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1. It is considered negligent when the nurse delegates which of the following tasks to a CNA?

a.Ambulating a patient to the restroom.
b.Nasotracheal suctioning an alert and oriented patient.
c. Obtaining a urine sample from the Foley catheter.
d. Obtaining a blood glucose value using a lancet and password protected glucometer.

b. The scope of practice of CNA's allows for sampling of urine and blood with an appropriate order and delegation by a registered nurse. Ambulating a patient in a safe manner is also acceptable. Invasive procedures such as nasotracheal suctioning are beyond the scope of practice of non-licensed assistive personnel.

2. The nurse should intervene when observing a student nurse doing the following:

a.Not aspirating before injecting insulin.
b.Performing an intra-muscular injection at a 90-degree angle.
c.Using the patient's name and date of birth to confirm their identity.
d.Preparing oral medications for more than one patient at a time.

d. Intramuscular injection can be performed at a 90-degree angle and subcutaneous injections do not require aspiration, although IM injections do, to rule out accidental intravascular placement. Patient identifiers include name, date of birth, room number, and medical ID number. Preparing medications for more than one patient at a time can create confusion and increases the chance of medication errors.

4. The nurse has several tasks to perform this afternoon. Which of the following should the nurse delegate to the CNA?

a. Assessing the breath sounds of a patient with shortness of breath.
b. Removing a pressure ulcer dressing in anticipation of the rounding physician.
c. Performing a rectal temperature on a febrile patient receiving Tylenol.
d. Administering tube feeding through the Dobhoff of a patient with increased intracranial pressures.

d. In most states CNA's are not allowed to perform invasive procedures like rectal temperatures, apply or remove dressings, or perform assessments especially when a change in the patient's conditions requires nursing skills. Administering tube feedings is acceptable despite the increased ICP. As long as the tube is already in place and it's appropriate position confirmed and the CNA is following orders closely, they are practicing within their guidelines and in no threat of increasing the ICP any further.

5. The nurse observes a female patient appearing nervous during the health history when her husband is present. She continually glances at her husband before answering questions. Several bruises in various stages of healing are present on physical examination around her back and shoulders along with several abrasions. How should the nurse chart the findings?

a. "Two abrasions measuring 1 inch in length and several small bruises."
b. "Multiple bruises and abrasions the result of blunt trauma."
c. "Two abrasions measuring 1 inch in length and five bruises in multiple stages of healing, abuse suspected."
d. "Five bruises along lower back in multiple stages of healing and two open abrasions between shoulder blades 1 inch in length."

d. Charting based on speculation is not a standard of practice. Only include objective information and observations. Remember to include measurable information when possible.

6. A nurse on the neurology unit has the following patients. Which would be the most concerning and require the nurse to contact the physician?

a. A patient who states, “I have a headache and my balance has been off all day”.
b. A patient becomes dizzy and almost falls when standing from a seated position.
c. A patient states, “My vision becomes blurring when I get up in the morning”.
d. A patient recovering from a motor vehicle collision with intracranial monitoring and an ICP that has risen from 6 mmHg to 11 mmHg.

a. The patient may be experiencing a stroke. Headache is a warning sign along with subjective findings such as feeling “funny” or “off”. Orthostatic hypotension is not an urgent situation and normal ICP ranges from 5 mmHg to 15 mmHg.

8. The home care nurse reviews the patient list in order to prioritize home visitations. Which patient should the nurse see first?

a. A 65-year-old patient with chronic obstructive pulmonary disease on supplemental oxygen.
b. A 40-year-old patient diagnosed with type 2 diabetes reporting poor sensation in his feet.
c. A 45-year-old reporting a cough 3 days post hysterectomy.
d. A 50-year-old complaining of tenderness at the incision site 2 days post inguinal hernia repair.

c. Patients are at a high risk for pulmonary embolism after hysterectomy surgery. Shortness of breath, cough, and chest pain are common signs. The COPD and diabetes patients are experiences expected complications of non-acute diseases. Although the inguinal hernia is an acute problem, it is an expected finding.

9. The nurse driving home from work comes upon a multiple motor vehicle accident. As the first responder on site, which person should the nurse see first?

a. A child crying and clutching a visibly disfigured and bloody arm, appears pale.
b. An older man standing at side of road yelling in a hoarse tone of voice that he is “fine”, singed nose hairs noted.
c. A woman with deep abrasions to head who is reporting severe pain and appears disoriented.
d. A middle-aged man with blistered burns on upper and lower back with rapid pulse.

b. This patient has signs of inhalation injury and must be triaged first as prompