely to ovulate if she states that ovulation should occur on day:

- A. 14+2 days
- B. 16+2 days
- C. 20+2 days
- D. 22+2 days

Answer: C (LEAVE A REPLY)

Explanation

(A) Ovulation is dependent on average length of menstrual cycle, not standard 14 days. (B)

Ovulation occurs

14+2 days before next menses (34 minus 14 does not equal 16). (C) Ovulation occurs

14+2 days before next menses (34 minus 14 equals 20). (D) Ovulation occurs 14+2 days before next menses (34 minus 14 does not equal 22).

NEW QUESTION: 22

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: 23

A 2-year-old child with a scalp laceration and subdural hematoma of the temporal area as a result of falling out of bed should be prevented from:

- A. Crying
- B. Falling asleep
- C. Rolling from his back to his tummy
- D. Sucking his thumb

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

Explanation/Reference:

Explanation:

- (A) A child with a subdural hematoma has increased ICP. Crying may significantly increase this pressure.
- (B) Adequate sleep is essential, but it is important that the child can be aroused from sleep after head injury. (C) This child is free to roll from his back to his abdomen. (D) Thumb-sucking serves to reduce anxiety and should not be prevented at this time.

NEW QUESTION: 24

A client's prenatal screening indicated that she has no immunity to rubella. She is now 10 weeks pregnant.

The best time to immunize her is:

- A. In the immediate postpartum period
- B. After the first trimester
- C. At 28 weeks' gestation
- D. Within 72 hours postpartum

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

- (A) The rubella vaccine is made with attenuated virus and is given in the immediate postpartal period to prevent infection during pregnancy and subsequent adverse fetal and neonatal sequelae. Mothers are advised to prevent pregnancy for 3 months following immunization. (B) Rubella infection during the second trimester may result in permanent hearing loss for the fetus. (C) RhoGam is the drug generally administered at 28 weeks' gestation to Rh-negative women. It is contraindicated to administer rubella vaccine during pregnancy. (D) RhoGam is the drug administered within 72 hours postpartum to Rh-negative women to prevent the development of antibodies to fetal cells.

NEW QUESTION: 25

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: D (LEAVE A REPLY)

Explanation

(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: 26

A client has chronic obstructive pulmonary disease. She is slowly losing weight, and her daughter is very concerned about increasing her nutrition. The nurse helps the daughter devise a plan of care for her mother. The plan of care should include which of the following interventions to promote nutrition?

- A. Offer her oral hygiene before and after meals.
- B. Encourage her to consume milk products.
- C. Encourage her to engage in an activity before a meal to stimulate her appetite.
- D. Restrict her fluid intake to three glasses of water a day.

Answer: A (LEAVE A REPLY)

(A) Clients with respiratory diseases are generally mouth breathers. Cleaning the oral cavity may improve the client's appetite, increase her feelings of well-being, and remove the taste and odor of sputum. (B) Milk causes thick sputum; therefore, milk products would not be beneficial for this client. (C) Exercise prior to a meal would require increased O₂ consumption and most likely would decrease the client's ability to eat. (D) Clients with respiratory diseases need increased fluid to liquefy secretions.

NEW QUESTION: 27

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)

Explanation

(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: 28

The nurse instructs a pregnant client (G2P1) to rest in a side-lying position and avoid lying flat on her back. The nurse explains that this is to avoid "vena caval syndrome," a condition which:

- A.** Occurs when blood pressure increases sharply with changes in position
- B.** Results when blood flow from the extremities is blocked or slowed
- C.** Is seen mainly in first pregnancies
- D.** May require medication if positioning does not help

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

(A) Blood pressure changes are predominantly due to pressure of the gravid uterus. (B) Pressure of the gravid uterus on the inferior vena cava decreases blood return from lower extremities. (C) Inferior vena cava syndrome is experienced in the latter months of pregnancy regardless of parity. (D) There are no medications useful in the treatment of inferior vena cava syndrome; alleviating pressure by position changes is effective.

NEW QUESTION: 29

A 32-year-old mother of two was brought to the hospital by her husband. He reported that his wife could no longer manage the house and children. She does not sleep and talks day and night. She has purchased some very expensive clothes. The nurse noted that the client speaks rapidly and changes the subject irrationally. This is an example of:

- A.** Flight of ideas
- B.** Delusions
- C.** Hallucinations
- D.** Echolalia

Answer: (SHOW ANSWER)

(A) Rapidly moving from one topic to another without following any logical sequence is called flight of ideas. (B) False beliefs are delusions. (C) False sensory perceptions are hallucinations ("hearing voices"). (D) Repeating words is called echolalia.

NEW QUESTION: 30

A 55-year-old client is admitted with a diagnosis of renal calculi. He presented with severe right flank pain, nausea, and vomiting. The most important nursing action for him at this time is:

- A.** Intake and output measurement
- B.** Daily weights
- C.** Straining of all urine
- D.** Administration of O2 therapy

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

Explanation

(A) Intake and output measurements are important but must be accompanied by straining urine. (B) Daily weights would not provide for identification of calculi. (C) Straining urine provides for assessment of calculi and evaluation of calculi descent through ureters and urethra. (D) O2therapy should not be necessary for renal calculi.

NEW QUESTION: 31

A female client comes for her second prenatal visit. The nurse-midwife tells her, "Your blood tests reveal that you do not show immunity to the German measles." Which notation will the nurse include in her plan of care for the client? "Will need . . .

- A. Rh-immune globulin at the next visit"
- B. Rh-immune globulin within 3 days of delivery"
- C. Rubella vaccine at the next visit"
- D. Rubella vaccine after delivery on the day of discharge"

Answer: D (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) Rh immune globulin is given to Rh-negative mothers to prevent the maternal Rh immune response. (B) Rh immune globulin is given to Rh-negative mothers to prevent the maternal Rh immune response. (C) The rubella vaccine is not given during pregnancy because of its teratogenicity. (D) Nonimmune mothers are vaccinated early in the postpartum period to prevent future infection with the rubella virus.

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NEW QUESTION: 32

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: ([SHOW ANSWER](#))

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: 33

A 13-year-old hemophiliac is hospitalized for hemarthrosis of his right knee. To relieve the pain, the nurse should:

A. Place on bed rest; elevate and splint the right knee

B. Apply moist heat to the right knee

C. Administer aspirin for pain

D. Encourage active range of motion to right knee

Answer: ([SHOW ANSWER](#))

Section: Questions Set C

Explanation:

(A) Immobilization, splinting, and bed rest will reduce the bleeding. Once bleeding is reduced or stopped, the pain will subside. (B) Moist heat causes vasodilation and bleeding. Ice or cold compresses should be applied.

(C) Aspirin decreases platelet aggregation, which causes bleeding. (D) Active range of motion aggravates bleeding and damages the synovial sac during bleeding episodes.

NEW QUESTION: 34

A 32-year-old female client is being treated for Guillain- Barré 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](#))

Explanation/Reference:

Explanation:

(A) Headaches are not associated with Guillain-Barré 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: 35

A 33-year-old client was brought into the emergency room unconscious, and it is determined that surgery is needed. Informed consent must be obtained from his next of kin. The sequence in which the next of kin would be asked for the consent would be:

- A. Parent, spouse, adult child, sibling
- B. Spouse, adult child, parent, sibling
- C. Spouse, parent, sibling, adult child
- D. Parent, spouse, sibling, adult child

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

Explanation

(A) Spouse and adult child would be asked before a parent. (B) The order of kin relationship for an adult, as determined from legal intestate succession, is usually spouse, adult child, parent, sibling. (C) Parent and sibling would be asked after adult child. (D) Spouse and adult child would be asked before parent. Sibling would be asked last.

NEW QUESTION: 36

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: (SHOW ANSWER)

Explanation/Reference:

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.

NEW QUESTION: 37

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: 38

The therapeutic blood-level range for lithium is:

- A. 0.25-1.0 mEq/L
- B. 0.5-1.5 mEq/L
- C. 1.0-2.0 mEq/L
- D. 2.0-2.5 mEq/L

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

Explanation/Reference:

Explanation:

(A) This range is too low to be therapeutic. (B) This is the therapeutic range for lithium. (C) This range is above the therapeutic level. (D) This range is toxic and may cause severe side effects.

NEW QUESTION: 39

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: ([SHOW ANSWER](#))

(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: 40

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: B (LEAVE A REPLY)

(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: 41

A client's wife is concerned over his behavior in recent months. He has been diagnosed with Parkinson's disease, and she is telling his nurse that he has been doing "strange things." The nurse reassures the wife that the following behavior is normal with Parkinson's disease:

- A.** "Your husband will experience some periods of muscle flaccidity. Be sure to make him sit down during these periods."
- B.** "Your husband may move his hands in motions that look like he is rolling a pill between his fingers."
- C.** "Twitching of the muscles is to be expected and can occur at any time during the day."
- D.** "Parkinson's disease causes severe pain in the joints. You should give your husband Tylenol at those times."

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Clients with Parkinson's disease generally experience stiffness and rigid movement. (B) Pill-rolling movements are a symptom experienced by the Parkinson client. (C) Twitching of the muscles is not an expected symptom of Parkinson's disease. (D) Parkinson's disease does not cause joint pain. Mild muscular pain may be present.

NEW QUESTION: 42

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/Reference:

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: 43

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](#))

Section: Questions Set A

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 non-respiratory contributor to acid-base balance. It would increase to compensate for acidosis.

NEW QUESTION: 44

The physician has prescribed metoclopramide (Reglan). When assessing the client, the nurse would expect to find which of the following responses?

- A. Increase in gastric secretions
- B. Increase in peristalsis
- C. Disorientation
- D. Drowsiness

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

Explanation/Reference:

Explanation:

(A) Metoclopramide does not stimulate gastric secretions. (B) This response is expected with metoclopramide, in addition to increasing gastric emptying. (C) Disorientation is a symptom of metoclopramide overdose. The drug should be discontinued. (D) Drowsiness is a symptom of metoclopramide overdose and the drug should be discontinued.

NEW QUESTION: 45

After several days, an IDDM client's serum glucose stabilizes, and the registered nurse continues client teaching in preparation for his discharge. The nurse helps him plan an American Diabetes Association diet and explains how foods can be substituted on the exchange list. He can substitute 1 oz of poultry for:

- A. One frankfurter
- B. One ounce of ham
- C. Two slices of bacon
- D. One-fourth cup dry cottage cheese

Answer: D (LEAVE A REPLY)

(A) A frankfurter is a high-fat meat on the diabetic exchange list. (B) Ham is a medium-fat meat on the diabetic exchange list, unless it is a center-cut slice. (C) One strip of bacon equals one fat exchange rather than a meat exchange. Dietary substitutions should occur within exchange lists and not between exchange lists. (D) Diabetic meat-exchange lists are categorized into lean meat foods, medium-fat meats, and high-fat meats. Cottage cheese (dry, 2% butterfat), one-fourth cup, can substitute for one lean-meat exchange.

NEW QUESTION: 46

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/Reference:

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.

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NEW QUESTION: 47

Parents of young children often need anticipatory guidance from the nurse. Parents may have little knowledge regarding growth and development. Which of the following toys and activities would the nurse suggest as appropriate for a toddler?

- A.** Cutting, pasting, string beads, music, dolls
- B.** Mobiles, rattle, squeeze toys
- C.** Pull-toys, large ball, dolls, sand and water play, music
- D.** Simple card games, puzzles, bicycle, television

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) These activities are suited for the preschool-age child (3-5 years old). The activities are not safe for a toddler. (B) Infants (0-1 year) like these toys. (C) These activities provide the toddler (1-3 years old) with a variety of physical activities for play. (D) The toddler lacks the physical and cognitive abilities for these activities. The tasks are far better suited for the school-age child.

NEW QUESTION: 48

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](#))

(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: 49

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

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: 50

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: 51

A measurable outcome criterion in the nursing care of an adolescent with anorexia nervosa would be:

- A. Accepting her present body image

- B. Verbalizing realistic feelings about her body
- C. Having an improved perception of her body image
- D. Exhibiting increased self-esteem

Answer: B (LEAVE A REPLY)

Explanation

(A) This outcome criterion is inadequate because the term "accepts" is not directly measurable. (B) This outcome criterion is directly measurable because specific goal-related verbalizations can be heard and verified by the nurse. (C) "Improved perception of body image" is not directly measurable and is therefore open to many interpretations. (D) Although long-term goals for the anorexic client should focus on increased self-esteem, this outcome criterion (as stated) does not include specific indicators or behaviors for which to observe.

NEW QUESTION: 52

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)

(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: 53

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: D (LEAVE A REPLY)

Section: Questions Set D

Explanation:

(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: 54

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: ([SHOW ANSWER](#))

Explanation/Reference:

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: 55

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: ([SHOW ANSWER](#))

(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: 56

A 38-year-old pregnant woman visits her nurse practitioner for her regular prenatal checkup. She is 30 weeks' gestation. The nurse should be alert to which condition related to her age?

- A. Iron-deficiency anemia
- B. Sexually transmitted disease (STD)
- C. Intrauterine growth retardation
- D. Pregnancy-induced hypertension (PIH)

Answer: D (LEAVE A REPLY)

(A) Iron-deficiency anemia can occur throughout pregnancy and is not age related. (B) STDs can occur prior to or during pregnancy and are not age related. (C) Intrauterine growth retardation is an abnormal process where fetal development and maturation are delayed. It is not age related. (D) Physical risks for the pregnant client older than 35 include increased risk for PIH, cesarean delivery, fetal and neonatal mortality, and trisomy.

NEW QUESTION: 57

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)

Section: Questions Set A

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: 58

A 15-year-old child is admitted to the pediatric unit with a diagnosis of thalassemia. Which of the following would be included in educating the mother and child as part of discharge planning?

- A. Give oral iron medication every day.

- B. Have the child's blood pressure monitored every week.
- C. Know the signs and symptoms of iron overload.
- D. Keep exercise at a minimum to reduce stress.

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

(A) Oral iron supplements are contraindicated in thalassemia. (B) Although heart failure may be an end result of this disease, this action is unnecessary. (C) Iron overload is a potential complication of frequent blood transfusions of children with thalassemia. (D) Children should be encouraged to pursue activities related to their exercise tolerance.

NEW QUESTION: 59

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.

NEW QUESTION: 60

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 (insulin-dependent 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)

(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: 61

A pregnant client experiences a precipitous delivery. The nursing action during a precipitous delivery is to:

- A. Control the delivery by guiding expulsion of fetus
- B. Leave the room to call the physician
- C. Push against the perineum to stop delivery
- D. Cross client's legs tightly

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Controlling the rapid delivery will reduce the risk of fetal injury and perineal lacerations. (B) The nurse should always remain with a client experiencing a precipitous delivery. (C) Pushing against the perineum may cause fetal distress. (D) Crossing of legs may cause fetal distress and does not stop the delivery process.

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NEW QUESTION: 62

A 29-year-old client is diagnosed with borderline personality disorder. He has aroused the nurse's anger by using a condescending tone of voice with other clients and staff persons. Which of the following statements from the nurse would be most appropriate in acknowledging feelings regarding the client's behavior?

- A. "I feel angry when I hear that tone of voice."
- B. "You make me angry when you talk to me that way."

C. "Are you trying to get me angry?"

D. "Why do you treat me that way?"

Answer: (SHOW ANSWER)

Explanation

The nurse appropriately states how he or she feels when the client speaks in a condescending manner. (B) This statement indicates that the client has control over the nurse. No one makes another person angry; each individual has a choice. (C) "Why" questions usually put a person on the defensive. In addition, the client cannot "make" the nurse angry. The client does not have that control. (D) Again, a "why" statement places the client on the defensive.

NEW QUESTION: 63

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)

Section: Questions Set F

Explanation:

(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: 64

A pregnant client during labor is irritable and feels the urge to vomit. The nurse should recognize this as the:

A. Fourth stage of labor

B. Third stage of labor

C. Transition stage of labor

D. Second stage of labor

Answer: C (LEAVE A REPLY)

Explanation

(A) The fourth stage begins after expulsion of the placenta. Client symptoms are: fatigue; chills; scant, bloody vaginal discharge; and nausea. (B) The third stage is from birth to expulsion of placenta. Client symptoms are uterine contractions, gush of blood, and perineal pain. (C) The transition stage is characterized by strong uterine contractions and cervical dilation. Clientsymptoms are irritability, restlessness, belching, muscle tremors, nausea, and vomiting. (D) The second stage is characterized by full dilation of cervix. Client symptoms are perineal bulge, pushing with contractions, great irritability, and leg cramps.

NEW QUESTION: 65

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: D (LEAVE A REPLY)

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: 66

A 29-year-old client is admitted for a hysterectomy. She has repeatedly told the nurses that she is worried about having this surgery, has not slept well lately, and is afraid that her husband will not find her desirable after the surgery. Shortly into the preoperative teaching, she complains of a tightness in her chest, a feeling of suffocation, lightheadedness, and tingling in her hands. Her respirations are rapid and deep.

Assessment reveals that the client is:

- A. Having a heart attack
- B. Wanting attention from the nurses
- C. Suffering from complete upper airway obstruction
- D. Hyperventilating

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

Explanation/Reference:

Explanation:

(A) Classic symptoms of a heart attack include heaviness or squeezing pain in the chest, pain spreading to the jaw, neck, and arm. Nausea and vomiting, sweating, and shortness of breath may be present. The client does not exhibit these symptoms. (B) Clients suffering from anxiety or fear prior to surgical procedures may develop hyperventilation. This client is not seeking attention. (C) Symptoms of complete airway obstruction include not being able to speak, and no airflow between the nose and mouth. Breath sounds are absent. (D) Tightness in the chest; a feeling of suffocation; lightheadedness; tingling in the hands; and rapid, deep respirations are signs and symptoms of hyperventilation. This is almost always a manifestation of anxiety.

NEW QUESTION: 67

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](#))

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: 68

A client is diagnosed with Mycobacterium tuberculosis. He is placed in respiratory isolation, intubated, and receives mechanical ventilation. When performing suctioning, the nurse should:

- A. Suction for a maximum of 20 seconds

- B. Hyperoxygenate before and after suctioning
- C. Suction for a maximum of 30 seconds
- D. Maintain clean technique during suctioning

Answer: (SHOW ANSWER)

(A) The maximum time for suctioning is 10-15 seconds. (B) Supplemental O₂ should be administered before and after suctioning to reduce hypoxia. (C) The maximum time for suctioning is 10-15 seconds. (D) Strict sterile technique should be used during suctioning.

NEW QUESTION: 69

A client has begun to exhibit signs of alcohol withdrawal. Her blood pressure has risen from 120/60 to 190/100, pulse is increased from 88 to 110 bpm, and she is irritable and agitated and has gross motor tremors of the hands. The nurse notifies the doctor. The nurse can anticipate that the doctor will order which of the following?

- A. An opiate such as propoxyphene napsylate (Darvocet)
- B. A benzodiazepine such as chlordiazepoxide (Librium)
- C. A tricyclic antidepressant such as amitriptyline (Elavil)
- D. A phenothiazine such as chlorpromazine (Thorazine)

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This answer is incorrect. Benzodiazepines are drugs of choice for alcohol withdrawal. (B) This answer is correct. The drug has a sedative effect, is safe, and has an anticonvulsant effect. (C) This answer is incorrect. Amitriptyline is an antidepressant. (D) This answer is incorrect. Chlorpromazine is most effective in psychotic disorders.

NEW QUESTION: 70

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)

(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: 71

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: (SHOW ANSWER)

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: 72

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)

Explanation/Reference:

Explanation:

(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.

NEW QUESTION: 73

A client's physician has prescribed theophylline (Theo- Dur) to help control the bronchospasm associated with the client's COPD. Instructions that should be given to the client include:

- A. "Call your physician if you develop palpitations, dizziness, or restlessness."
- B. "Cigarette smoking may significantly increase the risk for theophylline toxicity."
- C. "Take this medication on an empty stomach."
- D. "Do not take your medicine if your pulse is less than 60 beats per minute."

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

Explanation

(A) Indications of theophylline toxicity include palpitations, dizziness, restlessness, nausea, vomiting, shakiness, and anorexia. (B) Cigarette smoking significantly lowers theophylline plasma levels. (C) Theophylline should be taken with food to decrease stomach upset. (D) These instructions are appropriate for someone taking digoxin.

NEW QUESTION: 74

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.

NEW QUESTION: 75

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)

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: 76

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)

Explanation/Reference:

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).

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NEW QUESTION: 77

The mother of a child taking phenytoin will need to plan appropriate mouth care and gingival stimulation. When tooth-brushing is contraindicated, the next most effective cleansing and gingival stimulation technique would be:

- A. Using a water pik
- B. Rinsing with water
- C. Rinsing with hydrogen peroxide
- D. Rinsing with baking soda

Answer: (SHOW ANSWER)

Section: Questions Set G

Explanation:

(A) This technique provides effective rinsing and gingival stimulation. (B) This technique does not provide gingival stimulation. (C) This technique provides effective rinsing but not gingival stimulation. Using peroxide is not pleasant for the child. (D) This technique provides effective rinsing but not gingival stimulation.

NEW QUESTION: 78

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

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: 79

A 42-year-old client on an inpatient psychiatric unit comments that he was brought to the hospital by his wife because he had taken too many pills and states, "I just couldn't take it anymore." The nurse's best response to this disclosure would be:

- A. "You shouldn't do things like that, just tell someone you feel bad."
- B. "Tell me more about what you couldn't take anymore."
- C. "I'm sure you probably didn't mean to kill yourself."
- D. "How long have you been in the hospital."

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

Explanation

(A) Disapproving gives the impression that the nurse has a right to pass judgment on the client's thoughts, actions, or ideas. (B) Giving a broad opening gives the client encouragement to continue with verbalization.

(C) Failing to acknowledge the client's feelings conveys a lack of understanding and empathy. (D) Changing the subject takes the conversation away from the client and is indicative of the nurse's anxiety or insensitivity.

NEW QUESTION: 80

A 25-year-old lawyer who is married with three young children works long hours in an effort to become a partner in the law firm. Following a recent hospitalization for a bleeding ulcer,

he was referred for therapy to treat this psychophysiological disorder. On meeting with the therapist, he informed him or her that he was a busy man and did not have much time for this "psych stuff." When guiding the client to ventilate his feelings, the therapist can expect him to express feelings of:

- A. Guilt
- B. Shame
- C. Despair
- D. Anger

Answer: ([SHOW ANSWER](#))

Section: Questions Set D

Explanation:

(A) Guilt relates to depression. (B) Shame is not associated with psychophysiological disorders. (C) Despair relates to depression. (D) Repressed anger is associated with psychophysiological disorders.

NEW QUESTION: 81

In acute episodes of mania, lithium is effective in 1-2 weeks, but it may take up to 4 weeks, or even a few months, to treat symptoms fully. Sometimes an antipsychotic agent is prescribed during the first few days or weeks of an acute episode to manage severe behavioral excitement and acute psychotic symptoms. In addition to the lithium, which one of the following medications might the physician prescribe?

- A. Diazepam (Valium)
- B. Haloperidol (Haldol)
- C. Sertraline (Zoloft)
- D. Alprazolam (Xanax)

Answer: ([SHOW ANSWER](#))

Explanation

(A) Diazepam is an antianxiety medication and is not designed to reduce psychotic symptoms. (B) Haloperidol is an antipsychotic medication and may be used until the lithium takes effect. (C) Sertraline is an antidepressant and is used primarily to reduce symptoms of depression. (D) Alprazolam is an antianxiety medication and is not designed to reduce psychotic symptoms.

NEW QUESTION: 82

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

(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: 83

A 27-year-old man was diagnosed with type I diabetes 3 months ago. Two weeks ago he complained of pain, redness, and tenderness in his right lower leg. He is admitted to the hospital with a slight elevation of temperature and vague complaints of "not feeling well." At 4:30 PM on the day of his admission, his blood glucose level is 50 mg; dinner will be served at 5:00 PM. The best nursing action would be to:

- A.** Give him 3 tbsp of sugar dissolved in 4 oz of grape juice to drink
- B.** Ask him to dissolve three pieces of hard candy in his mouth
- C.** Have him drink 4 oz of orange juice
- D.** Monitor him closely until dinner arrives

Answer: C (LEAVE A REPLY)

Section: Questions Set A

Explanation:

(A) The combination of sugar and juice will increase the blood sugar beyond the normal range. (B) Concentrated sweets are not absorbed as fast as juice; consequently, they elevate the blood sugar beyond the normal limit. (C) Four ounces of orange juice will act immediately to raise the blood sugar to a normal level and sustain it for 30 minutes until supper is served. (D) There is an increased potential for the client's blood sugar to decrease even further, resulting in diabetic coma.

NEW QUESTION: 84

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)

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: 85

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/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.

NEW QUESTION: 86

The nurse provides a male client with diet teaching so that he can help prevent constipation in the future.

Which food choices indicate that this teaching has been understood?

- A.** Omelette and hash browns
- B.** Pancakes and syrup
- C.** Bagel with cream cheese
- D.** Cooked oatmeal and grapefruit half

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Eggs and hash browns do not provide much fiber and bulk, so they do not effectively prevent constipation. (B) Pancakes and syrup also have little fiber and bulk, so they do not effectively prevent constipation. (C) Bagel and cream cheese do not provide intestinal bulk. (D) A combination of oatmeal and fresh fruit will provide fiber and intestinal bulk.

NEW QUESTION: 87

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)

Section: Questions Set C

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: 88

A 15-year-old client is admitted to the adolescent unit. The nurse recognizes that encouraging a client to speak openly depends on how clearly questions are phrased. Which of the following statements is most desirable in eliciting information from an adolescent client?

- A. "Do you get along well with your family?"
- B. "Do you communicate with your parents?"
- C. "You don't hate your family, do you?"
- D. "What is it like between you and your family?"

Answer: D (LEAVE A REPLY)

Explanation

(A, B) This statement can be answered with a simple yes or no. (C) This statement is asked in a negative manner and therefore has a negative connotation. (D) This statement is open ended and positively stated.

NEW QUESTION: 89

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/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: 90

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: 91

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.

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NEW QUESTION: 92

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.

NEW QUESTION: 93

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: 94

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)

(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: 95

A client is being treated for congestive heart failure. His medical regimen consists of digoxin (Lanoxin) 0.25 mg po daily and furosemide 20 mg po bid. Which laboratory test should the nurse monitor?

- A. Intake and output
- B. Calcium
- C. Potassium
- D. Magnesium

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Intake and output are not laboratory tests. (B) Serum calcium levels are not affected by digoxin or furosemide. (C) Furosemide is a non-potassium-sparing loop diuretic. Hypokalemia is a common side effect of furosemide and may enhance digoxin toxicity. (D) Serum magnesium levels are not affected by digoxin or furosemide.

NEW QUESTION: 96

A male client is admitted to the medical-surgical unit from the emergency room with a diagnosis of acute pancreatitis. The nurse performs the admission nursing assessment. He is NPO with IV fluids infusing at 100 mL/hour. He is experiencing excruciating abdominal pain. Based on an analysis of these data, which nursing diagnosis would receive the highest priority?

- A. Pain related to stimulation of nerve endings associated with obstruction of the pancreatic tract
- B. Fluid volume deficit related to vomiting and nasogastric tube drainage
- C. Knowledge deficit related to treatment regimen
- D. Altered nutrition: less than body requirements, related to inadequate intake associated with current anorexia, nausea, vomiting, and digestive enzyme loss

Answer: A (LEAVE A REPLY)

Explanation

(A) Relief of pain is the primary goal of nursing intervention because this client is experiencing acute pain. (B) Fluid volume deficit is being treated with IV fluid replacement.

(C) Knowledge deficit will not be addressed at this time because a client in acute pain is not ready to learn. (D) Alteration in nutrition is the third priority after relief of pain and fluid volume deficit.

NEW QUESTION: 97

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)

Explanation/Reference:

Explanation:

(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: 98

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)

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: 99

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: B (LEAVE A REPLY)

Explanation

(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: 100

A type I diabetic client delivers a male newborn. The newborn is 45 minutes old. What is the primary nursing goal in the nursery during the first hours for this newborn?

- A.** Bonding
- B.** Maintain normal blood sugar
- C.** Maintain normal nutrition
- D.** Monitor intake and output

Answer: B (LEAVE A REPLY)

(A) Bonding is necessary but would not be the priority with this newborn in the nursery. (B) The infant will be at risk for hypoglycemia because of excess insulin production. (C) Normal nutrition is a goal for all newborns. (D) Monitoring intake and output is necessary but is not the most critical nursing goal.

NEW QUESTION: 101

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](#))

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: 102

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

(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: 103

A female client decides on hemodialysis. She has an internal vascular access device placed. To ensure patency of the device, the nurse must:

- A. Assess the site for leakage of blood or fluids
- B. Auscultate the site for a bruit
- C. Assess the site for bruising or hematoma
- D. Inspect the site for color, warmth, and sensation

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) This is an internal device. Assessment of the site should include assessing for swelling, pain, warmth, and discoloration. This measure does not assess patency. (B) The presence of a bruit indicates good blood flow through the device. (C) The nurse should inspect the site for bruising or hematoma; however, this measure does not assure patency of the device. (D) The nurse should inspect the vascular access site frequently for signs of infection. However, this does not assure patency.

NEW QUESTION: 104

A gravida 2 para 1 client is hospitalized with severe preeclampsia. While she receives magnesium sulfate

(MgSO₄) therapy, the nurse knows it is safe to repeat the dosage if:

- A. Deep tendon reflexes are absent
- B. Urine output is 20 mL/hr
- C. MgSO₄ serum levels are >15 mg/dL
- D. Respirations are >16 breaths/min

Answer: ([SHOW ANSWER](#))

(A) MgSO₄ is a central nervous system depressant. Loss of reflexes is often the first sign of developing toxicity. (B) Urinary output at <25 mL/hr or 100 mL in 4 hours may result in the accumulation of toxic levels of magnesium. (C) The therapeutic serum range for MgSO₄ is 6-8 mg/dL. Higher levels indicate toxicity. (D) Respirations of >16 breaths/min indicate that toxic levels of magnesium have not been reached. Medication administration would be safe.

NEW QUESTION: 105

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](#))

(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: 106

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

(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.

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NEW QUESTION: 107

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](#))

(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: 108

A 24-year-old male client is admitted with a diagnosis of sickle cell anemia. The nurse discusses his disease with him and emphasizes the following information:

- A. He should monitor his sputum, stools, and urine for signs of bleeding.
- B. His daily diet should include a large amount of fluid.
- C. He should not be concerned about having to fly on a commuter airplane on a weekly basis.
- D. He should not worry about having children because this disease is passed on only by female carriers.

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

Section: Questions Set E

Explanation:

(A) Bleeding is not a symptom of sickle cell anemia or sickle cell crisis. (B) Decreased blood viscosity leads to sickling of red blood cells. Increased fluid intake maintains adequate circulating blood volume and decreases the chance of sickling. (C) Hypoxia leads to sickling of cells. Flying in nonpressurized planes places the client in a situation of low O₂ tension, which can lead to sickling. (D) Male and female clients with sickle cell disease can pass the trait on to their offspring. Therefore, this client should receive genetic counseling prior to having children.

NEW QUESTION: 109

A 67-year-old client will be undergoing a coronary arteriography in the morning. Client teaching about postprocedure nursing care should include that:

- A. Bed rest with bathroom privileges will be ordered
- B. He will be kept NPO for 8-12 hours
- C. Some oozing of blood at the arterial puncture site is normal
- D. The leg used for arterial puncture should be kept straight for 8-12 hours

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Bed rest will be ordered for 8-12 hours postprocedure. Flexing of the leg at the arterial puncture site will occur if the client gets out of bed, and this is contraindicated after arteriography. (B) The client will be able to eat as soon as he is alert enough to swallow safely and that will depend on what medications are used for sedation during the procedure. (C) Oozing at the arterial puncture site is not normal and should be closely evaluated. (D) The leg where the arterial puncture occurred must be kept straight for 8-12 hours to minimize the risk of bleeding.

NEW QUESTION: 110

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)

(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: 111

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

(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: 112

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

Section: Questions Set F

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: 113

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: A (LEAVE A REPLY)

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: 114

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)

(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: 115

A group of nursing students at a local preschool day care center are going to screen each child's fine and gross motor, language, and social skills. The students will use which one of the most widely used screening tests?

A. Revised Prescreening Developmental Questionnaire

B. Goodenough Draw-a-Person Screening Test

C. Denver Development Screening Test

D. Caldwell Home Inventory

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

(A) The Revised Prescreening Developmental Questionnaire is more age appropriate and offers simplified parent scoring and easier comparison. It is used by parents instead of professionals. (B) The Goodenough Draw-a-Person test is used to assess intellectual development. (C) The Denver Developmental Screening Test is one of the most widely used screening tests. It offers a concise, easy-to-administer, systematic approach to assessing the preschool child. It is widely used because of its reliability and validity. (D) The Caldwell Home Inventory is used to assess the home environment in areas of social, emotional, and cognitive supports.

NEW QUESTION: 116

Due to his prolonged history of alcohol abuse, an alcoholic client will most likely have deficiencies of which of the following nutrients?

A. Vitamin C and zinc

B. Folic acid and niacin

C. Vitamin A and biotin

D. Thiamine and pyroxidine

Answer: ([SHOW ANSWER](#))

Explanation

(A) Chronic alcoholism can lead to deficiencies of B complex vitamins including thiamine and pyroxidine. (B) Chronic alcoholism can lead to deficiencies of vitamins A, D, K, and B complex. (C) Chronic alcoholism can lead to deficiencies of vitamins A, D, K, and B complex. (D) Vitamins A, D, K, and B require bile salts to be absorbed from the gastrointestinal tract. A damaged liver does not form bile salts.

NEW QUESTION: 117

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: ([SHOW ANSWER](#))

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: 118

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

(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: 119

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)

Explanation/Reference:

Explanation:

(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: 120

A mother who is breast-feeding her newborn asks the RN, "How can I express milk from my breasts manually?" The RN tells her that the correct method for manual milk expression includes using the thumb and the index finger to:

- A.** Alternately compress and release each nipple
- B.** Roll the nipple and gently pull the nipple forward
- C.** Slide the thumb and index finger forward from the outer border of the areola toward the end of the nipple
- D.** Compress and release each breast at the outer border of the areola

Answer: D (LEAVE A REPLY)

(A) Manipulation of nipples will cause soreness and trauma. (B) Pulling the nipples will cause discomfort and soreness. (C) Sliding the thumb and index finger forward over the nipple will cause soreness. (D) The best method to express milk from the breast is to position the thumb and index finger at the outer border of the areola and compress. This is the location of the milk sinuses.

NEW QUESTION: 121

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)

(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.

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NEW QUESTION: 122

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: 123

While the RN is assessing a mother's perineum on her 2nd postpartum day after having a vaginal delivery, the RN notes a large ecchymotic area located to the left of the mother's perineum. Which one of the following interventions should the RN initiate at this time?

- A. Have the client expose the area to air.
- B. Apply ice to the perineum.
- C. Encourage the client to take warm sitz baths.
- D. Inform the physician.

Answer: C (LEAVE A REPLY)

(A) The area is bruised and painful. This action would do nothing to help with the healing process of the perineum or to provide comfort. (B) Ice is effective immediately after birth to reduce edema and discomfort, but not on the 2nd postpartum day. (C) Sitz baths are useful if the perineum has been traumatized, because the moist heat increases circulation

to the area to promote healing, relaxes tissue, and decreases edema. (D) The physician is not notified of bruising, but if a hematoma is present, then the physician is notified.

NEW QUESTION: 124

A client's transfusion of packed red blood cells has been infusing for 2 hours. She is complaining of a raised, itchy rash and shortness of breath. She is wheezing, anxious, and very restless. The nurse knows these assessment findings are congruent with:

- A.** Hemolytic transfusion reaction
- B.** Febrile transfusion reaction
- C.** Circulatory overload
- D.** Allergic transfusion reaction

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) A hemolytic transfusion reaction would be characterized by fever, chills, chest pain, hypotension, and tachypnea. (B) Fever, chills, and headaches are indicative of a febrile transfusion reaction. (C) Circulatory overload is manifest by dyspnea, cough, and pulmonary crackles. (D) Urticaria, pruritus, wheezing, and anxiety are indicative of an allergic transfusion reaction.

NEW QUESTION: 125

Discharge teaching for the client who has a total gastrectomy should include which of the following?

- A.** Need for the client to increase fluid intake to 3000 mL/day
- B.** Follow-up visits every 3 weeks for the first 6 months
- C.** B12 injections needed for the rest of the client's life
- D.** Need to eat three full meals with plenty of fiber per day

Answer: C (LEAVE A REPLY)

(A) There will be no need to increase fluid intake excessively, because dumping syndrome could present a problem. (B) Followup visits every 3 weeks are not a standard recommendation. Follow-up visits will be highly individualized. (C) With removal of the stomach, intrinsic factor will no longer be produced. Intrinsic factor is necessary for vitamin B12 absorption. Parenteral injections of B12 will be needed on a monthly basis for the rest of the person's life. (D) Smaller, more frequent meals, rather than large, bulky meals, are recommended to prevent problems with dumping syndrome.

NEW QUESTION: 126

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

Explanation/Reference:

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: 127

When assessing residual volume in tube feeding, the feeding should be delayed if the amount of gastric contents (residual) exceeds:

- A.** 20 mL
- B.** 25 mL
- C.** 30 mL
- D.** 50 mL

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

Section: Questions Set D

Explanation:

(A) A residual volume of 20 mL is not excessive. (B) A residual volume of 25 mL is not excessive. (C) A residual volume of 30 mL is not excessive. (D) Tube feedings should be withheld and physician notified for residual volumes of 50-100 mL.

NEW QUESTION: 128

A 40-year-old client has lived for 8 years with an abusive spouse. She married her husband in her senior year of high school after becoming pregnant. Shortly after the baby was born, he began to physically abuse her. She has attempted to leave him several times, but she has always returned. She is unable to support herself financially, and her husband threatens to kill her if she leaves him. This time, her husband has beaten her so badly she cannot stop the bleeding from the gash above her eye. She admits her husband

caused her injury. In assessing a person after experiencing spousal abuse, which need has the highest priority?

- A.** Assess the level of anxiety, coping responses, and support systems.
- B.** Assess the history of physical abuse.
- C.** Assess suicide potential.
- D.** Assess drug and alcohol use.

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Assessing the level of anxiety, coping responses, and support systems is very important, but not of highest priority at this time. (B) A history of physical abuse is an important part of assessment. The nurses must also always ask if there is abuse of the children. (C) Although all of these answers are very important in assessment, the highest priority is assessment of suicide potential, because this could cause the greatest harm to the client. Feeling there is no other way out, abused spouses may consider suicide. (D) The spouse may be self-medicating herself with alcohol or drugs to escape an awful situation. The abuser may also be abusing drugs or alcohol. If this is so, the nurse should encourage the spouse to seek counseling and not to return to the home.

NEW QUESTION: 129

A 70-year-old female client is admitted to the medical intensive care unit with a diagnosis of cerebrovascular accident (CVA). She is semicomatose, responding to pain and change in position. She is unable to speak or cough. In planning her nursing care for the first 24 hours following a CVA, which nursing diagnosis should receive the highest priority?

- A.** Ineffective airway clearance related to immobility, ineffective cough, and decreased level of consciousness
- B.** Altered cerebral tissue perfusion related to pathophysiological changes that decrease blood flow
- C.** Potential for injury related to impaired mobility and seizures
- D.** Impaired verbal communication related to aphasia

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) An effective airway is necessary to prevent hypoxia and subsequent cardiac arrest. (B) Cerebral tissue perfusion is necessary to preserve remaining cerebral tissue, but this goal is secondary to maintenance of an effective airway. (C) While prevention of injury is important, it is secondary to maintaining an effective airway and cerebral tissue perfusion. (D) Impaired verbal communication is not life threatening in the acute phase of recovery. It is the lowest priority of the nursing diagnoses listed.

NEW QUESTION: 130

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)

Explanation/Reference:

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: 131

MgSO₄ blood levels are monitored and the nurse would be prepared to administer the following antidote for MgSO₄ side effects or toxicity:

- A. Magnesium oxide
- B. Calcium hydroxide
- C. Calcium gluconate
- D. Naloxone (Narcan)

Answer: C (LEAVE A REPLY)

Explanation

(A, B) These drugs are not antidotes for MgSO₄. (C) This drug is the standard antidote and should always be readily available when MgSO₄ is being administered. (D) This drug is an antidote for narcotics, not MgSO₄.

NEW QUESTION: 132

The nurse instructs a pregnant client (G2P1) to rest in a side-lying position and avoid lying flat on her back.

The nurse explains that this is to avoid "vena caval syndrome," a condition which:

- A. Occurs when blood pressure increases sharply with changes in position
- B. Results when blood flow from the extremities is blocked or slowed
- C. Is seen mainly in first pregnancies
- D. May require medication if positioning does not help

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Blood pressure changes are predominantly due to pressure of the gravid uterus. (B) Pressure of the gravid uterus on the inferior vena cava decreases blood return from lower extremities. (C) Inferior vena cava syndrome is experienced in the latter months of pregnancy regardless of parity. (D) There are no medications useful in the treatment of inferior vena cava syndrome; alleviating pressure by position changes is effective.

NEW QUESTION: 133

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: ([SHOW ANSWER](#))

(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: 134

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: ([SHOW ANSWER](#))

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: 135

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: 136

A client is medically cleared for ECT and is tentatively scheduled for six treatments over a 2-week period. Her husband asks, "Isn't that a lot?" The nurse's best response is:

- A.** "Yes, that does seem like a lot."
- B.** "You'll have to talk to the doctor about that. The physician knows what's best for the client."
- C.** "Six to 10 treatments are common. Are you concerned about permanent effects?"
- D.** "Don't worry. Some clients have lots more than that."

Answer: ([SHOW ANSWER](#))

(A) This response indicates that the nurse is unsure of herself and not knowledgeable about ECT. It also reinforces the husband's fears. (B) This response is "passing the buck" unnecessarily. The information needed to appropriately answer the husband's question is well within the nurse's knowledge base. (C) The most common range for affective disorders is 6-10 treatments. This response confirms and reinforces the physician's plan for treatment. It also opens communication with the husband to identify underlying fears and knowledge deficits. (D) This response offers false reassurance and dismisses the husband's underlying concerns about his wife.

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NEW QUESTION: 137

A client who is 7 months pregnant is diagnosed with pyelonephritis. The nurse anticipates the physician ordering:

- A. Oxytocin
- B. Magnesium sulfate (MgSO₄)
- C. Ampicillin
- D. Tetracycline

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Oxytocin is prescribed to stimulate uterine contractions. (B) MgSO₄ is a central nervous system depressant prescribed to prevent and control convulsions related to preeclampsia. (C) Ampicillin is a penicillin derivative with no known teratogenic effects. This is the safest antibiotic during pregnancy. (D) Tetracycline stains teeth yellow and is not as safe as ampicillin during pregnancy.

NEW QUESTION: 138

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 Nagele'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)

(A) Using Nagele'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: 139

A female client decides on hemodialysis. She has an internal vascular access device placed. To ensure patency of the device, the nurse must:

- A. Assess the site for leakage of blood or fluids
- B. Auscultate the site for a bruit
- C. Assess the site for bruising or hematoma
- D. Inspect the site for color, warmth, and sensation

Answer: ([SHOW ANSWER](#))

(A) This is an internal device. Assessment of the site should include assessing for swelling, pain, warmth, and discoloration. This measure does not assess patency. (B) The presence of a bruit indicates good blood flow through the device. (C) The nurse should inspect the site for bruising or hematoma; however, this measure does not assure patency of the device. (D) The nurse should inspect the vascular access site frequently for signs of infection. However, this does not assure patency.

NEW QUESTION: 140

A female client is concerned that she is in a "high-risk" group for the development of acquired immunodeficiency syndrome (AIDS). She wants to know about the advisability of donating blood. Which of the following responses is correct?

- A. "Individuals who donate blood are at risk of getting the AIDS virus. You should not donate."
- B. "It's OK for you to donate because the blood bank has a test that is 100% effective."
- C. "You should not donate since it takes time to develop antibodies to the AIDS virus. If you donate blood before you develop the antibody, you could pass it on in the blood."
- D. "It is not a good idea for you to donate. If you have AIDS, the information is made public and could destroy your personal life."

Answer: ([SHOW ANSWER](#))

Explanation

(A) The AIDS virus cannot be transmitted to the donor through the blood donation procedure. (B) The test for the AIDS virus is not absolutely foolproof; therefore, it is not wise for a person with known risk factors to donate blood. (C) It takes time for antibodies to the AIDS virus to develop. An infected individual could donate contaminated blood without it testing positive for the virus. (D) For reasons of confidentiality, information about individuals infected with AIDS is not made public.

NEW QUESTION: 141

A 4-week-old infant is admitted to the emergency room in respiratory distress. Which of the following statements indicates the nurse's knowledge of the anatomy of the respiratory system in pediatric clients?

- A. The diameter of the trachea is much smaller in children than in adults.
- B. The tongue is proportionally smaller in children than in adults.
- C. The pediatric airway is more rigid than that of the adults.

D. The length of the pediatric airway is longer in children than in adults.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) The airway in children is much smaller than it is in adults. The diameter of the trachea in the newborn is

4 mm and that of the adult is 20 mm. A small change in the diameter of the airway can make a major difference in the pediatric client. (B) The tongue is proportionally larger in children and fills most of the oral cavity, thereby decreasing air space. (C) The entire pediatric airway is elastic. Elasticity diminishes with age, however. (D) The distances between respiratory structures are shorter than that of adults, and therefore organisms are able to move more rapidly down the throat, leading to more extensive respiratory involvement.

NEW QUESTION: 142

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](#))

Explanation

(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: 143

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](#))

(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: 144

A male client is experiencing extreme distress. He begins to pace up and down the corridor. What nursing intervention is appropriate when communicating with the pacing client?

- A.** Ask him to sit down. Speak slowly and use short, simple sentences.
- B.** Help him to recognize his anxiety.
- C.** Walk with him as he paces.
- D.** Increase the level of his supervision.

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

Explanation

(A) The nurse should not ask him to sit down. Pacing is the activity he has chosen to deal with his anxiety. The nurse dealing with this client should speak slowly and with short, simple sentences. (B) The client may already recognize the anxiety and is attempting to deal with it. (C) Walk with the client as he paces. This gives support while he uses anxiety-generated energy. (D) Increasing the level of supervision may be appropriate after he stops pacing. It would minimize self-injury and/or loss of control.

NEW QUESTION: 145

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: (SHOW ANSWER)

(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: 146

Which of the following lab data is representative of a client with aplastic anemia?

- A. Hemoglobin 9.2, hematocrit 27, red blood cells 3.2 million
- B. White blood cells 4000, erythrocytes 2.5 million, thrombocytes 100,000
- C. White blood cells 3000, hematocrit 27, red blood cells 2.8 million
- D. Red blood cells 1 million, white blood cells 1500, thrombocytes 16,000

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

Explanation

(A, B, C) Although all of the lab data are abnormal and although these values are decreased in aplastic anemia, the disorder is defined by severe deficits in red cell, white cell, and platelet counts. (D) Aplastic anemia is typically defined in terms of abnormalities of red blood cell count, usually <1 million, white cell count <2,000, and thrombocytes <20,000.

NEW QUESTION: 147

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](#))

Explanation/Reference:

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: 148

The parents of a 9-year-old child with acute lymphocytic leukemia expressed concern about his alopecia from cranial irradiation. The nurse explains that:

- A. Alopecia is an unavoidable side effect.
- B. There are several wig makers for children.
- C. Most children select a favorite hat to protect their heads.
- D. His hair will grow back in a few months.

Answer: ([SHOW ANSWER](#))

(A)

Alopecia has occurred, and knowing it is a side effect does not address their concern.

(B)

Although true, it does not give them hope for the future. (C) Although true, it does not provide them with information of the temporary nature of the situation. (D) Knowing the hair will grow back provides comfort that the alopecia is temporary.

NEW QUESTION: 149

A mother called the physician's office to ask if it would help relieve her small daughter's abdominal pain if she gave an enema and placed a heating pad on the abdomen. Her daughter has a fever and has vomited twice.

The nurse's response is based on the knowledge that:

- A.** The symptoms could easily have been caused by constipation, which an enema would relieve
- B.** Heat would help to relax the abdominal muscles and relieve her pain
- C.** Both heat and enemas stimulate intestinal motility and could increase the risk of perforation
- D.** Complaints of stomach ache are common in young children and are generally best ignored

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

Explanation

(A) Constipation does not cause fever or vomiting but may cause anorexia. Risk of perforation outweighs the possible benefits of an enema. (B) Heat will not relieve her symptoms but will increase intestinal motility and increase the risk of perforation. (C) Heat and enemas are contraindicated where severe abdominal pain is suspected because they increase intestinal motility and the risk of perforation. (D) Complaints accompanied by physical symptoms such as pain, anorexia, and fever should never be ignored.

NEW QUESTION: 150

Painless vaginal bleeding in the last trimester may be caused by:

- A.** Menstruation
- B.** Abruptio placentae
- C.** Placenta previa
- D.** Polyhydramnios

Answer: ([SHOW ANSWER](#))

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: 151

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.

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NEW QUESTION: 152

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: A (LEAVE A REPLY)

Section: Questions Set E

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: 153

A female client is concerned that she is in a "high-risk" group for the development of acquired immunodeficiency syndrome (AIDS). She wants to know about the advisability of donating blood. Which of the following responses is correct?

- A.** "Individuals who donate blood are at risk of getting the AIDS virus. You should not donate."
- B.** "It's OK for you to donate because the blood bank has a test that is 100% effective."
- C.** "You should not donate since it takes time to develop antibodies to the AIDS virus. If you donate blood before you develop the antibody, you could pass it on in the blood."
- D.** "It is not a good idea for you to donate. If you have AIDS, the information is made public and could destroy your personal life."

Answer: C (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) The AIDS virus cannot be transmitted to the donor through the blood donation procedure. (B) The test for the AIDS virus is not absolutely foolproof; therefore, it is not wise for a person with known risk factors to donate blood. (C) It takes time for antibodies to the AIDS virus to develop. An infected individual could donate contaminated blood without it testing positive for the virus. (D) For reasons of confidentiality, information about individuals infected with AIDS is not made public.

NEW QUESTION: 154

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: 155

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: 156

A 17-year-old pregnant client who is gravida 1, para 0, is at 36 weeks' gestation. Based on the nurse's knowledge of the maternal physiological changes in pregnancy, which of these findings would be of concern?

A. Complaints of dyspnea

B. Edema of face and hands

C. Pulse of 65 bpm at 8 weeks, 73 bpm at 36 weeks

D. Hematocrit 39%

Answer: B (LEAVE A REPLY)

(A) Dyspnea is a common complaint during the third trimester owing to the increasing size of the uterus and the resulting pressure against the diaphragm. (B) Edema of the face, hands, or pitting edema after 12 hours of bed rest may be indicative of preeclampsia and would be of great concern to the healthcare provider. (C) An increase in heart rate of 10-15 bpm is a normal physiological change in pregnancy due to the multiple hemodynamic changes. (D) A hematocrit value of 39% is within the normal range. A value <35% would indicate anemia.

NEW QUESTION: 157

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](#))

(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: 158

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: ([SHOW ANSWER](#))

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: 159

Which of the following risk factors associated with breast cancer would a nurse consider most significant in a client's history?

- A. Menarche after age 13
- B. Nulliparity
- C. Maternal family history of breast cancer
- D. Early menopause

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

Explanation

(A) Women who begin menarche late (after 13 years old) have a lower risk of developing breast cancer than women who have begun earlier. Average age for menarche is 12.5 years. (B) Women who have never been pregnant have an increased risk for breast cancer, but a positive family history poses an even greater risk. (C) A positive family history puts a woman at an increased risk of developing breast cancer. It is recommended that mammography screening begin 5 years before the age at which an immediate female

relative was diagnosed with breast cancer. (D) Early menopause decreases the risk of developing breast cancer.

NEW QUESTION: 160

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

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: 161

A client is having an amniocentesis. Prior to the procedure, an ultrasound is performed. In preparing the client, the nurse explains the reason for a sonogram in this situation to be:

- A.** Determination of multiple gestations
- B.** Determination of gross anomalies
- C.** Determination of placental location
- D.** Determination of fetal age

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

Section: Questions Set F

Explanation:

(A) Sonography can be used to determine the presence of multiple gestation. In this question, the sonogram is used as a preparatory step for a specific invasive procedure. (B) Sonography can be used to determine the presence of gross anomalies. In this question, the sonogram is used as a preparatory step for a specific invasive procedure. (C) Prior to amniocentesis, the abdomen is scanned by ultrasound to locate the placenta, thus reducing the possibility of penetrating it with the spinal needle used to obtain amniotic fluid. (D) Sonography can be used to determine fetal age. In this question, the sonogram is used as a preparatory step for a specific invasive procedure.

NEW QUESTION: 162

Four days after admission for cirrhosis of the liver, the nurse observes the following when assessing a male client: increased irritability, asterixis, and changes in his speech pattern. Which of the following foods would be appropriate for his bedtime snack?

- A. Fresh fruit
- B. A milkshake
- C. Saltine crackers and peanut butter
- D. A ham and cheese sandwich

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

(A) High levels of ammonia, a by-product of protein metabolism, can precipitate metabolic encephalopathy. These clients need a diet high in carbohydrates and bulk. (B) Metabolic encephalopathy of the brain associated with liver failure is precipitated by elevated ammonia levels. Ammonia is a by-product of protein metabolism. (C, D) Metabolic encephalopathy in liver failure is precipitated by elevated ammonia levels. Ammonia is a by-product of protein metabolism.

NEW QUESTION: 163

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](#))

Explanation

(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: 164

A 1-year-old child is to receive an IM injection ordered by his pediatrician. He has fallen asleep in his mother's arms when the nurse approaches. Which approach is most appropriate at this time?

- A. Give the injection in the vastus lateralis site before the child awakens.
- B. Awaken the child first and give the injection in the ventrogluteal site.
- C. Awaken the child first and give the injection in the dorsogluteal site.
- D. Ask the mother to place the child on the examination table and leave the room, and then give the injection in an appropriate site.

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

Explanation/Reference:

Explanation:

(A) If awakened first, the child will know that nothing painful will be done without the child being alerted. (B) The ventrogluteal site is a safe site for children because it is a large muscle free of major nerves and blood vessels. (C) The dorsogluteal site is not recommended in children who have not been walking for at least 1 year because the muscle is not fully developed. (D) The parent will be able to offer support and comfort during and after the injection.

NEW QUESTION: 165

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: 166

A client's prenatal screening indicated that she has no immunity to rubella. She is now 10 weeks pregnant. The best time to immunize her is:

- A. In the immediate postpartum period
- B. After the first trimester
- C. At 28 weeks' gestation
- D. Within 72 hours postpartum

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

Explanation

(A) The rubella vaccine is made with attenuated virus and is given in the immediate postpartal period to prevent infection during pregnancy and subsequent adverse fetal and neonatal sequelae. Mothers are advised to prevent pregnancy for 3 months following immunization. (B) Rubella infection during the second trimester may result in permanent hearing loss for the fetus. (C) RhoGam is the drug generally administered at 28 weeks' gestation to Rh-negative women. It is contraindicated to administer rubella vaccine during pregnancy.

(D) RhoGam is the drug administered within 72 hours postpartum to Rh-negative women to prevent the development of antibodies to fetal cells.

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NEW QUESTION: 167

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)

Explanation/Reference:

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: 168

A 33-year-old client is diagnosed with bipolar disorder, acute phase. This is her first psychiatric hospitalization, and she is being evaluated for treatment with lithium. Which of the following diagnostic tests are essential prior to the initiation of lithium therapy with this client?

- A. Hematocrit, hemoglobin, and white blood cell (WBC) count
- B. Blood urea nitrogen, electrolytes, and creatinine
- C. Glucose, glucose tolerance test, and random blood sugar
- D. X-rays, electroencephalogram, and electrocardiogram(ECG)

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

Explanation/Reference:

Explanation:

(A) These are general diagnostic blood studies (usually done on admission), but they are not reliable indicators of lithium therapy clearance. (B) These are the primary diagnostic tests to determine kidney functioning. Because lithium is excreted through the kidneys and because it can be very toxic, adequate renal function must be ascertained before therapy begins. (C) These are diagnostic blood tests used to determine the presence of endocrine (not renal) dysfunction. (D) These are other types of diagnostic procedures used to determine musculoskeletal, neural, and cardiac (rather than renal) functioning.

NEW QUESTION: 169

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: ([SHOW ANSWER](#))

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: 170

A client has been diagnosed as being preeclamptic. The physician orders magnesium sulfate. Magnesium sulfate (MgSO₄) is used in the management of preeclampsia for:

- A. Prevention of seizures

- B. Prevention of uterine contractions
- C. Sedation
- D. Fetal lung protection

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

Explanation

(A) MgSO₄ is classified as an anticonvulsant drug. In preeclampsia management, MgSO₄ is used for prevention of seizures. (B) MgSO₄ has been used to inhibit hyperactive labor, but results are questionable. (C) Negative side effects such as respiratory depression should not be confused with generalized sedation. (D) MgSO₄ does not affect lung maturity. The infant should be assessed for neuromuscular and respiratory depression.

NEW QUESTION: 171

A postpartum client complains of rectal pressure and severe pain in her perineum; this may be indicative of:

- A. Afterbirth pains
- B. Constipation
- C. Cystitis
- D. A hematoma of the vagina or vulva

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

Explanation/Reference:

Explanation:

(A) Afterbirth pains are a common complaint in the postpartum client, but they are located in the uterus. (B) Constipation may cause rectal pressure but is not usually associated with "severe pain." (C) Cystitis may cause pain, but the location is different. (D) Hematomas are frequently associated with severe pain and pressure. Further assessments are indicated for this client.

NEW QUESTION: 172

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](#))

Explanation

(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: 173

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](#))

Explanation

(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: 174

Cystic fibrosis is transmitted as an autosomal recessive trait. This means that:

- A. Mothers carry the gene and pass it to their sons
- B. Fathers carry the gene and pass it to their daughters
- C. Both parents must have the disease for a child to have the disease
- D. Both parents must be carriers for a child to have the disease

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

(A) Cystic fibrosis is not an X-linked or sex-linked disease. (B) The only characteristic on the Y chromosome is the trait for hairy ears. (C) Both parents do not need to have the disease but must be carriers. (D) If a trait is recessive, two genes (one from each parent) are necessary to produce an affected child.

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](#))

Explanation/Reference:

Explanation:

(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 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: D (LEAVE A REPLY)

(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.

NEW QUESTION: 177

A 70-year-old homeless woman is admitted with pneumonia. She is weak, emaciated, and febrile. The physician orders enteral feedings intermittently by nasogastric tube. When inserting the nasogastric tube, once the tube passes through the oropharynx, the nurse will instruct the client to:

- A. Tilt her head backwards
- B. Swallow as tube passes
- C. Hold breath as tube passes
- D. Cough as tube passes

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Head should be tilted slightly forward to facilitate insertion. (B) Swallowing assists with insertion of tube and closes off airway. (C) Client should be swallowing as tube passes; holding the breath facilitates nothing. (D) Coughing may expel tube.

NEW QUESTION: 178

The nurse explains perineal hygiene self-care postpartum to the client. She should be instructed to:

- A. Wear gloves for the procedure
- B. Place and adjust the pad from back to front
- C. Cleanse and wipe the perineum from front to back
- D. Protect the outer surface of the pad from contamination

Answer: C (LEAVE A REPLY)

Explanation

(A) Perineal hygiene is a clean procedure and does not require the client to wear gloves. A care provider should wear gloves to adhere to universal precautions. (B) The pad should be applied from front to back to prevent contamination of the birth canal or urinary tract from rectal bacteria. (C) Wiping from front to back and discarding the wipe prevents contamination of the urinary tract and birth canal from rectal bacteria. (D) The inner surface of the pad should not be touched to maintain asepsis.

NEW QUESTION: 179

A psychiatric client has been stabilized and is to be discharged. The nurse will recognize client insight and behavioral change by which of the following client statements?

- A. "When I get home, I will need to take my medicines and call my therapist if I have any side effects or begin to hear voices."
- B. "If I have any side effects from my medicines, I will take an extra dose of Cogentin."
- C. "When I get home, I should be able to taper myself off the Haldol because the voices are gone now."
- D. "As soon as I leave here, I'm throwing away my medicines. I never thought I needed them anyway."

Answer: A (LEAVE A REPLY)

(A)

The client verbalizes that he is responsible for compliance and keeping the treatment team member informed of progress. This behavior puts him at the lowest risk for relapse.

(B)

Noncompliance is a major cause of relapse. This statement reflects lack of responsibility for his own health maintenance. (C) This statement reflects lack of insight into the importance of compliance. (D) This statement reflects no insight into his illness or his responsibility in health maintenance.

NEW QUESTION: 180

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)

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: 181

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

(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.

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NEW QUESTION: 182

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)

(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: 183

A 14-year-old teenager is demonstrating behavior indicative of an obsessive-compulsive disorder. She is obsessed with her appearance. She will not leave her room until her hair, clothes, and makeup are perfect. She always dresses immaculately. Recently, she expressed disgust over her appearance after she gained 5 lb. After observing a marked weight loss over a 2-week period, her mother suspects that she is experiencing bulimia. She eats everything on her plate, then runs to the bathroom. In interviewing the teenager, she discusses in great detail all of the events leading to her bulimia, but not her feelings. What defense mechanism is she using?

A. Dissociation

B. Intellectualization

C. Rationalization

D. Displacement

Answer: B (LEAVE A REPLY)

(A) Dissociation is separating a group of mental processes from consciousness or identity, such as multiple personalities. That is not evident in this situation. (B) Intellectualization is excessive use of reasoning, logic, or words usually without experiencing associated feelings. This is the defense mechanism that this client is using. (C) Rationalization is giving a socially acceptable reason for behavior rather than the actual reason. She is discussing events, not reasons. (D) Displacement is a shift of emotion associated with an anxiety-producing person, object, or situation to a less threatening object.

NEW QUESTION: 184

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)

(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: 185

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](#))

Section: Questions Set D

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: 186

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)

Section: Questions Set C

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: 187

Nursing interventions designed to decrease the risk of infection in a client with an indwelling catheter include:

- A.** Cleanse area around the meatus twice a day
- B.** Empty the catheter drainage bag at least daily
- C.** Change the catheter tubing and bag every 48 hours
- D.** Maintain fluid intake of 1200-1500 mL every day

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Catheter site care is to be done at least twice daily to prevent pathogen growth at the catheter insertion site. (B) Catheter drainage bags are usually emptied every 8 hours to prevent urine stasis and pathogen growth. (C) Tubing and collection bags are not changed this often, because research studies have not demonstrated the efficacy of this practice. (D) Fluid intake needs to be in the 2000-2500 mL range if possible to help irrigate the bladder and prevent infection.

NEW QUESTION: 188

A 14-year-old client has a history of lying, stealing, and destruction of property. Personal items of peers have been found missing. After group therapy, a peer approaches the nurse to report that he has seen the 14-year-old with some of the missing items. The best response of the nurse is to:

- A.** Request that he explain to the group why he took personal items from peers
- B.** Approach him when he is alone to inquire about his involvement in the incident
- C.** Imply to him that you doubt his involvement in the incident and request his denial
- D.** Confront him openly in group and request an apology

Answer: B (LEAVE A REPLY)

(A) This answer is incorrect. There is no proof that he removed the missing items. (B) This answer is correct. Anxiety and defensiveness are lessened if the individual is approached in this manner. (C) This answer is incorrect. It is difficult for one to admit to wrongdoing with this approach. (D) This answer is incorrect. He has not yet been proved guilty. Confrontation will only increase defensiveness and anxiety.

NEW QUESTION: 189

A 3-year-old child is admitted with a diagnosis of possible noncommunicating hydrocephalus. What is the first symptom that indicates increased intracranial pressure?

- A. Bulging fontanelles
- B. Seizure
- C. Headache
- D. Ataxia

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

Explanation

(A) Bulging fontanelles are a symptom of increased intracranial pressure in infants. (B) Seizure is a late sign of increased intracranial pressure. (C) Headache is a very early symptom of increased intracranial pressure in the child. (D) Ataxia is a late sign of increased intracranial pressure.

NEW QUESTION: 190

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: 191

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: (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: 192

A client had a renal transplant 3 months ago. He has suddenly developed graft tenderness, an increased white blood cell count, and malaise. The client is experiencing which type of rejection?

- A.** Acute
- B.** Chronic
- C.** Hyperacute
- D.** Hyperchronic

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

Explanation

(A) The sudden development of fever, graft tenderness, increased white blood count, and malaise are signs and symptoms of an acute rejection that commonly occurs at 3 months. (B) Chronic rejection occurs slowly over a period of months to years and mimics chronic renal failure. (C) Hyperacute rejection occurs immediately after surgery up to 48 hours postoperatively. (D) Hyperchronic rejection is not a type of rejection.

NEW QUESTION: 193

The family member of a child scheduled for heart surgery states, "I just don't understand this open-heart or closed-heart business. I'm so confused! Can you help me understand it?" The nurse explains that patent ductus arteriosus repair is:

- A.** Open-heart surgery. The child will be placed on a heart-lung machine while the surgery is being performed.
- B.** Closed-heart surgery. It does not require that the child be placed on the heart-lung machine while the surgery is being performed.
- C.** A pediatric version of the coronary artery bypass graft surgery performed on adults. It is an open-heart surgery.
- D.** A pediatric version of percutaneous transluminal coronary angioplasty performed on adults. It is a closed-heart surgery.

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

Explanation

(A) Patent ductus arteriosus repair is a closed-heart procedure. The client is not placed on a heart-lung machine. (B) Patent ductus arteriosus is a ductus arteriosus that does not close shortly after birth but remains patent. Repair is a closed-heart procedure involving ligation of the patent ductus arteriosus. (C) Coronary artery bypass graft surgery is an open-heart surgical procedure in which blocked coronary arteries are bypassed using vessel grafts. (D) Percutaneous transluminal coronary angioplasty is a closed heart

procedure that improves coronary blood flow by increasing the lumen size of narrowed vessels.

NEW QUESTION: 194

A 14-year-old boy fell off his bike while "popping a wheelie" on the dirt trails. He has sustained a head injury with laceration of his scalp over his temporal lobe. If he were to complain of headache during the first 24 hours of his hospitalization, the nurse would:

- A.** Ask the physician to order a sedative
- B.** Have the client describe his headache every 15 minutes
- C.** Increase his fluid intake to 3000 mL/24 hr
- D.** Offer diversionary activities

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

(A) CNS depressants are not given for headache due to head injury because they would mask changes in neurological status and because they could further depress the CNS. (B) The client should not be asked to think about his headache every 15 minutes. (C) Fluid intake should be normal or restricted for a client with a head injury. Normal fluid intake for a 14 year old is about 2000-2400 mL daily. (D) Diversion may help the child to focus on a pleasant activity instead of on his headache.

NEW QUESTION: 195

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 \(LEAVE A REPLY\)](#)

Explanation/Reference:

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: 196

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)

Explanation/Reference:

Explanation:

(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.

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NEW QUESTION: 197

The physician orders medication for a client's unpleasant side effects from the haloperidol. The most appropriate drug at this time is:

- A. Lorazepam
- B. Triazolam (Halcion)
- C. Benztropine
- D. Thiothixene

Answer: (SHOW ANSWER)

(A) Lorazepam is a benzodiazepine, or antianxiety agent, that potentiates the effects of γ -aminobutyric acid in the CNS, which is not the CNS neurotransmitter EPS. (B) Triazolam is a benzodiazepine sedative-hypnotic whose action is mediated in the limbic, thalamic, and hypothalamic levels of the CNS by γ -aminobutyric acid. (C) Benztropine is an anticholinergic agent, and the drug of choice for blocking CNS synaptic response, which causes EPS. (D) Thiothixene is an antipsychotic and neuroleptic drug that blocks dopamine neurotransmission at the CNS synapses, thereby causing EPS.

NEW QUESTION: 198

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: (SHOW ANSWER)

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: 199

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: B (LEAVE A REPLY)

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: 200

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)

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: 201

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)

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Explanation:

(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: 202

A behavioral modification program is recommended by the multidisciplinary team working with a 15-year-old client with anorexia nervosa. A nursing plan of care based on this modality would include:

- A.** Role playing the client's eating behaviors
- B.** Restriction to the unit until she has gained 2 lb
- C.** Encouraging her to verbalize her feelings concerning food and food intake
- D.** Provision for a high-calorie, high-protein snack between meals

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This answer is incorrect. Role playing is based on learning but is not based on the behavioral modification model. (B) This answer is correct. The behavioral modification model is based on negative and positive reinforcers to change behavior. (C) This answer is incorrect. Verbal catharsis is not an intervention based on behavioral modification. (D) This answer is incorrect. Although an acceptable nursing intervention, it is not based on behavioral modification.

NEW QUESTION: 203

Which of the following would have the physiological effect of decreasing intracranial pressure (ICP)?

- A.** Increased core body temperature
- B.** Decreased serum osmolality
- C.** Administration of hypo-osmolar fluids
- D.** Decreased PaCO₂

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) An increase in core body temperature increases metabolism and results in an increase in ICP. (B) Decreased serum osmolality indicates a fluid overload and may result in an increase in ICP. (C) Hypo- osmolar fluids are generally voided in the neurologically compromised. Using IV fluids such as D5W results in the dextrose being metabolized, releasing free water that is absorbed by the brain cells, leading to cerebral edema. (D) Hypercapnia and hypoventilation, which cause retention of CO₂ and lead to respiratory acidosis, both increase ICP. CO₂ is the most potent vasodilator known.

NEW QUESTION: 204

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)

Explanation

(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: 205

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)

(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: 206

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 2-4 minute intervals
- D.** Question the order

Answer: D (LEAVE A REPLY)

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 a dysfunctional labor pattern that may be caused by CPD. Oxytocin administration is contraindicated in CPD.

NEW QUESTION: 207

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](#))

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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: 208

The physician recommends immediate hospital admission for a client with PIH. She says to the nurse, "It's not so easy for me to just go right to the hospital like that." After acknowledging her feelings, which of these approaches by the nurse would probably be best?

- A. Stress to the client that her husband would want her to do what is best for her health.
- B. Explore with the client her perceptions of why she is unable to go to the hospital.
- C. Repeat the physician's reasons for advising immediate hospitalization.
- D. Explain to the client that she is ultimately responsible for her own welfare and that of her baby.

Answer: ([SHOW ANSWER](#))

Explanation

(A) This answer does not hold the client accountable for her own health. (B) The nurse should explore potential reasons for the client's anxiety: are there small children at home, is the husband out of town? The nurse should aid the client in seeking support or interventions to decrease the anxiety of hospitalization. (C) Repeating the physician's reason for recommending hospitalization may not aid the client in dealing with her reasons for anxiety. (D) The concern for self and welfare of baby may be secondary to a woman who is in a crisis situation. The nurse should explore the client's potential reasons for anxiety. For example, is there another child in the home who is ill, or is there a husband who is overseas and not able to return on short notice?

NEW QUESTION: 209

A 30-year-old client in the third trimester of her pregnancy asks the nurse for advice about upper respiratory discomforts. She complains of nasal stuffiness and epistaxis, most noticeable on the left side.

Which reply by the nurse is correct?

- A.** "It sounds as though you are coming down with a bad cold. I'll ask the doctor to prescribe a decongestant for relief of symptoms."
- B.** "A good vaporizer will help; avoid the cool air kind. Also, try saline nose drops, and spend less time on your left side."
- C.** "These discomforts are all a result of increased blood supply; one of the pregnancy hormones, estrogen, causes them."
- D.** "This is most unusual. I'm sure your obstetrician will want you to see an ENT (ear, nose, throat) specialist."

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Decongestants may exaggerate the nasal stuffiness associated with pregnancy. Judicious use of decongestants and nasal sprays is advocated during pregnancy. (B) Cool air vaporizers and saline drops may help to relieve the nasal stuffiness. Positioning on either lateral side does not decrease nasal stuffiness or prevent epistaxis. (C) Increased estrogen levels result in nasal mucosa edema with subsequent nasal stuffiness. Estrogen also promotes vasodilation, which contributes to epistaxis. The nurse may recommend cool air vaporizers and saline drops to help with the nasal stuffiness. (D) Increased estrogen levels result in nasal mucosa edema with subsequent nasal stuffiness. Estrogen also promotes vasodilation discomforts associated with pregnancy.

NEW QUESTION: 210

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)

(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: 211

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.

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NEW QUESTION: 212

A child becomes neutropenic and is placed on protective isolation. The purpose of protective isolation is to:

- A. Protect the child from infection
- B. Provide the child with privacy
- C. Protect the family from curious visitors
- D. Isolate the child from other clients and the nursing staff

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) The child no longer has normal white blood cells and is extremely susceptible to infection. (B) There are more appropriate ways to provide privacy, and there is no need to protect the child from healthy visitors. (C) Visitors and visiting hours may be at the client's and/or family's request without regard to the isolation precaution. (D) The child may have

strong positive relationships with other clients or staff. As long as proper precautions are observed, there is no reason to isolate her from them.

NEW QUESTION: 213

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: C (LEAVE A REPLY)

Explanation/Reference:

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: 214

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)

Explanation/Reference:

Explanation:

(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: 215

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

Explanation

(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: 216

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/Reference:

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: 217

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 \(LEAVE A REPLY\)](#)

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: 218

A 3-year-old child is hospitalized with burns covering her trunk and lower extremities. Which of the following would the nurse use to assess adequacy of fluid resuscitation in the burned child?

- A. Blood pressure
- B. Serum potassium level
- C. Urine output
- D. Pulse rate

Answer: C (LEAVE A REPLY)

(A) Blood pressure can remain normotensive even in a state of hypovolemia. (B) Serum potassium is not reliable for determining adequacy of fluid resuscitation. (C) Urine output, alteration in sensorium, and capillary refill are the most reliable indicators for assessing adequacy of fluid resuscitation. (D) Pulse rate may vary for many reasons and is not a reliable indicator for assessing adequacy of fluid resuscitation.

NEW QUESTION: 219

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: 220

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: 221

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)

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: 222

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)

(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: 223

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: (SHOW ANSWER)

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: 224

A 33-year-old client was brought into the emergency room unconscious, and it is determined that surgery is needed. Informed consent must be obtained from his next of kin.

The sequence in which the next of kin would be asked for the consent would be:

- A. Parent, spouse, adult child, sibling
- B. Spouse, adult child, parent, sibling
- C. Spouse, parent, sibling, adult child
- D. Parent, spouse, sibling, adult child

Answer: B (LEAVE A REPLY)

(A) Spouse and adult child would be asked before a parent. (B) The order of kin relationship for an adult, as determined from legal intestate succession, is usually spouse,

adult child, parent, sibling. (C) Parent and sibling would be asked after adult child. (D) Spouse and adult child would be asked before parent. Sibling would be asked last.

NEW QUESTION: 225

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

Explanation/Reference:

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: 226

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.

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NEW QUESTION: 227

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: (SHOW ANSWER)

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: 228

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

(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: 229

A client is pleased about being pregnant, yet states, "It is really not the best time, but I guess it will be OK." The nurse's assessment of this response is:

- A. Initial maternal-infant bonding may be poor.
- B. Client may have a poor relationship with her husband.
- C. This response is normal in the first trimester.
- D. This response is abnormal, to be re-evaluated at the next visit.

Answer: C (LEAVE A REPLY)

Explanation

(A) Ambivalence is normal during the first trimester. Reva Rubin addresses the issue of "not now" in the first trimester. The statement still leaves room for exploration. (B) There are no data to support this. This statement by the mother still leaves room for exploration. (C) Ambivalence is normal during the first trimester. Reva Rubin addresses the issue of "not now." This fact should be shared with the mother during further exploration of the comment. (D) It is not abnormal. If it were, another month would also be too long to wait.

NEW QUESTION: 230

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: 231

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)

(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: 232

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)

Section: Questions Set B

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: 233

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)

(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: 234

Pin care is a part of the care plan for a client who is in skeletal traction. When assessing the site of pin insertion, which one of the following findings would the nurse know as an indicator of normal wound healing?

- A. Exudate
- B. Crust
- C. Edema
- D. Erythema

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Exudate (moist, active drainage) is a clinical sign of wound infection. (B) Crust (dry, scaly) is part of the normal stages of wound healing and should not be removed from around the pin site. It usually sloughs off after the underlying tissue has healed. (C) Edema (swelling) is a clinical sign of wound infection. (D) Erythema (redness) is a clinical sign of wound infection.

NEW QUESTION: 235

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: D (LEAVE A REPLY)

Explanation/Reference:

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: 236

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 renal 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: 237

A couple is planning the conception of their first child.

The wife, whose normal menstrual cycle is 34 days in length, correctly identifies the time that she is most likely to ovulate if she states that ovulation should occur on day:

A. 14+2 days

B. 16+2 days

C. 20+2 days

D. 22+2 days

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Ovulation is dependent on average length of menstrual cycle, not standard 14 days. (B) Ovulation occurs 14+2 days before next menses (34 minus 14 does not equal 16). (C) Ovulation occurs 14+2 days before next menses (34 minus 14 equals 20). (D) Ovulation occurs 14+2 days before next menses (34 minus 14 does not equal 22).

NEW QUESTION: 238

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: A (LEAVE A REPLY)

(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: 239

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: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(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: 240

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 the etiology?

- A. Hypernatremia
- B. Hypocalcemia
- C. Hypokalemia
- D. Hypomagnesemia

Answer: (SHOW ANSWER)

(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: 241

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)

(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.

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NEW QUESTION: 242

In admitting a client to the psychiatric unit, the nurse must explain the rules and regulations of the unit. A client with antisocial personality disorder makes the following remark, "Forget

all those rules. I always get along well with the nurses." Which nursing response to him would be most effective?

- A. "OK, don't listen to the rules. See where you end up."
- B. "I'm pleased that you get along so well with the staff. You must still know and abide by the rules."
- C. "It is irrelevant whether you get along with the nurses."
- D. "I'm not the other nurses. You better read the rules yourself."

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

Explanation

(A) This answer is incorrect. A nurse should be an appropriate role model. Threats are not appropriate. No limit setting was stated. (B) This answer is correct. The nurse made a positive statement followed by a simple, clear, concise setting of limits. (C) This answer is incorrect. It appears to have a negative connotation. There was no limit setting. (D) This answer is incorrect. The nurse obviously responded in a negative manner.

Learning takes place more readily when one is accepted, not rejected. No limits were set.

NEW QUESTION: 243

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](#))

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: 244

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

- A. O₂ content of the blood
- B. Oxygen saturation of arterial blood
- C. PO₂
- D. Affinity of hemoglobin for O₂

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

Explanation

(A) The O₂ content of whole blood is determined by the partial pressure of oxygen (PO₂) and the oxygen saturation. The pulse oximeter does not measure the PO₂. (B) The pulse oximeter is a noninvasive method of measuring the arterial oxygen saturation. (C) The PO₂ is the amount of O₂ dissolved in plasma, which the pulse oximeter does not measure. (D) The affinity of hemoglobin for O₂ is the relationship between oxygen saturation and PO₂ and is not measured by the pulse oximeter.

NEW QUESTION: 245

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](#))

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: 246

During the assessment, the nurse observes a client scratching his skin. He has been admitted to rule out Laennec's cirrhosis of the liver. The nurse knows the pruritus is directly related to:

- A. A loss of phagocytic activity
- B. Faulty processing of bilirubin
- C. Enhanced detoxification of drugs
- D. The formation of collateral circulation

Answer: ([SHOW ANSWER](#))

Explanation

(A) A loss in the phagocytic activity of the Kupffer cells occurs with cirrhosis of the liver, which increases the susceptibility to infections. (B) The faulty processing of bilirubin produces bilesalts, which are irritating to the skin. (C) The detoxification of drugs is impaired with cirrhosis of the liver. (D) Collateral circulation develops due to portal

hypertension. This is manifest through the development of esophageal varices, hemorrhoids, and caput medusae.

NEW QUESTION: 247

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: (SHOW ANSWER)

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: 248

Which of the following symptoms might the nurse observe in a client with a lithium blood level over 2.0?

- A. Fine hand tremor, headache, mental dullness
- B. Vomiting, impaired consciousness, decreased blood pressure
- C. Polyuria, polydipsia, edema
- D. Gastric irritation, nausea, diarrhea

Answer: B (LEAVE A REPLY)

(A)

These symptoms are acute, common, and usually harmless central nervous system side effects of lithium. (B) These symptoms of lithium toxicity are usually dose related. (C)

These symptoms are acute, common, and usually harmless renal side effects of lithium.

(D)

These symptoms are acute, common, and usually harmless gastrointestinal side effects of lithium.

NEW QUESTION: 249

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

Explanation/Reference:

Explanation:

(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: 250

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](#))

Section: Questions Set D

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: 251

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](#))

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: 252

The nurse is in the hallway and one of the visitors faints. The nurse should:

A. Sit the victim up and lightly slap his face

B. Elevate the victim's legs

C. Apply a cool cloth to the victim's neck and forehead until he recovers

D. Sit the victim up and place the head between the knees

Answer: (SHOW ANSWER)

(A) Sitting the client up defeats the goal of re-establishing cerebral blood flow. (B)

Elevating the legs anatomically redirects blood flow to the cerebral area. (C) This strategy is a nice general comfort measure after the victim has regained consciousness. (D) This strategy is not as effective a strategy in helping the client to regain consciousness as elevating the legs.

NEW QUESTION: 253

A male client had a right below-the-knee amputation 4 days ago. His incision is healing well. He has gotten out of bed several times and sat at the side of the bed. Each time after returning to bed, he has experienced pain as if it were located in his right foot. Which nursing measure indicates the nurse has a thorough understanding of phantom pain and its management?

A. Phantom pain is entirely in the client's mind. The client should be instructed that the pain is psychological and should not be treated.

B. The basis for phantom pain may occur because the nerves still carry pain sensation to the brain even though the limb has been amputated. The pain is real, intense, and should be treated.

C. The cause of phantom pain is unknown. The nurse should provide the client with support, promote sleep, and handle the injured limb smoothly and gently.

D. Phantom pain is caused by trauma, spasms, and edema at the incisional site. It will decrease when postoperative edema decreases. It should be treated with nonnarcotic medication whenever possible.

Answer: B (LEAVE A REPLY)

(A) This statement is entirely false. (B) Phantom pain may be caused by nerves continuing to carry sensation to the brain even though the limb is removed. It is real, intense, and should be treated as ordinary pain would. (C) Although the cause of phantom pain is still unknown, these measures may promote the relief of any type of pain, not just phantom

pain. (D) Phantom pain is not caused by trauma, spasms, and edema and will not be relieved by decreasing edema.

NEW QUESTION: 254

A client is to have a coronary artery bypass graft performed in the morning using a saphenous vein. He wants to know why the physician does not use the internal mammary artery for his bypass graft because his friend's physician uses this artery. The nurse tells the client that the internal mammary artery:

- A.** Takes more time to remove
- B.** Has a greater risk of becoming reoccluded
- C.** Is smaller in diameter
- D.** Has too many valves

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

Section: Questions Set D

Explanation:

(A) It does take more time to remove the internal mammary artery, and this is one reason why some physicians do not use it. (B) There is not a greater risk of reocclusion. In fact, it may actually stay patent longer. (C) The internal mammary artery is actually larger in diameter than the saphenous vein. (D) The internal mammary artery does not have too many valves.

NEW QUESTION: 255

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/Reference:

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: 256

A 48-year-old client is in the surgical intensive care unit after having had three-vessel coronary artery bypass surgery yesterday. She is extubated, awake, alert and talking. She is receiving digitalis for atrial arrhythmias. This morning serum electrolytes were drawn. Which abnormality would require immediate intervention by the nurse after contacting the physician?

- A. Serum osmolality is elevated indicating hemoconcentration. The nurse should increase IV fluid rate.
- B. Serum sodium is low. The nurse should change IV fluids to normal saline.
- C. Blood urea nitrogen is subnormal. The nurse should increase the protein in the client's diet as soon as possible.
- D. Serum potassium is low. The nurse should administer KCl as ordered.

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) An elevated serum osmolality poses no immediate danger and is not corrected rapidly. (B) A low serum sodium alone does not warrant changing IV fluids to normal saline. Other assessment parameters, such as hydration status, must be considered. (C) A low serum blood urea nitrogen is not necessarily indicative of protein deprivation. It may also be the result of overhydration. (D) A low serum potassium potentiates the effects of digitalis, predisposing the client to dangerous arrhythmias. It must be corrected immediately.

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NEW QUESTION: 257

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/Reference:

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.

NEW QUESTION: 258

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: (SHOW ANSWER)

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: 259

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)

- (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: 260

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: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(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: 261

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/Reference:

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: 262

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)

Explanation/Reference:

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: 263

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: 264

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/Reference:

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: 265

A 30-year-old client has been admitted to the psychiatric service with the diagnosis of schizophrenia. He tells the nurse that when the woman he had been dating broke up with him, the CIA had replaced her with an identical twin. The client is experiencing:

- A.** Grandiose delusions
- B.** Paranoid delusions
- C.** Auditory hallucinations
- D.** Visual hallucinations

Answer: ([SHOW ANSWER](#))

(A) There are no indications that the client's thoughts reflect special powers or talents characteristic of grandiosity. (B) The client's thought content is fixed, false, persecutory, and suspicious in nature, which is characteristic of paranoid delusions. (C, D) The client is

not demonstrating a sensory experience.

NEW QUESTION: 266

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)

Explanation/Reference:

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: 267

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: 268

A client suffering from schizophrenia has been taking chlorpromazine (Thorazine) for 6 months. On one of his follow-up visits to the mental health center, the nurse reports to the physician that he has developed tardive dyskinesia. Which of the following symptoms might she have observed in the client to support this conclusion?

- A. High fever, tachycardia, stupor, renal failure
- B. Lip smacking, chewing, blinking, lateral jaw movements
- C. Photosensitivity, orthostatic hypotension, dry mouth
- D. Constipation, blurred vision, drowsiness

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

Explanation/Reference:

Explanation:

(A) These symptoms are found in clients with neuroleptic malignant syndrome. (B) These symptoms are found in clients with tardive dyskinesia. (C) These are normal side effects found in clients taking antipsychotic medications. (D) These are also normal side effects found in clients taking antipsychotic medications.

NEW QUESTION: 269

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

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: 270

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: 271

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.

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NEW QUESTION: 272

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/Reference:

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: 273

A client is being discharged on warfarin (Coumadin), an oral anticoagulant. The nurse instructs him about using this drug. Which following response by the client indicates the need for further teaching?

- A. "I should shave with my electric razor while on Coumadin."
- B. "I will inform my dentist that I am on anticoagulant therapy before receiving dental work."
- C. "I will continue with my usual dosage of aspirin for my arthritis when I return home."
- D. "I will wear an ID bracelet stating that I am on anticoagulants."

Answer: C (LEAVE A REPLY)

(A) Using an electric razor prevents the risk of cuts while shaving. (B) Any physician or dentist should be informed of anticoagulant therapy because of the risk of bleeding due to a prolonged PT. (C) The client should be instructed to consult with his physician. Aspirin is avoided because it potentiates the affects of oral anticoagulants by interfering with platelet aggregation. (D) Identification bracelets are necessary to direct treatment, especially in an emergency situation.

NEW QUESTION: 274

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

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: 275

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: 276

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](#))

Section: Questions Set D

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: 277

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: 278

A client has renal failure. Today's lab values indicate he has an elevated serum potassium. What additional priority information does the nurse need to obtain?

- A.** Evaluation of his level of consciousness
- B.** Evaluation of an electrocardiogram
- C.** Measurement of his urine output for the past 8 hours
- D.** Serum potassium lab values for the last several days

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The level of consciousness is not affected by elevated potassium levels. (B) An electrocardiogram (EKG) can tell the nurse whether this client is experiencing any cardiac dysfunction or arrhythmias related to the elevated potassium level. (C) Measurement of the urine output is not a priority nursing action at this time. (D) The client's serum potassium

values for the past several days may provide information about his renal function, but they are not a priority at this time.

NEW QUESTION: 279

The most commonly known vectors of Lyme disease are:

- A. Mites
- B. Fleas
- C. Ticks
- D. Mosquitoes

Answer: C (LEAVE A REPLY)

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: 280

A male client is being treated in the burn unit for thirddegree burns on his head, neck, and upper chest received in the last 24 hours. The nurse is evaluating the effectiveness of fluid resuscitation. Which of the following indicates effective fluid balance?

- A. His weight increases from 165 to 175 lb.
- B. His urine output is equal to his total fluid intake.
- C. His urine output has been >35 mL/hr for the past 12 hours.
- D. His blood pressure is 94/62.

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) A weight gain of 10 lb represents a state of overhydration. (B) He is losing fluids through insensible losses; a urine output equal to his intake indicates that he is receiving too little fluids. (C) A urine output greater than his intake indicates that he is receiving adequate fluid resuscitation to account for urinary and insensible losses. (D) A blood pressure of 94/62 indicates a state of underhydration and inadequate circulatory volume.

NEW QUESTION: 281

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

(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: 282

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](#))

Section: Questions Set C

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: 283

The most important goal in the care plan for a child who was hospitalized with an accidental overdose would be to:

A. Determine child's activity pattern

B. Reduce mother's sense of guilt

C. Instruct parents in use of ipecac

D. Teach parents appropriate safety precautions

Answer: D (LEAVE A REPLY)

Section: Questions Set G

Explanation

Explanation:

(A) This goal is not the most important. (B) There is always some guilt when an accident occurs; however, the priority is to be sure future accidents are prevented. (C) Ipecac is not used for caustic alkali and acid ingestions. (D) Determining the parent's knowledge about safety hazards and teaching appropriate preventive measures are likely to prevent recurrence of accidents.

NEW QUESTION: 284

The mother of a child taking phenytoin will need to plan appropriate mouth care and gingival stimulation.

When tooth-brushing is contraindicated, the next most effective cleansing and gingival stimulation technique would be:

- A. Using a water pik
- B. Rinsing with water
- C. Rinsing with hydrogen peroxide
- D. Rinsing with baking soda

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This technique provides effective rinsing and gingival stimulation. (B) This technique does not provide gingival stimulation. (C) This technique provides effective rinsing but not gingival stimulation. Using peroxide is not pleasant for the child. (D) This technique provides effective rinsing but not gingival stimulation.

NEW QUESTION: 285

A newborn is admitted to the newborn nursery with tremors, apnea periods, and poor sucking reflex. The nurse should suspect:

- A. Central nervous system damage
- B. Hypoglycemia
- C. Hyperglycemia
- D. These are normal newborn responses to extrauterine life

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Central nervous system damage presents as seizures, decreased arousal, and absence of newborn reflexes. (B) In a diabetic mother, the infant is exposed to high serum glucose. The fetal pancreas produces large amounts of insulin, which causes hypoglycemia after birth. (C) Hypoglycemia is a common newborn problem. Increased

insulin production causes hypoglycemia, not hyperglycemia. (D) These are not normal adaptive behaviors to extrauterine life.

NEW QUESTION: 286

One of the medications that is prescribed for a male client is furosemide (Lasix) 80 mg bid. To reduce his risk of falls, the nurse would teach him to take this medication:

- A. On arising and no later than 6 PM
- B. At evenly spaced intervals, such as 8 AM and 8 PM
- C. With at least one glass of water per pill
- D. With breakfast and at bedtime

Answer: A (LEAVE A REPLY)

Explanation

(A) This option provides adequate spacing of the medication and will limit the client's need to get up to go to the bathroom during the night hours, when he is especially at high risk for falls. (B) This option would result in the need to get up during the night to urinate and would thus increase the risk of falls. This option also does not take into consideration the client's usual daily routine. (C) Taking this medication with at least one glass of water would not have an impact on the risk of falls. (D) This option would result in the need to get up during the night to urinate and would thus increase the risk of falls.

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NEW QUESTION: 287

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: A (LEAVE A REPLY)

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: 288

Degenerative disorders are attributed to many factors. As a nurse assigned to a convalescent home, one must often educate families about how such conditions occur. Which of the following statements might the nurse need to explore when a daughter tries to explain to her mother what caused her degenerative disorder?

- A. "Some folks believe that aging causes this, Mother."
- B. "Perhaps, it's the way your parents used those double- bind messages, Mother."
- C. "I know some people who are having this problem and they were exposed to chemicals at work, Mother."
- D. "It can be caused by lots of things, toxic agents and even alcohol, Mother."

Answer: B (LEAVE A REPLY)

(A) Aging is a factor in the cause of degenerative disorders. (B) Double-bind messages may be found in the histories of families of individuals who develop schizophrenia, but they are not related to degenerative disorders. (C) Chemicals (toxic agents) in work environments are predisposing factors to degenerative disorders. (D) Alcohol causes some degenerative disorders, such as Wernicke's syndrome.

NEW QUESTION: 289

A 24-year-old woman who is gravida 1 reports, "I can't take iron pills because they make me sick." She continues, "My bowels aren't moving either." In counseling her based on these complaints, the nurse's most appropriate response would be, "It would be beneficial for you to eat . . .

- A. prunes."
- B. green leafy vegetables."
- C. red meat."
- D. eggs."

Answer: A (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) Prunes provide fiber to decrease constipation and are an excellent source of dietary iron, as the prenatal client is not taking her supplemental iron and iron-deficiency anemia is common during pregnancy. (B) Green leafy vegetables provide a source of fiber and iron; however, prunes are a better source of both. (C) Red meat is a good iron source but will

not address the constipation problem. (D) Eggs are a good iron source but do not address the constipation problem.

NEW QUESTION: 290

When caring for a postoperative cholecystectomy client, the nurse assesses patency and documents drainage of the T-tube. The nurse recognizes that the expected amount of drainage during the first 24 hours postoperatively is:

- A.** 50-100 mL
- B.** 200-300 mL
- C.** 300-500 mL
- D.** 1000-1200 mL

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

Explanation

(A) During the first 24 hours after surgery, the drainage is normally 300-500 mL and then decreases to about 200 mL in 24 hours during the next 3-4 days. (B) This range is the amount of drainage after the first 24 hours postoperatively. During the first 24 hours, it is 300-500 mL. (C) During the first 24 hours after surgery, this range is the expected amount of drainage. (D) The expected amount of drainage during the first 24 hours is 300-500 mL. An output of >500 mL should be reported to the physician, because an occlusion of some type, caused by a retained gallstone or an inflammatory process within the biliary drainage system, is evident.

NEW QUESTION: 291

A nurse is taking a maternal history for a client at her first prenatal visit. Her pregnancy test was positive, she has two living children, she had one spontaneous abortion, and one infant died at the age of 3 months. Which of the following best describes the client at the present?

- A.** Gravida 4, para 2, ab 1
- B.** Gravida 5, para 3, ab 1
- C.** Gravida 5, para 4, ab 0
- D.** Gravida 4, para 3, ab 0

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

Explanation

(A) This individual has been pregnant four times, delivered two children, and had one abortion. (B) Your client has been pregnant five times, delivered three children, and had one abortion. (C) This individual has been pregnant five times, delivered four children, and has not had an abortion. (D) This individual has been pregnant four times, delivered three children, and has not had an abortion.

NEW QUESTION: 292

Goal setting for a client with Meniere's disease should include which of the following?

- A. Frequent ambulation
- B. Prevention of a fall injury
- C. Consumption of three meals per day
- D. Prevention of infection

Answer: B (LEAVE A REPLY)

Explanation

(A) Although not contraindicated, initially ambulation may be difficult because of vertigo and is recommended only with assistance. (B) Vertigo resulting in balance problems is one of the most common manifestations of Meniere's disease. (C) Adequate nutrition is important, but the emphasis in Meniere's disease is not the number of meals per day but a decrease in intake of sodium. (D) Infection is not an anticipated problem.

NEW QUESTION: 293

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.

NEW QUESTION: 294

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)

(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: 295

A 10-year-old has been diagnosed with acute poststreptococcal glomerulonephritis. The clinical findings were proteinuria, moderately elevated blood pressure, and periorbital edema. Which dietary plan is most appropriate for this client?

- A.** Low-protein diet
- B.** Low-sodium diet
- C.** Increased fluid intake
- D.** High-cholesterol diet

Answer: ([SHOW ANSWER](#))

Explanation

(A) A high-protein diet is usually indicated because protein is excreted in urine. Protein restriction is usually prescribed with severe azotemia. (B) The kidneys usually enlarge in these children, and sodium and water are retained. (C) Fluid restriction may be ordered to help reduce edema; however, monitoring for dehydration is indicated. (D) A high-cholesterol diet would not be indicated for any child, especially one with elevated blood pressure.

NEW QUESTION: 296

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: ([SHOW ANSWER](#))

Explanation/Reference:

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 coun teract 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), haldoperidol (an antipsychotic), and trihexyphenydl (an antiparkinsonism agent) are usually administered in psychiatric settings to control problems associated with psychotic behavior.

NEW QUESTION: 297

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

- A.** O2 content of the blood
- B.** Oxygen saturation of arterial blood
- C.** PO2
- D.** Affinity of hemoglobin for O2

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) The O2 content of whole blood is determined by the partial pressure of oxygen (PO2) and the oxygen saturation. The pulse oximeter does not measure the PO2. (B) The pulse oximeter is a noninvasive method of measuring the arterial oxygen saturation. (C) The PO2 is the amount of O2 dissolved in plasma, which the pulse oximeter does not measure. (D) The affinity of hemoglobin for O2 is the relationship between oxygen saturation and PO2 and is not measured by the pulse oximeter.

NEW QUESTION: 298

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: 299

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

(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: 300

A client had a right below-the-knee amputation 4 days ago. He is complaining of pain in his right lower leg.

The nurse should:

- A. Remind the client that he no longer has that part of his leg and assure him he will be OK
- B. Call the physician to request a psychological consultation for the client
- C. Turn on the television to distract the client's attention from his amputated leg
- D. Give the client his order of Demerol 50 mg IM prn

Answer: (SHOW ANSWER)

Explanation

(A) The nurse is ignoring the client's pain. Telling the client that he will be OK will not relieve his phantom pain. (B) The client does not need a psychological consultation.

Phantom pain is a normal sensation experienced by clients with amputations. (C) Using the television as a distractor will not relieve the client's phantom pain. (D) Phantom pain is a normal, very real experience for an amputee and should be treated with pain medication.

NEW QUESTION: 301

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](#))

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.

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NEW QUESTION: 302

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

(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: 303

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)

Section: Questions Set B

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.

NEW QUESTION: 304

A 2-year-old child with a scalp laceration and subdural hematoma of the temporal area as a result of falling out of bed should be prevented from:

- A. Crying
- B. Falling asleep
- C. Rolling from his back to his tummy
- D. Sucking his thumb

Answer: ([SHOW ANSWER](#))

(A) A child with a subdural hematoma has increased ICP. Crying may significantly increase this pressure. (B) Adequate sleep is essential, but it is important that the child can be aroused from sleep after head injury. (C) This child is free to roll from his back to his abdomen. (D) Thumb-sucking serves to reduce anxiety and should not be prevented at this time.

NEW QUESTION: 305

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](#))

Section: Questions Set G

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: 306

Which of the following activities would be most appropriate during occupational therapy for a client with bipolar disorder?

- A. Playing cards with other clients
- B. Working crossword puzzles
- C. Playing tennis with a staff member
- D. Sewing beads on a leather belt

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

Explanation

(A) This activity is too competitive, and the manic client might become abusive toward the other clients. (B) During mania, the client's attention span is too short to accomplish this task. (C) This activity uses gross motor skills, eases tension, and expands excess energy.

A staff member is better equipped to interact therapeutically with clients. (D) This activity requires the use of fine motor skills and is very tedious.

NEW QUESTION: 307

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

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.

NEW QUESTION: 308

A client had a right below-the-knee amputation 4 days ago. He is complaining of pain in his right lower leg.

The nurse should:

- A. Call the physician to request a psychological consultation for the client
- B. Remind the client that he no longer has that part of his leg and assure him he will be OK
- C. Give the client his order of Demerol 50 mg IM prn
- D. Turn on the television to distract the client's attention from his amputated leg

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

NEW QUESTION: 309

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

Explanation/Reference:

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: 310

A client confides to the nurse that he tasted poison in his evening meal. This would be an example of what type of hallucination?

- A. Auditory
- B. Gustatory
- C. Olfactory
- D. Visceral

Answer: (SHOW ANSWER)

Explanation

(A) Auditory hallucinations involve sensory perceptions of hearing. (B) Gustatory hallucinations involve sensory perceptions of taste. (C) Olfactory hallucinations involve sensory perceptions of smell. (D) Visceral hallucinations involve sensory perceptions of sensation.

NEW QUESTION: 311

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)

Explanation

(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: 312

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)

(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: 313

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/Reference:

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: 314

A 45-year-old client has a permanent colostomy. Which of the following foods should he avoid?

- A.** Peanut butter and jelly sandwich and milk
- B.** Corn beef and cabbage and boiled potatoes
- C.** Oatmeal, whole-wheat toast, and milk
- D.** Tuna on whole-wheat bread and iced tea

Answer: ([SHOW ANSWER](#))

(A, C, D) These foods are allowed with a colostomy. (B) Gasforming foods such as cabbage should be avoided.

NEW QUESTION: 315

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)

(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.

NEW QUESTION: 316

A client is pregnant for the fourth time and has had three normal vaginal deliveries. She is in active labor and fully dilated. Suddenly she calls, "Nurse, the baby is coming." As the nurse responds to her call, which one of the following observations should the nurse make first?

- A. Inspect the perineum.
- B. Time the contractions.
- C. Prepare a sterile area for delivery.
- D. Auscultate for fetal heart rate (FHR).

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The nurse must assess the labor status to determine if birth is imminent. The nurse may note perineal bulging, crowning, or birth of the head to ascertain labor status. (B) Assessing uterine contractions is one intervention to ascertain labor status. Based on the client's cry, it is not the intervention of choice. (C) If delivery of the infant is imminent, preparing a clean or sterile area for delivery is appropriate, but labor status must be established, whether delivery is imminent, by perineal assessment. (D) Assessing FHR is one intervention to ascertain fetal well-being. Based on the client's cry, this is not the intervention of choice.

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NEW QUESTION: 317

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: 318

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

(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: 319

A pregnant client continues to visit the clinic regularly during her pregnancy. During one of her visits while lying supine on the examining table, she tells the RN that she is becoming light-headed. The RN notices that the client has pallor in her face and is perspiring profusely.

The first intervention the RN should initiate is to:

- A. Place the examining table in the Trendelenburg position
- B. Assess the client to see if she is having vaginal bleeding
- C. Obtain the client's vital signs immediately
- D. Help the client to a sitting position

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This position would cause the gravid uterus to bear the increased pressure of the vena cava, which could lead to maternal hypotension, in turn causing the client to continue to have pallor and to feel light-headed. (B) This would not be the first intervention the RN should initiate. The RN should understand the supine position and its effect on the gravid uterus and vena cava. (C) The RN's first intervention should be one that helps to alleviate the client's symptoms. Obtaining her vital signs will not alleviate her symptoms. (D) This would move the gravid uterus off of the client's vena cava, which would alleviate the maternal hypotension that is the cause of her symptoms.

NEW QUESTION: 320

A common complication of cirrhosis of the liver is prolonged bleeding. The nurse should be prepared to administer?

- A.** Vitamin C
- B.** Vitamin K
- C.** Vitamin E
- D.** Vitamin A

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

Explanation

(A) Vitamin C does not directly affect clotting. (B) Vitamin K is a fat-soluble vitamin that depends on liver function for absorption. Vitamin K is essential for clotting. (C) Vitamin E does not directly affect clotting. (D) Vitamin A does not directly affect clotting.

NEW QUESTION: 321

A male client is admitted to the medical-surgical unit from the emergency room with a diagnosis of acute pancreatitis. The nurse performs the admission nursing assessment. He is NPO with IV fluids infusing at 100 mL/hour. He is experiencing excruciating abdominal pain. Based on an analysis of these data, which nursing diagnosis would receive the highest priority?

- A.** Pain related to stimulation of nerve endings associated with obstruction of the pancreatic tract
- B.** Fluid volume deficit related to vomiting and nasogastric tube drainage
- C.** Knowledge deficit related to treatment regimen
- D.** Altered nutrition: less than body requirements, related to inadequate intake associated with current anorexia, nausea, vomiting, and digestive enzyme loss

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

Section: Questions Set E

Explanation:

(A) Relief of pain is the primary goal of nursing intervention because this client is experiencing acute pain. (B) Fluid volume deficit is being treated with IV fluid replacement. (C) Knowledge deficit will not be addressed at this time because a client in acute pain is

not ready to learn. (D) Alteration in nutrition is the third priority after relief of pain and fluid volume deficit.

NEW QUESTION: 322

A pregnant client continues to visit the clinic regularly during her pregnancy. During one of her visits while lying supine on the examining table, she tells the RN that she is becoming light-headed. The RN notices that the client has pallor in her face and is perspiring profusely.

The first intervention the RN should initiate is to:

- A. Place the examining table in the Trendelenburg position
- B. Assess the client to see if she is having vaginal bleeding
- C. Obtain the client's vital signs immediately
- D. Help the client to a sitting position

Answer: D (LEAVE A REPLY)

(A) This position would cause the gravid uterus to bear the increased pressure of the vena cava, which could lead to maternal hypotension, in turn causing the client to continue to have pallor and to feel light-headed. (B) This would not be the first intervention the RN should initiate. The RN should understand the supine position and its effect on the gravid uterus and vena cava. (C) The RN's first intervention should be one that helps to alleviate the client's symptoms. Obtaining her vital signs will not alleviate her symptoms. (D) This would move the gravid uterus off of the client's vena cava, which would alleviate the maternal hypotension that is the cause of her symptoms.

NEW QUESTION: 323

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)

Explanation

(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: 324

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: 325

A schizophrenic client has made sexual overtures toward her physician on numerous occasions. During lunch, the client tells the nurse, "My doctor is in love with me and wants to marry me." This client is using which of the following defense mechanisms?

- A. Displacement
- B. Projection
- C. Reaction formation
- D. Suppression

Answer: ([SHOW ANSWER](#))

(A) Displacement involves transferring feelings to a more acceptable object. (B) Projection involves attributing one's thoughts or feelings to another person. (C) Reaction formation involves transforming an unacceptable impulse into the opposite behavior. (D) Suppression involves the intentional exclusion of unpleasant thoughts or experiences.

NEW QUESTION: 326

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](#))

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: 327

A 16-year-old client comes to the prenatal clinic for her monthly appointment. She has gained 14 lb from her 7th to 8th month; her face and hands indicate edema. She is diagnosed as having PIH and referred to the high-risk prenatal clinic. The client's weight increase is most likely due to:

- A.** Overeating and subsequent obesity
- B.** Obesity prior to conception
- C.** Hypertension due to kidney lesions
- D.** Fluid retention

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

Explanation/Reference:

Explanation:

(A) Overeating can lead to obesity, but not to edema. (B) There is no indication of obesity prior to pregnancy. PIH is more prevalent in the underweight than in the obese in this age group. (C) Hypertension can be due to kidney lesions, but it would have been apparent earlier in the pregnancy. (D) The weight gain in PIH is due to the retention of sodium ions and fluid and is one of the three cardinal symptoms of PIH.

NEW QUESTION: 328

The nurse has been assigned a client who delivered a 6-lb, 12-oz baby boy vaginally 40 minutes ago. The initial assessment of greatest importance for this client would be:

- A.** Length of her labor
- B.** Type of episiotomy
- C.** Amount of IV fluid to be infused
- D.** Character of the fundus

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

The length of labor has little bearing on the fourth stage of labor. The type of labor and delivery is significant.

(B) The type of episiotomy will affect the client's comfort level. However, the nurse's assessment and implementations center on prevention of hemorrhage during the fourth stage of labor. The amount of bleeding from the episiotomy or hematoma formation is of higher priority than the type of episiotomy. (C) The amount of IV fluid to be infused is a nursing function to be attended to; however, it is lower in priority than determining if hemorrhaging is occurring. (D) Character of the fundus would be the priority nursing assessment because changes in uterine tone may identify possible postpartum hemorrhage.

NEW QUESTION: 329

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

(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: 330

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

(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: 331

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: ([SHOW ANSWER](#))

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.

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NEW QUESTION: 332

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: ([SHOW ANSWER](#))

(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: 333

A female client comes for her second prenatal visit. The nurse-midwife tells her, "Your blood tests reveal that you do not show immunity to the German measles." Which notation will the nurse include in her plan of care for the client? "Will need . . .

- A. Rh-immune globulin at the next visit"
- B. Rh-immune globulin within 3 days of delivery"
- C. Rubella vaccine at the next visit"
- D. Rubella vaccine after delivery on the day of discharge"

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

(A) Rh immune globulin is given to Rh-negative mothers to prevent the maternal Rh immune response. (B) Rh immune globulin is given to Rh-negative mothers to prevent the maternal Rh immune response. (C) The rubella vaccine is not given during pregnancy because of its teratogenicity. (D) Nonimmune mothers are vaccinated early in the postpartum period to prevent future infection with the rubella virus.

NEW QUESTION: 334

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

(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: 335

The serial sevens test is often used to determine delirium and dementia. This test aids in assessing which of the following?

A. Abstract thinking

B. Ability to focus and concentrate thoughts

C. Judgment

D. Memory

Answer: ([SHOW ANSWER](#))

(A) This answer is incorrect. The test measures the abilities to concentrate and calculate. The use of proverbs is the most common way to test abstraction. (B) This answer is correct. The serial sevens test is a common test of calculation ability. It is difficult for the demented or delirious client to perform. (C) This answer is incorrect. The test for judgment should predict whether the individual will behave in a socially accepted manner. (D) This

answer is incorrect. In testing memory, the nurse would attempt to get the client either to recall recent events or to think about past events.

NEW QUESTION: 336

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

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: 337

Which one of the following is considered a reliable indicator for assessing the adequacy of fluid resuscitation in a 3-year-old child who suffered partial- and full-thickness burns to 25% of her body?

- A.** Urine output
- B.** Edema
- C.** Hypertension
- D.** Bulging fontanelle

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

Explanation/Reference:

Explanation:

(A) Urinary output is a reliable indicator of renal perfusion, which in turn indicates that fluid resuscitation is adequate. IV fluids are adjusted based on the urinary output of the child during fluid resuscitation. (B) Edema is an indication of increased capillary permeability following a burn injury. (C) Hypertension is an indicator of fluid volume excess. (D) Fontanelles close by 18 months of age.

NEW QUESTION: 338

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: A (LEAVE A REPLY)

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: 339

A female client presents to the obstetric-gynecology clinic for a pregnancy test, the result which turns out to be positive. Her last menstrual period began December 10, 1993. Using Nägele's rule, the nurse estimates her date of delivery to be:

- A. September 17, 1994
- B. September 10, 1994
- C. September 3, 1994
- D. August 17, 1994

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) According to Nägele's rule, the estimated date of delivery is calculated by adding 7 days to the date of the first day of the normal menstrual period (December 10 + 7 days = December 17), and then by counting back 3 months (December 17 -3 mo = September 17). (B, C, D) These answers are incorrect.

NEW QUESTION: 340

A client suspects that she is pregnant. She reports two missed menstrual periods. The first day of her last menstrual period was August 3. Her estimated date of confinement would be:

- A. November 7
- B. November 10
- C. May 7
- D. May 10

Answer: D (LEAVE A REPLY)

Explanation

(A) Wrong calculation (B) Wrong calculation (C) Wrong calculation

(D) Nagele's rule is: Expected Date of Confinement = Last Menstrual Period - 3 months + 7 days + 1 year

NEW QUESTION: 341

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

Explanation

(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.

NEW QUESTION: 342

A 68-year-old woman is admitted to the hospital with chronic obstructive pulmonary disease (COPD). She is started on an aminophylline infusion. Three days later she is breathing easier. A serum theophylline level is drawn. Which of the following values represents a therapeutic level?

- A. 14 μ g/mL
- B. 25 μ g/mL
- C. 4 μ g/mL
- D. 30 μ g/mL

Answer: ([SHOW ANSWER](#))

Explanation

(A) The therapeutic blood level range of theophylline is 10-20 mg/mL. Therapeutic drug monitoring determines effective drug dosages and prevents toxicity. (B, D) This value is a toxic level of the drug. (C) This value is a nontherapeutic level of the drug.

NEW QUESTION: 343

Which classification of drugs is contraindicated for the client with hypertrophic cardiomyopathy?

- A. Positive inotropes
- B. Vasodilators
- C. Diuretics
- D. Antidysrhythmics

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

(A) Positive inotropic agents should not be administered owing to their action of increasing myocardial contractility. Increased ventricular contractility would increase outflow tract obstruction in the client with hypertrophic cardiomyopathy. (B) Vasodilators are not typically prescribed but are not contraindicated. (C) Diuretics are used with caution to avoid causing hypovolemia. (D) Antidysrhythmics are typically needed to treat both atrial and ventricular dysrhythmias.

NEW QUESTION: 344

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: 345

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: 346

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: ([SHOW ANSWER](#))

(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.

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NEW QUESTION: 347

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

(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: 348

A client with cystic fibrosis exhibits activity intolerance related to the pulmonary problems associated with his disease. However, he needs to be encouraged to participate in daily physical exercise. The ultimate aim of exercise is to:

- A. Create a sense of well-being and self-worth
- B. Help him overcome respiratory infections
- C. Establish an effective, habitual breathing pattern
- D. Promote normal growth and development

Answer: C (LEAVE A REPLY)

(A) Regular exercise does promote a sense of well-being and selfworth, but this is not the ultimate goal of exercise for this client. (B) Regular chest physiotherapy, not exercise per se, helps to prevent respiratory infections. (C) Physical exercise is an important adjunct to chest physiotherapy. It stimulates mucus secretion, promotes a feeling of well-being, and helps to establish a habitual breathing pattern. (D) Along with adequate nutrition and minimization of pulmonary complications, exercise does help promote normal growth and development. However, exercise is promoted primarily to help establish a habitual breathing pattern.

NEW QUESTION: 349

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: 350

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

(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.

NEW QUESTION: 351

Which of the following signs might indicate a complication during the labor process with vertex presentation?

- A. Fetal tachycardia to 170 bpm during a contraction
- B. Nausea and vomiting at 8-10 cm dilation
- C. Contraction lasting 60 seconds
- D. Appearance of dark-colored amniotic fluid

Answer: ([SHOW ANSWER](#))

Explanation

(A) Fetal tachycardia may indicate fetal hypoxia; however, 170 bpm is only mild tachycardia. (B) Nausea and vomiting occur frequently during transition and are not a complication. (C) Contractions frequently last 60-90 seconds during the transitional phase of labor and are not considered a complication as long as the uterus relaxes completely between contractions. (D) Passage of meconium in a vertex presentation is a sign of fetal distress; this may be normal in a breech presentation owing to pressure on the presenting part.

NEW QUESTION: 352

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: 353

A male client is being treated in the burn unit for third-degree burns on his head, neck, and upper chest received in the last 24 hours. The nurse is evaluating the effectiveness of fluid resuscitation. Which of the following indicates effective fluid balance?

- A.** His weight increases from 165 to 175 lb.
- B.** His urine output is equal to his total fluid intake.
- C.** His urine output has been >35 mL/hr for the past 12 hours.
- D.** His blood pressure is 94/62.

Answer: C (LEAVE A REPLY)

(A) A weight gain of 10 lb represents a state of overhydration. (B) He is losing fluids through insensible losses; a urine output equal to his intake indicates that he is receiving too little fluids. (C) A urine output greater than his intake indicates that he is receiving adequate fluid resuscitation to account for urinary and insensible losses. (D) A blood pressure of 94/62 indicates a state of underhydration and inadequate circulatory volume.

NEW QUESTION: 354

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)

Explanation/Reference:

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.

NEW QUESTION: 355

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

(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: 356

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

(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: 357

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: 358

After several days, an IDDM client's serum glucose stabilizes, and the registered nurse continues client teaching in preparation for his discharge. The nurse helps him plan an American Diabetes Association diet and explains how foods can be substituted on the exchange list. He can substitute 1 oz of poultry for:

- A.** One frankfurter
- B.** One ounce of ham
- C.** Two slices of bacon
- D.** One-fourth cup dry cottage cheese

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) A frankfurter is a high-fat meat on the diabetic exchange list. (B) Ham is a medium-fat meat on the diabetic exchange list, unless it is a center-cut slice. (C) One strip of bacon equals one fat exchange rather than a meat exchange. Dietary substitutions should occur within exchange lists and not between exchange lists. (D) Diabetic meat-exchange lists are categorized into lean meat foods, medium-fat meats, and high-fat meats. Cottage cheese (dry, 2% butterfat), one-fourth cup, can substitute for one lean-meat exchange.

NEW QUESTION: 359

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

(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: 360

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: (SHOW ANSWER)

(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: 361

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)

(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: 362

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)

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: 363

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: 364

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](#))

Section: Questions Set E

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: 365

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

Explanation

(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: 366

A client suspected of having anorexia nervosa is placed on bed rest with an IV infusion and a high- carbohydrate liquid diet. Within 72 hours, the results of her lab work show a return to normal limits. She is transferred to the psychiatric service for further treatment. A behavior modification plan is initiated. Three days after her transfer, the client tells the nurse, "I haven't exercised in 6 days. I won't be eating lunch today." This statement by her most likely reflects:

- A.** Her lack of internal awareness about the outcome of the behavior
- B.** Increased knowledge about personal exercise plans
- C.** A manipulative technique to trick the nurse into allowing her to miss a meal
- D.** A true desire to stay fit while in the hospital

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

Explanation/Reference:

Explanation:

(A) Indirect self-destructive behavior such as that seen in anorexia nervosa is characterized by the client's lack of insight and the awareness that the outcome of the dieting, exercising, and weight loss will ultimately result in death if uninterrupted. (B) Although the client is knowledgeable about exercise, knowledge about the balance between nutrition, exercise, and rest is absent. (C) The client's level of denial and lack of awareness disallow this behavior as a manipulative trick. (D) The client's illness-maintaining behaviors are inconsistent with fitness.

NEW QUESTION: 367

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

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: 368

A client is receiving IV morphine 2 days after colorectal surgery. Which of the following observations indicate that he may be becoming drug dependent?

- A.** The client requests pain medicine every 4 hours.
- B.** He is asleep 30 minutes after receiving the IV morphine.
- C.** He asks for pain medication although his blood pressure and pulse rate are normal.
- D.** He is euphoric for about an hour after each injection.

Answer: D (LEAVE A REPLY)

Section: Questions Set G

Explanation:

(A) Frequent requests for pain medication do not necessarily indicate drug dependence after complex surgeries such as colorectal surgery. (B) Sleeping after receiving IV morphine is not an unexpected effect because the pain is relieved. (C) A person may be in pain even with normal vital signs. (D) A subtle sign of drug dependency is the tendency for the person to appear more euphoric than relieved of pain.

NEW QUESTION: 369

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)

Section: Questions Set D

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: 370

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](#))

Explanation

(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: 371

The doctor has ordered a restricted fluid intake for a 2- year-old child with a head injury. Normal fluid intake for a child of 2 years is:

- A. 900 mL/24 hr
- B. 1300 mL/24 hr
- C. 1600 mL/24 hr
- D. 2000 mL/24 hr

Answer: ([SHOW ANSWER](#))

Explanation

(A, B, D) These values are incorrect. Normal intake for a child of 2 years is about 1600 mL in 24 hours. (C) This value is correct. Normal intake for a child of 2 years is about 1600 mL in 24 hours.

NEW QUESTION: 372

A 16-year-old client reports a weight loss of 20% of her previous weight. She has a history of food binges followed by self-induced vomiting (purging). The nurse should suspect a diagnosis of:

- A. Anorexia nervosa
- B. Anorexia hysteria
- C. Bulimia
- D. Conversion reaction

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

Explanation/Reference:

Explanation:

(A) Anorexia nervosa is characterized by self-starvation. (B) Anorexia hysteria is not a known disease or disorder. (C) Bulimia is characterized by food binges and self-induced vomiting. (D) Conversion reaction is a defense mechanism.

NEW QUESTION: 373

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: 374

The family member of a child scheduled for heart surgery states, "I just don't understand this open-heart or closed-heart business. I'm so confused! Can you help me understand it?" The nurse explains that patent ductus arteriosus repair is:

- A. Open-heart surgery. The child will be placed on a heart-lung machine while the surgery is being performed.
- B. Closed-heart surgery. It does not require that the child be placed on the heart-lung machine while the surgery is being performed.
- C. A pediatric version of the coronary artery bypass graft surgery performed on adults. It is an open-heart surgery.
- D. A pediatric version of percutaneous transluminal coronary angioplasty performed on adults. It is a closed-heart surgery.

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Patent ductus arteriosus repair is a closed-heart procedure. The client is not placed on a heart-lung machine. (B) Patent ductus arteriosus is a ductus arteriosus that does not close shortly after birth but remains patent. Repair is a closed-heart procedure involving

ligation of the patent ductus arteriosus. (C) Coronary artery bypass graft surgery is an open-heart surgical procedure in which blocked coronary arteries are bypassed using vessel grafts. (D) Percutaneous transluminal coronary angioplasty is a closedheart procedure that improves coronary blood flow by increasing the lumen size of narrowed vessels.

NEW QUESTION: 375

A nurse should carefully monitor a client for the following side effect of MgSO₄:

- A. Visual blurring
- B. Tachypnea
- C. Epigastric pain
- D. Respiratory depression

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

Section: Questions Set B

Explanation:

(A, C) The nurse should provide good distractors because these symptoms indicate that PIH has become more severe and may precede the convulsive or eclamptic phase. (B) This is the opposite-side effect of this medication. (D) This is a common side effect of this medication and needs to be monitored and recorded frequently.

NEW QUESTION: 376

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.

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NEW QUESTION: 377

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: (SHOW ANSWER)

(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: 378

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)

(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: 379

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

(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: 380

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 \(LEAVE A REPLY\)](#)

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: 381

A pregnant client is having a nonstress test (NST). It is noted that the fetal heart beat rises 20 bpm, lasting 20 seconds, every time the fetus moves. The nurse explains that:

- A. The test is inconclusive and should be repeated
- B. Further testing is needed
- C. The test is normal and the fetus is reacting appropriately
- D. The fetus is distressed

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

(A)

The test results were normal, so there would be no need to repeat to determine results.

(B)

There are no data to indicate further tests are needed, because the result of the NST was normal. (C) An NST is reported as reactive if there are two to three increases in the fetal heart rate of 15 bpm, lasting at least 15 seconds during a 15-minute period. (D) The NST results were normal, so there was no fetal distress.

NEW QUESTION: 382

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

(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: 383

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)

(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: 384

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: ([SHOW ANSWER](#))

(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: 385

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: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(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: 386

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: 387

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/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: 388

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

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: 389

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](#))

Explanation/Reference:

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: 390

The usual treatment for diabetes insipidus is with IM or SC injection of vasopressin tannate in oil. Nursing care related to the client receiving IM vasopressin tannate would include:

A. Weigh once a week and report to the physician any weight gain of 10 lb.

B. Limit fluid intake to 500 mL/day.

C. Store the medication in a refrigerator and allow to stand at room temperature for 30 minutes prior to administration.

D. Hold the vial under warm water for 10-15 minutes and shake vigorously before drawing medication into the syringe.

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

Explanation/Reference:

Explanation:

(A) Weight should be obtained daily. (B) Fluid is not restricted but is given according to urine output. (C) The medication does not have to be stored in a refrigerator. (D) Holding the vial under warm water for 10-15 minutes or rolling between your hands and shaking vigorously before drawing medication into the syringe activates the medication in the oil solution.

NEW QUESTION: 391

A newborn has been delivered with a meningomyelocele. The nursery nurse should position the newborn:

- A. Prone
- B. Supine
- C. Side lying
- D. Semi-Fowler

Answer: (SHOW ANSWER)

Section: Questions Set C

Explanation:

(A) The prone position reduces pressure and tension on the sac. Primary nursing goals are to prevent trauma and infection of the sac. (B) The supine position exerts pressure on the sac. (C) Newborns usually cannot maintain side-lying position. (D) The semi-Fowler position exerts pressure on the sac.

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NEW QUESTION: 392

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. O2 2 L/min via nasal cannula
- D. Nitroglycerin (Nitrol) 1 inch topically every 4 hours

Answer: A (LEAVE A REPLY)

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: 393

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)

Explanation/Reference:

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: 394

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)

(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: 395

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)

Section: Questions Set G

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: 396

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: 397

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: 398

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: B (LEAVE A REPLY)

(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: 399

In the coronary care unit, a client has developed multifocal premature ventricular contractions. The nurse should anticipate the administration of:

- A. Furosemide
- B. Nitroglycerin
- C. Lidocaine
- D. Digoxin

Answer: C (LEAVE A REPLY)

Explanation

(A) Furosemide is a loop diuretic. (B) Nitroglycerin is a vasodilator. (C) Lidocaine is the drug of choice to treat ectopic ventricular beats. (D) Digoxin slows down the electrical impulses and increases ventricular contractions, but it does not rapidly correct ventricular ectopy.

NEW QUESTION: 400

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: ([SHOW ANSWER](#))

Explanation/Reference:

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: 401

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.

NEW QUESTION: 402

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)

(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: 403

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: B (LEAVE A REPLY)

(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: 404

A female client has been treated since childhood for mitral valve prolapse. The antibiotic of choice for her during pregnancy would be:

- A. Sulfa
- B. Tetracycline
- C. Hydralazine
- D. Erythromycin

Answer: D (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) Sulfa is a teratogen and will cause kernicterus. (B) Tetracycline is a teratogen and will affect tooth development. (C) Hydralazine is not an antibiotic but a calcium channel blocker. (D) Erythromycin is safe during pregnancy and can be used when the client is allergic to penicillin.

NEW QUESTION: 405

A client is being treated for congestive heart failure. His medical regimen consists of digoxin (Lanoxin) 0.25 mg po daily and furosemide 20 mg po bid. Which laboratory test should the nurse monitor?

- A.** Intake and output
- B.** Calcium
- C.** Potassium
- D.** Magnesium

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

Explanation

(A) Intake and output are not laboratory tests. (B) Serum calcium levels are not affected by digoxin or furosemide. (C) Furosemide is a non-potassium-sparing loop diuretic. Hypokalemia is a common side effect of furosemide and may enhance digoxin toxicity. (D) Serum magnesium levels are not affected by digoxin or furosemide.

NEW QUESTION: 406

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: 407

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: C (LEAVE A REPLY)

(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: 408

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: C (LEAVE A REPLY)

Explanation/Reference:

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.

NEW QUESTION: 409

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: (SHOW ANSWER)

Explanation

(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: 410

Because a client is taking an MAO inhibitor, it is necessary to discuss the need for adherence to a low-tyramine diet. Which of the following are foods that she should avoid?

- A. Pickled, aged, smoked, and fermented foods
- B. Fresh vegetables
- C. Broiled fresh fish and fowl
- D. Fresh fruit such as apples and oranges

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) These foods may produce elevation in blood pressure when consumed during MAO inhibition therapy. (B) These foods have not been pickled, fermented, smoked, or aged. They contain very little, if any, tyramine or tryptophan. (C) As long as the meat has not been aged or smoked, it is within the dietary regimen. (D) Fresh fruits can be consumed as desired. However, the consumption of bananas is limited.

NEW QUESTION: 411

A client who has been diagnosed with anorexia nervosa reluctantly agrees to eat all prescribed meals. The most important intervention in monitoring her dietary compliance would be to:

- A. Allow her privacy at mealtimes
- B. Praise her for eating everything
- C. Observe behavior for 1-2 hours after meals to prevent vomiting
- D. Encourage her to eat in moderation, choose foods that she likes, and avoid foods that she dislikes

Answer: C (LEAVE A REPLY)

Section: Questions Set F

Explanation:

- (A) Eating alone is not recommended for anorexic clients because they tend to hoard food instead of eating it.
- (B) The client should be praised for whatever she eats, which is usually a small portion or percentage of what is served. Praise should not be withheld until she eats everything.
- (C) The client should be observed eye-to-eye for at least 1 hour following meals to prevent discarding food stashed in her clothing at mealtime or engaging in self-induced vomiting.
- (D) If offered these choices, the client would choose low-caloric foods, not a nutritious diet.

NEW QUESTION: 412

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: A (LEAVE A REPLY)

(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: 413

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)

Section: Questions Set D

Explanation:

(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: 414

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: ([SHOW ANSWER](#))

(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: 415

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

(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: 416

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

(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: 417

The nurse writes the following nursing diagnosis for a client in acute renal failure - Impaired gas exchange related to:

- A. Decreased red blood cell production
- B. Increased levels of vitamin D
- C. Increased red blood cell production
- D. Decreased production of renin

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation:

(A) Red blood cell production is impaired in renal failure owing to impaired erythropoietin production. This causes a decrease in the delivery of oxygen to the tissue and impairs gas exchange. (B) The conversion of vitamin D to its physiologically active form is impaired in renal failure. (C) In renal failure, a decrease in red blood cell production occurs owing to an impaired production of erythropoietin, leading to impaired gas exchange at the cellular level. (D) The decreased production of renin in renal failure causes an increased production of aldosterone causing sodium and water retention.

NEW QUESTION: 418

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

(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.

NEW QUESTION: 419

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](#))

Explanation/Reference:

Explanation:

(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: 420

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)

Section: Questions Set B

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: 421

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)

(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.

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NEW QUESTION: 422

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

Explanation

(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: 423

The physician orders medication for a client's unpleasant side effects from the haloperidol. The most appropriate drug at this time is:

- A. Lorazepam
- B. Triazolam (Halcion)
- C. Benztropine
- D. Thiothixene

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Lorazepam is a benzodiazepine, or antianxiety agent, that potentiates the effects of γ -aminobutyric acid in the CNS, which is not the CNS neurotransmitter EPS. (B) Triazolam is a benzodiazepine sedative- hypnotic whose action is mediated in the limbic, thalamic, and hypothalamic levels of the CNS by γ -aminobutyric acid. (C) Benztropine is an anticholinergic agent, and the drug of choice for blocking CNS synaptic response, which causes EPS. (D) Thiothixene is an antipsychotic and neuroleptic drug that blocks dopamine neurotransmission at the CNS synapses, thereby causing EPS.

NEW QUESTION: 424

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/Reference:

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: 425

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/Reference:

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: 426

A male client has burns over 90% of his body after an automobile accident resulting in a fire. He was trapped inside the auto and pulled out by a bystander. After several months in the hospital and over 20 surgeries, discharge planning has begun. Throughout his hospitalization the nursing staff has been aware of psychological changes the client faces after burns over a large portion of his body resulting in disfigurement.

The nursing staff can best foster the client's self-esteem by:

- A.** Adhering to a strict schedule of diet, exercise, and wound care
- B.** Allowing him to go to physical therapy for whirlpool treatment when other clients were not in physical therapy
- C.** Following a standardized plan of care for burn clients formulated by a world-renowned burn center
- D.** Allowing him to plan, assist in, and perform his own care whenever possible

Answer: D (LEAVE A REPLY)

Explanation

(A) A regimented schedule, allowing no flexibility, will not foster the client's self-esteem. (B) Isolating the client may only enhance his feelings of social isolation due to his disfigurement. (C) Standardized care plans must be personalized and adapted to each client's situation. (D) Allowing the client control over his care will foster his self-esteem and prepare him for life outside of the hospital.

NEW QUESTION: 427

Diabetes mellitus is a disorder that affects 3.1 out of every 1000 children younger than 20 years old. It is characterized by an absence of, or marked decrease in, circulating insulin. When teaching a newly diagnosed diabetes client, the nurse includes information on the functions of insulin:

- A.** Transport of glucose into body cells and storage of glycogen in the liver
- B.** Glycogenolysis and facilitation of glucose use for energy
- C.** Glycogenolysis and catabolism
- D.** Catabolism and hyperglycemia

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

Section: Questions Set G

Explanation:

(A) Lack of insulin causes glycogenolysis, catabolism, and hyperglycemia. (B) Insulin promotes the conversion of glucose to glycogen for storage and regulates the rate at which carbohydrates are used by cells for energy. (C) Insulin is anabolic in nature. (D) Glucose stimulates protein synthesis within the tissue and inhibits the breakdown of protein into amino acids.

NEW QUESTION: 428

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: ([SHOW ANSWER](#))

Explanation/Reference:

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: 429

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](#))

Explanation

(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: 430

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](#))

Explanation/Reference:

Explanation:

(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: 431

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: D (LEAVE A REPLY)

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: 432

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.** A low birth weight
- B.** A birth defect
- C.** Anemia
- D.** Nicotine withdrawal

Answer: A (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(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: 433

A 74-year-old obese man who has undergone open reduction and internal fixation of the right hip is 8 days postoperative. He has a history of arthritis and atrial fibrillation. He admits to right lower leg pain, described as "a cramp in my leg." An appropriate nursing action is to:

- A.** Assess for pain with plantiflexion
- B.** Assess for edema and heat of the right leg
- C.** Instruct him to rub the cramp out of his leg
- D.** Elevate right lower extremity with pillows propped under the knee

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Calf pain with dorsiflexion of the foot (Homans' sign) can be a sign of a deep venous thrombosis; however, it is not diagnostic of the condition. (B) Swelling and warmth along

the affected vein are commonly observed clinical manifestations of a deep venous thrombosis as a result of inflammation of the vessel wall. (C) Rubbing or massaging of the affected leg is contraindicated because of the risk of the clot breaking loose and becoming an embolus. (D) A pillow behind the knee can be constricting and further impair blood flow.

NEW QUESTION: 434

A client is diagnosed with diabetic ketoacidosis. The nurse should be prepared to administer which of the following IV solutions?

- A. D5in normal saline
- B. D5W
- C. 0.9 normal saline
- D. D5in lactated Ringer's

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) D5in normal saline would increase serum glucose. (B) D5W would increase serum glucose. (C) A concentration of 0.9 NS is used to correct extracellular fluid depletion. (D) D5in Ringer's lactate would increase serum glucose.

NEW QUESTION: 435

Parents of young children often need anticipatory guidance from the nurse. Parents may have little knowledge regarding growth and development. Which of the following toys and activities would the nurse suggest as appropriate for a toddler?

- A. Cutting, pasting, string beads, music, dolls
- B. Mobiles, rattle, squeeze toys
- C. Pull-toys, large ball, dolls, sand and water play, music
- D. Simple card games, puzzles, bicycle, television

Answer: C (LEAVE A REPLY)

(A) These activities are suited for the preschool-age child (3-5 years old). The activities are not safe for a toddler. (B) Infants (0-1 year) like these toys. (C) These activities provide the toddler (1-3 years old) with a variety of physical activities for play. (D) The toddler lacks the physical and cognitive abilities for these activities. The tasks are far better suited for the school-age child.

NEW QUESTION: 436

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/Reference:

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.

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NEW QUESTION: 437

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.

NEW QUESTION: 438

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: ([SHOW ANSWER](#))

Explanation/Reference:

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: 439

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/Reference:

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: 440

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

Explanation

(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: 441

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: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(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: 442

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: 443

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/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.

NEW QUESTION: 444

The doctor has ordered a restricted fluid intake for a 2- year-old child with a head injury. Normal fluid intake for a child of 2 years is:

- A. 900 mL/24 hr
- B. 1300 mL/24 hr
- C. 1600 mL/24 hr
- D. 2000 mL/24 hr

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A, B, D) These values are incorrect. Normal intake for a child of 2 years is about 1600 mL in 24 hours. (C) This value is correct. Normal intake for a child of 2 years is about 1600 mL in 24 hours.

NEW QUESTION: 445

A female client is concerned that she is in a "high-risk" group for the development of acquired immunodeficiency syndrome (AIDS). She wants to know about the advisability of donating blood. Which of the following responses is correct?

- A. "Individuals who donate blood are at risk of getting the AIDS virus. You should not donate."
- B. "It's OK for you to donate because the blood bank has a test that is 100% effective."
- C. "You should not donate since it takes time to develop antibodies to the AIDS virus. If you donate blood before you develop the antibody, you could pass it on in the blood."
- D. "It is not a good idea for you to donate. If you have AIDS, the information is made public and could destroy your personal life."

Answer: C (LEAVE A REPLY)

(A) The AIDS virus cannot be transmitted to the donor through the blood donation procedure. (B) The test for the AIDS virus is not absolutely foolproof; therefore, it is not wise for a person with known risk factors to donate blood. (C) It takes time for antibodies to the AIDS virus to develop. An infected individual could donate contaminated blood without

it testing positive for the virus. (D) For reasons of confidentiality, information about individuals infected with AIDS is not made public.

NEW QUESTION: 446

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: ([SHOW ANSWER](#))

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: 447

The initial focus when providing nursing care for a child with rheumatic fever during the acute phase of the illness should be to:

- A. Maintain contact with her parents
- B. Provide for physical and psychological rest
- C. Provide a nutritious diet
- D. Maintain her interest in school

Answer: ([SHOW ANSWER](#))

Section: Questions Set G

Explanation:

(A) This goal is helpful, but rest is essential during the acute phase. (B) Rest is essential for healing to occur and for pain to be relieved. (C) This goal is important, but rest is essential. (D) This goal should be part of the plan of care, but it is not the priority during the acute phase.

NEW QUESTION: 448

After several days, an IDDM client's serum glucose stabilizes, and the registered nurse continues client teaching in preparation for his discharge. The nurse helps him plan an

American Diabetes Association diet and explains how foods can be substituted on the exchange list. He can substitute 1 oz of poultry for:

- A. One frankfurter
- B. One ounce of ham
- C. Two slices of bacon
- D. One-fourth cup dry cottage cheese

Answer: D (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) A frankfurter is a high-fat meat on the diabetic exchange list. (B) Ham is a medium-fat meat on the diabetic exchange list, unless it is a center-cut slice. (C) One strip of bacon equals one fat exchange rather than a meat exchange. Dietary substitutions should occur within exchange lists and not between exchange lists. (D) Diabetic meat-exchange lists are categorized into lean meat foods, medium-fat meats, and high-fat meats.

Cottage cheese (dry, 2% butterfat), one-fourth cup, can substitute for one lean-meat exchange.

NEW QUESTION: 449

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)

(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: 450

A schizophrenic client has made sexual overtures toward her physician on numerous occasions. During lunch, the client tells the nurse, "My doctor is in love with me and wants to marry me." This client is using which of the following defense mechanisms?

- A. Displacement
- B. Projection
- C. Reaction formation
- D. Suppression

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Displacement involves transferring feelings to a more acceptable object. (B) Projection involves attributing one's thoughts or feelings to another person. (C) Reaction formation involves transforming an unacceptable impulse into the opposite behavior. (D) Suppression involves the intentional exclusion of unpleasant thoughts or experiences.

NEW QUESTION: 451

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)

(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).

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NEW QUESTION: 452

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

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: 453

A client is to have a coronary artery bypass graft performed in the morning using a saphenous vein. He wants to know why the physician does not use the internal mammary artery for his bypass graft because his friend's physician uses this artery. The nurse tells the client that the internal mammary artery:

- A. Takes more time to remove
- B. Has a greater risk of becoming reoccluded
- C. Is smaller in diameter
- D. Has too many valves

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

Explanation/Reference:

Explanation:

(A) It does take more time to remove the internal mammary artery, and this is one reason why some physicians do not use it. (B) There is not a greater risk of reocclusion. In fact, it may actually stay patent longer. (C) The internal mammary artery is actually larger in diameter than the saphenous vein. (D) The internal mammary artery does not have too many valves.

NEW QUESTION: 454

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: (SHOW ANSWER)

Explanation/Reference:

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: 455

When inspecting a cardiovascular client, the nurse notes that he needs to sit upright to breathe. This behavior is most indicative of:

- A. Pericarditis
- B. Anxiety
- C. Congestive heart failure
- D. Angina

Answer: C (LEAVE A REPLY)

(A) Pericarditis can cause dyspnea but primarily causes chest pain. (B) Anxiety can cause dyspnea resulting in SOB, yet it is not typically influenced by degree of head elevation. (C) The inability to oxygenate well without being upright is most indicative of congestive heart failure, due to alveolar drowning. (D) Angina causes primarily chest pain; any SOB associated with angina is not influenced by body position.

NEW QUESTION: 456

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: 457

The postpartum nurse should include which of the following instructions to breast-feeding mothers?

- A.** Limit feeding times for several days to avoid nipple soreness.
- B.** Wash the nipples with soap and water before and after each feeding.
- C.** Daily caloric intake should be increased by 500 cal.
- D.** Breast milk is totally digestible by the baby because it contains lactose.

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) Limiting initial feeding times will only delay nipple soreness as well as the establishment of the letdown reflex, thus encouraging engorgement from clogged ducts and ductules. (B) Soap should be avoided because it may be excessively drying, predisposing nipples to cracking. (C) For optimal milk production, an additional 500 kcal over maintenance levels are needed daily. (D) Lipase, not lactose, emulsifies the fat in breast milk, making it almost totally digestible by infants.

NEW QUESTION: 458

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: ([SHOW ANSWER](#))

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: 459

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: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(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: 460

The serial sevens test is often used to determine delirium and dementia. This test aids in assessing which of the following?

A. Abstract thinking

B. Ability to focus and concentrate thoughts

C. Judgment

D. Memory

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) This answer is incorrect. The test measures the abilities to concentrate and calculate. The use of proverbs is the most common way to test abstraction. (B) This answer is correct. The serial sevens test is a common test of calculation ability. It is difficult for the demented or delirious client to perform. (C) This answer is incorrect. The test for judgment should predict whether the individual will behave in a socially accepted manner. (D) This answer is incorrect. In testing memory, the nurse would attempt to get the client either to recall recent events or to think about past events.

NEW QUESTION: 461

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: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(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: 462

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: (SHOW ANSWER)

Explanation

(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: 463

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)

(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: 464

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: C (LEAVE A REPLY)

(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: 465

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/Reference:

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: 466

A female client has been treated since childhood for mitral valve prolapse. The antibiotic of choice for her during pregnancy would be:

- A. Sulfa
- B. Tetracycline

- C. Hydralazine
- D. Erythromycin

Answer: D (LEAVE A REPLY)

(A) Sulfa is a teratogen and will cause kernicterus. (B) Tetracycline is a teratogen and will effect tooth development. (C) Hydralazine is not an antibiotic but a calcium channel blocker. (D) Erythromycin is safe during pregnancy and can be used when the client is allergic to penicillin.

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NEW QUESTION: 467

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: 468

A client had a cardiac catheterization with angiography and thrombolytic therapy with streptokinase. The nurse should initiate which of the following interventions immediately after he returns to his room?

- A. Place him on NPO restriction for 4 hours.
- B. Monitor the catheterization site every 15 minutes.
- C. Place him in a high Fowler position.
- D. Ambulate him to the bathroom to void.

Answer: B (LEAVE A REPLY)

(A)

A contrast dye, iodine, is used in this procedure. This dye is nephrotoxic. The client must be encouraged to drink plenty of liquids to assist the kidneys in eliminating the dye.

(B)

Streptokinase activates plasminogen, dissolving fibrin deposits. To prevent bleeding, pressure is applied at the insertion site. The client is assessed for both internal and external bleeding. (C) The extremity used for the insertion site must be kept straight and be immobilized because of the potential for bleeding. (D) The client is kept on bed rest for 8-12 hours following the procedure because of the potential for bleeding.

NEW QUESTION: 469

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: 470

After a liver biopsy, the best position for the client is:

- A. High Fowler
- B. Prone
- C. Supine
- D. Right lateral

Answer: D (LEAVE A REPLY)

Explanation/Reference:

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: 471

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: C (LEAVE A REPLY)

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: 472

A client had a renal transplant 3 months ago. He has suddenly developed graft tenderness, an increased white blood cell count, and malaise. The client is experiencing which type of rejection?

- A. Acute
- B. Chronic
- C. Hyperacute
- D. Hyperchronic

Answer: A (LEAVE A REPLY)

(A)

The sudden development of fever, graft tenderness, increased white blood count, and malaise are signs and symptoms of an acute rejection that commonly occurs at 3 months.

(B)

Chronic rejection occurs slowly over a period of months to years and mimics chronic renal failure. (C) Hyperacute rejection occurs immediately after surgery up to 48 hours postoperatively. (D) Hyperchronic rejection is not a type of rejection.

NEW QUESTION: 473

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: 474

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: B (LEAVE A REPLY)

Explanation/Reference:

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: 475

A 3-year-old female client is brought into the pediatric clinic because she limps. She has not been to the clinic since she was 9 months old. The nurse practitioner describes the limp as a "Trendelenburg gait." This gait is characteristic of:

- A.** Scoliosis
- B.** Dislocated hip
- C.** Fractured femur
- D.** Fractured pelvis

Answer: B (LEAVE A REPLY)

(A, C, D) A Trendelenburg gait is not characteristic of any of these disorders. (B) The downward slant of one hip is a positive sign of dislocation in the weight-bearing hip. If one hip is dislocated, the child walks with a characteristic limp known as the Trendelenburg gait.

NEW QUESTION: 476

A female client is seeking counseling for personal problems. She admits to being very unhappy lately at both home and work. During the nursing assessment, she uses many defense mechanisms. Which statement or action made by the client is an example of adaptive suppression?

A. "I did not get the raise because my boss does not like me."

B. "I felt a lump in my breast 2 weeks ago. I put off getting it checked until after my sister's wedding."

C. "My son died 3 years ago. I still cannot bring myself to clean out his room."

D. "My husband told me this morning that he wants a divorce. I am upset, but I cannot discuss the matter with him until after my company's board meeting today."

Answer: (SHOW ANSWER)

(A) This statement is an example of adaptive rationalization. She is coping with her disappointment by rationalizing. This is adaptive because no harm is done to self or others. It is used to protect her ego. (B) This is an example of maladaptive suppression. She is suppressing the seriousness of the lump. It is maladaptive because delaying treatment will cause harm to her. (C) The client's actions are an example of maladaptive denial. She is denying her son's death by not facing his possessions. Until she faces his death, she cannot face reality. (D) This is an example of adaptive suppression. She realizes the impact of her husband's statement but delays discussion until she can devote her full attention to the matter.

NEW QUESTION: 477

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: 478

A male client received a heart-lung transplant 1 month ago at a local transplant center. While visiting the nursing center to have his blood pressure taken, he complains of recent weakness and fatigue. He also tells the nurse that he is considering stopping his cyclosporine because it is expensive and is causing his face to become round. He fears he will catch viruses and be more susceptible to infections. The nurse responds to this last statement by explaining that cyclosporine:

- A.** Is given to prevent rejection and makes him less susceptible to infection than other oral corticosteroids
- B.** Is available at discount pharmacies for a reduced price
- C.** Is usually not necessary after the first year following transplantation
- D.** May initially cause weakness, dizziness, and fatigue, but these side effects will gradually resolve themselves

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

(A) Cyclosporine is the immunosuppressive drug of choice. It provides immunosuppression but does not lower the white blood cell count; therefore, the client is less susceptible to infection. (B) Cyclosporine is available at discount pharmacies. The cost may be absorbed by health insurance, or Medicare, if the client is eligible. However, this statement does not address the entire problem verbalized by the client. (C) Immunosuppressive agents will be taken for the client's entire life because rejection can occur at any time. (D) These side effects do not necessarily resolve in time; however, the client may adapt.

NEW QUESTION: 479

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: ([SHOW ANSWER](#)**)**

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: 480

Degenerative disorders are attributed to many factors. As a nurse assigned to a convalescent home, one must often educate families about how such conditions occur. Which of the following statements might the nurse need to explore when a daughter tries to explain to her mother what caused her degenerative disorder?

- A. "Some folks believe that aging causes this, Mother."
- B. "Perhaps, it's the way your parents used those double-bind messages, Mother."
- C. "I know some people who are having this problem and they were exposed to chemicals at work, Mother."
- D. "It can be caused by lots of things, toxic agents and even alcohol, Mother."

Answer: B (LEAVE A REPLY)

Section: Questions Set F

Explanation:

(A) Aging is a factor in the cause of degenerative disorders. (B) Double-bind messages may be found in the histories of families of individuals who develop schizophrenia, but they are not related to degenerative disorders. (C) Chemicals (toxic agents) in work environments are predisposing factors to degenerative disorders. (D) Alcohol causes some degenerative disorders, such as Wernicke's syndrome.

NEW QUESTION: 481

A 67-year-old postoperative TURP client has hematuria. The nurse caring for him reviews his postoperative orders and recognizes that which one of the following prescribed medications would best relieve this problem?

- A. Acetaminophen suppository 650 mg
- B. Meperidine 50 mg IM
- C. Promethazine 25 mg IM
- D. Aminocaproic acid (Amicar) 6 g/24 hr

Answer: D (LEAVE A REPLY)

(A) Acetaminophen (Tylenol) has analgesic and antipyretic actions approximately equivalent to those of aspirin. It produces analgesia possibly by action on the peripheral nervous system. It reduces fever by direct action on the hypothalamus heat-regulating center with consequent peripheral vasodilation. It is generally used for temporary relief of mild to moderate pain, such as a simple headache, minor joint and muscle pains, and control of fever. (B) Meperidine is a narcotic agonist analgesic with properties similar to morphine except that it has a shorter duration of action and produces less depression of urinary retention and smooth muscle spasm. It is used for moderate to severe pain, for a preoperative medication, for support of anesthesia, and for obstetrical analgesia. In a postoperative TURP client, it would be used in conjunction with other medications for relief of moderate to severe pain, but not specifically for bladder spasms associated with TURP surgery. (C) Promethazine hydrochloride is an antihistamine, antiemetic preparation. It

exerts antiserotonin, anticholinergic, and local anesthetic actions. It is used for symptomatic relief of various allergic conditions, motion sickness, nausea, and vomiting. It is used for preoperative, postoperative, and obstetrical sedation and as an adjunct to analgesics for control of pain. (D) This answer is correct because aminocaproic acid is prescribed specifically for hematuria. Aminocaproic acid is excreted in the urine. The nurse should be alert for possible signs of thrombosis, particularly in the extremities.

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NEW QUESTION: 482

A common complication of cirrhosis of the liver is prolonged bleeding. The nurse should be prepared to administer?

- A. Vitamin C
- B. Vitamin K
- C. Vitamin E
- D. Vitamin A

Answer: (SHOW ANSWER)

Section: Questions Set D

Explanation:

(A) Vitamin C does not directly affect clotting. (B) Vitamin K is a fat-soluble vitamin that depends on liver function for absorption. Vitamin K is essential for clotting. (C) Vitamin E does not directly affect clotting. (D) Vitamin A does not directly affect clotting.

NEW QUESTION: 483

A client with bipolar disorder taking lithium tells the nurse that he has ringing in his ears, blurred vision, and diarrhea. The nurse notices a slight tremor in his left hand and a slurring pattern to his speech. Which of the following actions by the nurse is appropriate?

- A. Administer a stat dose of lithium as necessary.
- B. Recognize this as an expected response to lithium.
- C. Request an order for a stat blood lithium level.
- D. Give an oral dose of lithium antidote.

Answer: (SHOW ANSWER)

Section: Questions Set A

Explanation:

(A) These symptoms are indicative of lithium toxicity. A stat dose of lithium could be fatal.
(B) These are toxic effects of lithium therapy. (C) The client is exhibiting symptoms of lithium toxicity, which may be validated by lab studies. (D) There is no known lithium antidote.

NEW QUESTION: 484

A client is diagnosed with *Mycobacterium tuberculosis*. He is placed in respiratory isolation, intubated, and receives mechanical ventilation. When performing suctioning, the nurse should:

- A.** Suction for a maximum of 20 seconds
- B.** Hyperoxygenate before and after suctioning
- C.** Suction for a maximum of 30 seconds
- D.** Maintain clean technique during suctioning

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

Explanation

(A) The maximum time for suctioning is 10-15 seconds. (B) Supplemental O₂ should be administered before and after suctioning to reduce hypoxia. (C) The maximum time for suctioning is 10-15 seconds. (D) Strict sterile technique should be used during suctioning.

NEW QUESTION: 485

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

(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: 486

A postoperative prostatectomy client is preparing for discharge from the hospital the next morning. The nurse realizes that additional instructions are necessary when he states:

- A.** "If I drink 10 to 12 glasses of fluids each day, that will help to prevent any clot formation in my urine."

B. "The isometric exercises will help to strengthen my perineal muscles and help me control my urine."

C. "If I feel as though I have developed a fever, I will take a rectal temperature, which is the most accurate."

D. "I do not plan to do any heavy lifting until I visit my doctor again."

Answer: ([SHOW ANSWER](#))

(A) This is correct health teaching. Drinking 10-12 glasses of clear liquid will help increase urine volumes and prevent clot formation. (B) This is correct health teaching. These types of exercises are prescribed by physicians to assist postprostatectomy clients to strengthen their perineal muscles. (C) This action is not recommended post-TURP because of the close proximity of the prostate and rectum. (D) This is correct healthcare teaching. The client should limit walking long distances, lifting heavy objects, or driving a car until these activities are cleared by the physician at the first office visit.

NEW QUESTION: 487

A client develops complications following a hysterectomy. Blood cultures reveal *Pseudomonas aeruginosa*. The nurse expects that the physician would order an appropriate antibiotic to treat

P. aeruginosa such as:

A. Cefoperazone (Cefobid)

B. Clindamycin (Cleocin)

C. Dicloxacillin (Dycill)

D. Erythromycin (Erythrocin)

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

Section: Questions Set G

Explanation:

(A) Cefoperazone is indicated in the treatment of infection with *Pseudomonas aeruginosa*.

(B) Clindamycin is not indicated in the treatment of infection with *P. aeruginosa*. (C)

Dicloxacillin is not indicated in the treatment of infection with

P. aeruginosa. (D) Erythromycin is not indicated in the treatment of infection with

P. aeruginosa.

NEW QUESTION: 488

A murmur has been discovered during the routine physical examination of a 1-year-old child. The parent is extremely concerned about this diagnosis. Which of the following explanations by the nurse indicates understanding of this dysfunction?

A. The blood shifts from the right to the left atrium.

B. Surgical closure by suture or patch is recommended before school age.

C. Most atrial septal defects close spontaneously.

D. The child can be treated medically with antibiotics to prevent bacterial endocarditis.

Answer: ([SHOW ANSWER](#))

Explanation

(A) Because the left atrial pressure is greater than right atrial pressure, oxygenated blood flows from the left to the right atria. (B) Because of the risk of pulmonary obstructive diseases and congestive heart failure later in life, surgery is usually performed between age 4 and 6 years, with essentially no operative mortality or postoperative complications. (C) Many ventricular septal defects close spontaneously (20-60%) as a result of growth and proliferation of the muscular septum or formation of a membrane across the opening. (D) This management is usually recommended with children with mild pulmonary stenosis.

NEW QUESTION: 489

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

(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: 490

A 67-year-old client will be undergoing a coronary arteriography in the morning. Client teaching about postprocedure nursing care should include that:

- A. Bed rest with bathroom privileges will be ordered
- B. He will be kept NPO for 8-12 hours
- C. Some oozing of blood at the arterial puncture site is normal
- D. The leg used for arterial puncture should be kept straight for 8-12 hours

Answer: ([SHOW ANSWER](#))

Explanation

(A) Bed rest will be ordered for 8-12 hours postprocedure. Flexing of the leg at the arterial puncture site will occur if the client gets out of bed, and this is contraindicated after arteriography. (B) The client will be able to eat as soon as he is alert enough to swallow safely and that will depend on what medications are used for sedation during the procedure. (C) Oozing at the arterial puncture site is not normal and should be closely evaluated. (D) The leg where the arterial puncture occurred must be kept straight for 8-12 hours to minimize the risk of bleeding.

NEW QUESTION: 491

A 1-year-old child is to receive an IM injection ordered by his pediatrician. He has fallen asleep in his mother's arms when the nurse approaches. Which approach is most appropriate at this time?

- A. Give the injection in the vastus lateralis site before the child awakens.
- B. Awaken the child first and give the injection in the ventrogluteal site.
- C. Awaken the child first and give the injection in the dorsogluteal site.
- D. Ask the mother to place the child on the examination table and leave the room, and then give the injection in an appropriate site.

Answer: B (LEAVE A REPLY)

Explanation

(A) If awakened first, the child will know that nothing painful will be done without the child being alerted. (B) The ventrogluteal site is a safe site for children because it is a large muscle free of major nerves and blood vessels. (C) The dorsogluteal site is not recommended in children who have not been walking for at least 1 year because the muscle is not fully developed. (D) The parent will be able to offer support and comfort during and after the injection.

NEW QUESTION: 492

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: D (LEAVE A REPLY)

Section: Questions Set D

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.

NEW QUESTION: 493

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)

Section: Questions Set F

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: 494

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)

Explanation

(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: 495

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: 496

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](#))

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.

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NEW QUESTION: 497

A 27-year-old man was diagnosed with type I diabetes 3 months ago. Two weeks ago he complained of pain, redness, and tenderness in his right lower leg. He is admitted to the hospital with a slight elevation of temperature and vague complaints of "not feeling well." At 4:30 PM on the day of his admission, his blood glucose level is 50 mg; dinner will be served at 5:00 PM. The best nursing action would be to:

- A. Give him 3 tbsp of sugar dissolved in 4 oz of grape juice to drink
- B. Ask him to dissolve three pieces of hard candy in his mouth
- C. Have him drink 4 oz of orange juice
- D. Monitor him closely until dinner arrives

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

Explanation

(A) The combination of sugar and juice will increase the blood sugar beyond the normal range. (B) Concentrated sweets are not absorbed as fast as juice; consequently, they elevate the blood sugar beyond the normal limit. (C) Four ounces of orange juice will act immediately to raise the blood sugar to a normal level and sustain it for 30 minutes until supper is served. (D) There is an increased potential for the client's blood sugar to decrease even further, resulting in diabetic coma.

NEW QUESTION: 498

In addition to changing the mother's position to relieve cord pressure, the nurse may employ the following measure (s) in the event that she observes the cord out of the vagina:

- A. Immediately pour sterile saline on the cord, and repeat this every 15 minutes to prevent drying.
- B. Cover the cord with a wet sponge.
- C. Apply a cord clamp to the exposed cord, and cover with a sterile towel.
- D. Keep the cord warm and moist by continuous applications of warm, sterile saline compresses.

Answer: D (LEAVE A REPLY)

(A) Saline should be warmed; waiting 15 minutes may not keep the cord moist. (B) This choice does not specify what the sponge was "wet" with. (C) This measure would stop circulation to the fetus. (D) The cord should be kept warm and moist to maintain fetal circulation. This measure is an accepted nursing action.

NEW QUESTION: 499

A pregnant client is having a nonstress test (NST). It is noted that the fetal heart beat rises 20 bpm, lasting 20 seconds, every time the fetus moves. The nurse explains that:

- A. The test is inconclusive and should be repeated
- B. Further testing is needed
- C. The test is normal and the fetus is reacting appropriately
- D. The fetus is distressed

Answer: (SHOW ANSWER)

Explanation

(A) The test results were normal, so there would be no need to repeat to determine results. (B) There are no data to indicate further tests are needed, because the result of the NST was normal. (C) An NST is reported as reactive if there are two to three increases in the fetal heart rate of 15 bpm, lasting at least 15 seconds during a 15-minute period. (D) The NST results were normal, so there was no fetal distress.

NEW QUESTION: 500

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

Section: Questions Set D

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: 501

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, brussels 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.

NEW QUESTION: 502

A client is in active labor and has been admitted to the labor and delivery unit. The RN has just done a sterile vaginal exam and determines that the client is dilated 5 cm, effaced 85%, and the fetus's head is at 0 station. She asks if she could have a lumbar epidural now. The epidural is started, and the anesthetic agent used is bupivacaine (Marcaine). After the client has received her lumbar epidural, it is important for the RN to monitor her for which of the following side effects:

- A. Hypertension
- B. Hypotension
- C. Hypoglycemia
- D. Hyperglycemia

Answer: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(A) The medication bupivacaine will cause vasodilation in the vascular system, and this does not result in elevation of the maternal blood pressure. (B) The medication bupivacaine will cause vasodilation in the vascular system, and this will result in lowering the maternal blood pressure. (C) Bupivacaine does not interfere with the functioning of the endocrine system. (D) Bupivacaine does not interfere with the functioning of the endocrine system.

NEW QUESTION: 503

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: (SHOW ANSWER)

Explanation/Reference:

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: 504

During the assessment, the nurse observes a client scratching his skin. He has been admitted to rule out Laennec's cirrhosis of the liver. The nurse knows the pruritus is directly related to:

- A.** A loss of phagocytic activity
- B.** Faulty processing of bilirubin
- C.** Enhanced detoxification of drugs
- D.** The formation of collateral circulation

Answer: B (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) A loss in the phagocytic activity of the Kupffer cells occurs with cirrhosis of the liver, which increases the susceptibility to infections. (B) The faulty processing of bilirubin

produces bilesalts, which are irritating to the skin. (C) The detoxification of drugs is impaired with cirrhosis of the liver. (D) Collateral circulation develops due to portal hypertension. This is manifest through the development of esophageal varices, hemorrhoids, and caput medusae.

NEW QUESTION: 505

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: ([SHOW ANSWER](#))

Section: Questions Set B

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: 506

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](#))

(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: 507

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: ([SHOW ANSWER](#))

(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: 508

A client suspects that she is pregnant. She reports two missed menstrual periods. The first day of her last menstrual period was August 3. Her estimated date of confinement would be:

- A. November 7
- B. November 10
- C. May 7
- D. May 10

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

(A)

Wrong calculation (B) Wrong calculation (C) Wrong calculation

(D)

Nagele's rule is: Expected Date of Confinement = Last Menstrual Period - 3 months + 7 days + 1 year

NEW QUESTION: 509

The nurse should know that according to current thinking, the most important prognostic factor for a client with breast cancer is:

- A. Tumor size
- B. Axillary node status
- C. Client's previous history of disease
- D. Client's level of estrogen-progesterone receptor assays

Answer: ([SHOW ANSWER](#))

Explanation

(A) Although tumor size is a factor in classification of cancer growth, it is not an indicator of lymph node spread. (B) Axillary node status is the most important indicator for predicting

how far the cancer has spread. If the lymph nodes are positive for cancer cells, the prognosis is poorer. (C) The client's previous history of cancer puts her at an increased risk for breast cancer recurrence, especially if the cancer occurred in the other breast. It does not predict prognosis, however. (D) The estrogen-progesterone assay test is used to identify present tumors being fed from an estrogen site within the body. Some breast cancers grow rapidly as long as there is an estrogen supply such as from the ovaries. The estrogen-progesterone assay test does not indicate the prognosis.

NEW QUESTION: 510

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

Explanation/Reference:

Explanation:

(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: 511

Diabetes during pregnancy requires tight metabolic control of glucose levels to prevent perinatal mortality.

When evaluating the pregnant client, the nurse knows the recommended serum glucose range during pregnancy is:

- A.** 70 mg/dL and 120 mg/dL
- B.** 100 mg/dL and 200 mg/dL
- C.** 40 mg/dL and 130 mg/dL
- D.** 90 mg/dL and 200 mg/dL

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

Explanation/Reference:

Explanation:

(A) The recommended range is 70-120 mg/dL to reduce the risk of perinatal mortality. (B, C, D) These levels are not recommended. The higher the blood glucose, the worse the prognosis for the fetus.

Hypoglycemia can also have detrimental effects on the fetus.

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NEW QUESTION: 512

Blood work reveals the following lab values for a client who has been diagnosed with anorexia nervosa:

hemoglobin 9.6 g/dL, hemocrit 27%, potassium 2.7 mEq/L, sodium 126 mEq/L. The greatest danger to her at this time is:

- A.** Hypoglycemia from low-carbohydrate intake
- B.** Possible cardiac dysrhythmias secondary to hypokalemia
- C.** Dehydration from vomiting
- D.** Anoxia secondary to anemia

Answer: B (LEAVE A REPLY)

Explanation

(A) There is no lab data to support hypoglycemia. (B) Hypokalemia, caused by vomiting and decreased dietary intake of potassium, can result in life-threatening dysrhythmias. (C) Evidence of dehydration is not life threatening at this time, although fluid volume deficit does need to be addressed. (D) The client's hemoglobin does not reflect a life threatening value sufficient to render the client anoxic.

NEW QUESTION: 513

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: 514

The cardiac client who exhibits the symptoms of disorientation, lethargy, and seizures may be exhibiting a toxic reaction to:

- A. Digoxin (Lanoxin)
- B. Lidocaine (Xylocaine)
- C. Quinidine gluconate or sulfate (Quinaglute, Quinidex)
- D. Nitroglycerin IV (Tridil)

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

Explanation/Reference:

Explanation:

(A) Side effects of digoxin include headache, hypotension, AV block, blurred vision, and yellow-green halos. (B) Side effects of lidocaine include heart block, headache, dizziness, confusion, tremor, lethargy, and convulsions. (C) Side effects of quinidine include heart block, hepatotoxicity, thrombocytopenia, and respiratory depression. (D) Side effects of nitroglycerin include postural hypotension, headache, dizziness, and flushing.

NEW QUESTION: 515

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.

NEW QUESTION: 516

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: ([SHOW ANSWER](#))

Explanation

(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: 517

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

(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.

NEW QUESTION: 518

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)

Explanation

(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: 519

A 43-year-old client is admitted to the hospital with a diagnosis of peripheral vascular disorder. She arrives in her room via stretcher and requires assistance to move to her bed. The nurse notes that her left leg is cold to touch. She complains of having recently experienced muscle spasms in that leg. To determine if these muscle spasms are indicative of intermittent claudication, the nurse would begin her assessment with the following question:

- A. "Would you describe the intensity, duration, and symptoms associated with your pain?"
- B. "Do you experience swelling at the end of the day in the affected and unaffected leg?"
- C. "Have you had any lesions of the affected leg that have been difficult to heal?"
- D. "Do your muscle spasms occur following rest, walking, or exercising?"

Answer: ([SHOW ANSWER](#))

(A)

Describing pain is an important aspect of the assessment; however, assessing activity preceding muscle spasms is equally important. (B) Edema may occur with peripheral vascular disease, but it is not of particular importance in assessing intermittent claudication.

(C)

Lesions may be present with peripheral vascular disease, but they are not an indication of intermittent claudication. (D) With intermittent claudication, muscle spasms occur intermittently, mainly with walking and after exercising. Rest may relieve muscle spasms.

NEW QUESTION: 520

Forty-eight hours after a thyroidectomy, a female client complains of numbness and tingling of the toes and fingers. The nurse notes upper arm and facial twitching. The nurse needs to:

- A. Report the findings to the physician
- B. Assist the client to do range of motion exercises
- C. Check the client's potassium level

D. Administer the as-needed dose of phenytoin (Dilantin)

Answer: ([SHOW ANSWER](#))

(A) Muscular hyperactivity and parasthesias may indicate hypocalcemic tetany and require immediate administration of calcium gluconate. Tetany can occur if the parathyroid glands were erroneously excised during surgery. (B) Range of motion exercises are not appropriate to presenting symptoms. (C) These characteristics are not usual signs of potassium imbalance, but of calcium imbalance. (D) Phenytoin is indicated for seizure activity mainly of neurological origin.

NEW QUESTION: 521

The mother of a child taking phenytoin will need to plan appropriate mouth care and gingival stimulation.

When tooth-brushing is contraindicated, the next most effective cleansing and gingival stimulation technique would be:

- A.** Using a water pik
- B.** Rinsing with water
- C.** Rinsing with hydrogen peroxide
- D.** Rinsing with baking soda

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

Explanation

(A) This technique provides effective rinsing and gingival stimulation. (B) This technique does not provide gingival stimulation. (C) This technique provides effective rinsing but not gingival stimulation. Using peroxide is not pleasant for the child. (D) This technique provides effective rinsing but not gingival stimulation.

NEW QUESTION: 522

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: ([SHOW ANSWER](#))

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: 523

Which of the following risk factors associated with breast cancer would a nurse consider most significant in a client's history?

- A. Menarche after age 13
- B. Nulliparity
- C. Maternal family history of breast cancer
- D. Early menopause

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

(A) Women who begin menarche late (after 13 years old) have a lower risk of developing breast cancer than women who have begun earlier. Average age for menarche is 12.5 years. (B) Women who have never been pregnant have an increased risk for breast cancer, but a positive family history poses an even greater risk. (C) A positive family history puts a woman at an increased risk of developing breast cancer. It is recommended that mammography screening begin 5 years before the age at which an immediate female relative was diagnosed with breast cancer. (D) Early menopause decreases the risk of developing breast cancer.

NEW QUESTION: 524

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](#)**)**

Section: Questions Set A

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: 525

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)

Explanation/Reference:

Explanation:

(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: 526

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: (SHOW ANSWER)

Section: Questions Set C

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.

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NEW QUESTION: 527

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)

Section: Questions Set F

Explanation:

(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: 528

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)

(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: 529

A 47-year-old client comes to the emergency department complaining of moderate flank, abdominal, and testicular pain with nausea of 4 hours' duration. After physical examination and obtaining the client's history, the physician suspects urethral obstruction by calculi. The nurse realizes that the physician will order which one of the following diagnostic studies to best confirm the diagnosis?

- A. Cystoscopy

- B.** Kidneys, ureter, bladder, x-ray of abdomen
- C.** Intravenous pyelogram with excretory urogram
- D.** Ureterolithotomy

Answer: C (LEAVE A REPLY)

Explanation

(A) Cystoscopy is an endoscopic procedure that uses an instrument (a cystoscope) to visualize the internal bladder and ureter structures and to capture and remove an obstructing stone. (B) Kidney, ureter, bladder x-ray is used to outline gross structural changes in the kidneys, ureter, and bladder and will determine the general location of a stone. (C) An intravenous pyelogram with excretory urogram is used to visualize the kidneys, kidney pelvis, ureters, and bladder. This procedure is used specifically to determine whether urethral obstruction is partial or complete; it shows the exact location of the stone and dilation of the ureter above the stone. (D) Ureterolithotomy is a surgical procedure in which the ureter is incised and the stone is manually removed because the stone is unable to pass through the ureter independently.

NEW QUESTION: 530

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: 531

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/Reference:

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: 532

A client is admitted to the psychiatric unit after lavage and stabilization in the emergency room for an overdose of antidepressants. This is her third attempt in 2 years. The highest priority intervention at this time is to:

- A.** Assess level of consciousness
- B.** Assess suicide potential
- C.** Observe for sedation and hypotension
- D.** Orient to her room and unit rules

Answer: ([SHOW ANSWER](#))

(A) The client was stabilized in the ED and consequently would not be sent to the psychiatric unit if comatose. (B) Suicide assessment is always appropriate for clients with a history of previous attempts or depression, because either of these factors places the client at high risk. (C) The admission assessment should include observation for sedation and hypotension, but this is not in priority over suicide assessment. (D) Orientation to room and unit rules is of low priority at this time.

NEW QUESTION: 533

A male client has heart failure. He has been instructed to gradually increase his activities. Which signs and symptoms of worsening heart failure should the nurse tell him to watch for that would indicate a need for him to lower his activity level?

- A.** Pain in his legs when he walks
- B.** Thirst, weight loss, and polyuria
- C.** Drowsiness and lethargy after his activities
- D.** Weight gain, edema in his lower extremities, and shortness of breath

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

(A) Pain in the legs could be indicative of doing too much too quickly, but not of worsening heart failure. The client should be cautioned to increase his activities slowly. (B) Thirst, weight loss, and frequent urination are not indicative of heart failure. The client should report these symptoms to his physician. (C) Drowsiness and lethargy are not indicative of worsening heart failure. The client should report these symptoms to his physician. (D) All of these symptoms indicate a worsening cardiac condition possibly associated with too much activity. The client's activity level should be evaluated.

NEW QUESTION: 534

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: 535

A 2-year-old child will undergo a cardiac catheterization tomorrow to evaluate his ventricular septal defect.

Based on his developmental stage, the nurse:

- A.** Uses pictures to explain the procedure to the child and his parents that evening
- B.** Explains the procedure using simple words and sentences just before the preoperative sedation
- C.** Asks the parents to explain the procedure to the child after she explains it to them
- D.** Asks the parents to leave the room while the preoperative medication and instructions are given

Answer: B (LEAVE A REPLY)

Explanation

(A) A toddler is not capable of conceptualizing about the inside of his body and is concerned about body intactness; therefore, diagrams would not be useful. Also, the previous evening is too far from the procedure for the toddler to remember the instructions. (B) A simple explanation the morning of the procedure is the best developmental strategy to use, because it focuses on the toddler's need for parental support, body intactness, and short attention span. (C) A relationship between the nurse and the child needs to develop. Also, misinformation may be given to the child if the parents explain the procedure to the child. (D) The parents are the child's support system and need to be there to strengthen the child.

NEW QUESTION: 536

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

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: 537

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](#))

Explanation/Reference:

Explanation:

(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: 538

A 3-year-old child is hospitalized with burns covering her trunk and lower extremities.

Which of the following would the nurse use to assess adequacy of fluid resuscitation in the burned child?

- A. Blood pressure
- B. Serum potassium level
- C. Urine output
- D. Pulse rate

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

Explanation/Reference:

Explanation:

(A) Blood pressure can remain normotensive even in a state of hypovolemia. (B) Serum potassium is not reliable for determining adequacy of fluid resuscitation. (C) Urine output, alteration in sensorium, and capillary refill are the most reliable indicators for assessing adequacy of fluid resuscitation. (D) Pulse rate may vary for many reasons and is not a reliable indicator for assessing adequacy of fluid resuscitation.

NEW QUESTION: 539

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)

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: 540

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: 541

When evaluating a client with symptoms of shock, it is important for the nurse to differentiate between neurogenic and hypovolemic shock. The symptoms of neurogenic shock differ from hypovolemic shock in that:

- A. In neurogenic shock, the skin is warm and dry
- B. In hypovolemic shock, there is a bradycardia
- C. In hypovolemic shock, capillary refill is less than 2 seconds
- D. In neurogenic shock, there is delayed capillary refill

Answer: A (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Neurogenic shock is caused by injury to the cervical region, which leads to loss of sympathetic control.

This loss leads to vasodilation of the vascular beds, bradycardia resulting from the lack of sympathetic balance to parasympathetic stimuli from the vagus nerve, and the loss of the ability to sweat below the level of injury. In neurogenic shock, the client is hypotensive but bradycardiac with warm, dry skin. (B) In hypovolemic shock, the client is hypotensive and tachycardiac with cool skin. (C) In hypovolemic shock, the capillary refill would be >5 seconds. (D) In neurogenic shock, there is no capillary delay, the vascular beds are dilated, and peripheral flow is good.

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NEW QUESTION: 542

A female client at 36 weeks' gestation has been treated successfully for premature labor for 4 weeks. She has begun having uterine contractions today and has been admitted to the labor and delivery suite. Her amniocentesis results reveal a lecithin/sphingomyelin (L/S) ratio of 2 and positive phosphatidylglycerol (PG). These lab values indicate:

- A. Placental maturity
- B. Suspected chronic asphyxia
- C. Cord compression
- D. Fetal lung maturity

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Placental maturity is assessed by a biophysical profile. (B) L/S ratio and presence of phosphatidylglycerol are not used to determine fetal asphyxia. A biophysical profile score of 6 may indicate this condition. (C) Cord compression is not reflected by the L/S ratio or presence of phosphatidylglycerol.

Variable decelerations observed through electronic fetal monitoring could reflect umbilical cord compression. (D) An L/S ratio >2 and the presence of phosphatidylglycerol in amniotic fluid indicate fetal lung maturity.

NEW QUESTION: 543

In counseling a client, the nurse emphasizes the danger signals during pregnancy. On the next visit, the client identifies which of the following as a danger signal that should be reported immediately?

- A. Backache
- B. Leaking of clear yellow fluid from breasts
- C. Constipation with hemorrhoids
- D. Visual changes

Answer: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) Backache is a common complaint during pregnancy. Proper body mechanics, pelvic rock, back rubs, and other comfort measures should relieve the discomfort. In the presence of uterine contractions, the backache would radiate to the lower abdomen. (B) Colostrum is normal and can be present anytime in the second half of pregnancy. (C) Constipation and hemorrhoids are common and do need attention, but they do not constitute a dangerous situation. (D) Visual changes are possibly related to PIH. The client should be assessed immediately to rule out or prevent worsening of PIH.

NEW QUESTION: 544

A 19-year-old primigravida is admitted to the labor and delivery suite of the hospital. Her husband is accompanying her. The couple tells the nurse that this is the first hospital admission for her. The client's vaginal exam indicates she is 3 cm dilated, 80% effaced, and at 0 station. Based on the vaginal exam, she is in:

- A. Stage 2, latent phase
- B. Stage 1, active phase
- C. Stage 3, transition phase
- D. Stage 1, latent phase

Answer: D (LEAVE A REPLY)

Section: Questions Set E

Explanation:

(A) The second stage of labor is from full cervical dilation through birth of the baby. The three phases of this stage include latency or resting, descent, and final transition. The client is less than fully dilated so she is not in stage 2. (B) The first stage of labor begins with regular uterine contractions and continues until the woman is 10 cm dilated. The three phases of this stage include the early or latent phase (0-3 cm), the active phase (4-7 cm), and the transitional phase (7-10 cm). The client is < 4 cm dilated so she is in the latent phase of the first stage of labor. (C) The third stage of labor is from the birth of the baby until the delivery of the placenta. The client is less than fully dilated. (D) The first stage of labor begins with regular uterine contractions and continues until the woman is 10 cm dilated. The three phases of this stage include the early or latent phase (0-3 cm), the active phase (4-7 cm), and the transitional phase (7-10 cm). The client is <4 cm dilated so she is in the latent phase of the first stage of labor.

NEW QUESTION: 545

The nurse knows that children are more susceptible to respiratory tract infections owing to physiological differences. These childhood differences, when compared to an adult, include:

- A. Fewer alveoli, slower respiratory rate
- B. Diaphragmatic breathing, larger volume of air
- C. Larger number of alveoli, diaphragmatic breathing
- D. Rounded shape of chest, smaller volume of air

Answer: D (LEAVE A REPLY)

(A) Although a child has fewer alveoli than an adult, the child's respiratory rate is faster. (B) Although a child may use diaphragmatic breathing, the adult exchanges a larger volume of air. (C) The adult has a larger number of alveoli than a child. (D) The child's chest is rounded whereas the adult chest is more of an oval shape, and the child does exchange a smaller volume of air than an adult.

NEW QUESTION: 546

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: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(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: 547

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: D (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(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.

NEW QUESTION: 548

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.

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

$$0.4 \text{ } x = 0.15$$

$$x = 0.15/0.4$$

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

(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: 549

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: A (LEAVE A REPLY)

(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: 550

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)

Section: Questions Set A

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: 551

A 14-year-old teenager is hospitalized for anorexia nervosa. She is admitted to the adolescent mental health unit and placed on a behavior modification program. Nursing interventions for the teenager will most likely include:

- A.** Establishing routine tasks and activities around mealtimes
- B.** Administering medications such as lithium
- C.** Requiring the client to eat more during meals
- D.** Checking the client's room frequently

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

(A) Providing a more structured, supportive environment addresses safety and comfort needs, thereby helping the anorexic client develop more internal control. (B) Medications (commonly antidepressants) are frequently ordered for the anorexic client. However, lithium (used primarily with bipolar disorder) is not commonly used to treat the anorexic client. (C) Requiring and/or demanding that the anorexic client "eat more" at mealtimes increases the client's feelings of powerlessness. (D) Like the previous strategy, checking the client's room frequently contributes to the client's feelings of powerlessness.

NEW QUESTION: 552

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: ([SHOW ANSWER](#))

Explanation/Reference:

Explanation:

(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: 553

Which classification of drugs is contraindicated for the client with hypertrophic cardiomyopathy?

- A. Positive inotropes
- B. Vasodilators
- C. Diuretics
- D. Antidysrhythmics

Answer: (SHOW ANSWER)

Explanation/Reference:

Explanation:

(A) Positive inotropic agents should not be administered owing to their action of increasing myocardial contractility. Increased ventricular contractility would increase outflow tract obstruction in the client with hypertrophic cardiomyopathy. (B) Vasodilators are not typically prescribed but are not contraindicated. (C) Diuretics are used with caution to avoid causing hypovolemia. (D) Antidysrhythmics are typically needed to treat both atrial and ventricular dysrhythmias.

NEW QUESTION: 554

In a client with chest trauma, the nurse needs to evaluate mediastinal position. This can best be done by:

- A. Auscultating bilateral breath sounds
- B. Palpating for presence of crepitus
- C. Palpating for trachial deviation
- D. Auscultating heart sounds

Answer: C (LEAVE A REPLY)

Explanation

(A) No change in the breath sounds occurs as a direct result of the mediastinal shift. (B) Crepitus can occur owing to the primary disorder, not to the mediastinal shift. (C) Mediastinal shift occurs primarily with tension pneumothorax, but it can occur with very large hemothorax or pneumothorax. Mediastinal shift causes trachial deviation and deviation of the heart's point of maximum impulse. (D) No change in the heart sounds occurs as a result of the mediastinal shift.

NEW QUESTION: 555

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/Reference:

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: 556

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)

Explanation/Reference:

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.

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NEW QUESTION: 557

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: (SHOW ANSWER)

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: 558

A pregnant client during labor is irritable and feels the urge to vomit. The nurse should recognize this as the:

- A. Fourth stage of labor
- B. Third stage of labor
- C. Transition stage of labor
- D. Second stage of labor

Answer: C (LEAVE A REPLY)

Explanation/Reference:

Explanation:

(A) The fourth stage begins after expulsion of the placenta. Client symptoms are: fatigue; chills; scant, bloody vaginal discharge; and nausea. (B) The third stage is from birth to expulsion of placenta. Client symptoms are uterine contractions, gush of blood, and perineal pain. (C) The transition stage is characterized by strong uterine contractions and cervical dilation. Client symptoms are irritability, restlessness, belching, muscle tremors, nausea, and vomiting. (D) The second stage is characterized by full dilation of cervix. Client symptoms are perineal bulge, pushing with contractions, great irritability, and leg cramps.

NEW QUESTION: 559

In addition to changing the mother's position to relieve cord pressure, the nurse may employ the following measure (s) in the event that she observes the cord out of the vagina:

- A. Immediately pour sterile saline on the cord, and repeat this every 15 minutes to prevent drying.
- B. Cover the cord with a wet sponge.

- C. Apply a cord clamp to the exposed cord, and cover with a sterile towel.
- D. Keep the cord warm and moist by continuous applications of warm, sterile saline compresses.

Answer: D (LEAVE A REPLY)

Explanation

(A) Saline should be warmed; waiting 15 minutes may not keep the cord moist. (B) This choice does not specify what the sponge was "wet" with. (C) This measure would stop circulation to the fetus. (D) The cord should be kept warm and moist to maintain fetal circulation. This measure is an accepted nursing action.

NEW QUESTION: 560

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)

(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: 561

A 29-year-old client is diagnosed with borderline personality disorder. He has aroused the nurse's anger by using a condescending tone of voice with other clients and staff persons. Which of the following statements from the nurse would be most appropriate in acknowledging feelings regarding the client's behavior?

- A. "I feel angry when I hear that tone of voice."
- B. "You make me angry when you talk to me that way."
- C. "Are you trying to get me angry?"
- D. "Why do you treat me that way?"

Answer: A (LEAVE A REPLY)

The nurse appropriately states how he or she feels when the client speaks in a condescending manner. (B) This statement indicates that the client has control over the nurse. No one makes another person angry; each individual has a choice. (C) "Why"

questions usually put a person on the defensive. In addition, the client cannot "make" the nurse angry. The client does not have that control. (D) Again, a "why" statement places the client on the defensive.

NEW QUESTION: 562

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)

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: 563

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)

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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: 564

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

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: 565

To appropriately monitor therapy and client progress, the nurse should be aware that increased myocardial work and O₂ demand will occur with which of the following?

- A.** Positive inotropic therapy
- B.** Negative chronotropic therapy
- C.** Increase in balance of myocardial O₂ supply and demand
- D.** Afterload reduction therapy

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

Explanation/Reference:

Explanation:

(A) Inotropic therapy will increase contractility, which will increase myocardial O₂ demand. (B) Decreased heart rate to the point of bradycardia will increase coronary artery filling time. This should be used cautiously because tachycardia may be a compensatory mechanism to increase cardiac output. (C) The goal in the care of the MI client with angina is to maintain a balance between myocardial O₂ supply and demand. (D) Decrease in systemic vascular resistance by drug therapy, such as IV nitroglycerin or nitroprusside, or intra-aortic balloon pump therapy, would decrease myocardial work and O₂ demand.

NEW QUESTION: 566

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)

Explanation

(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.

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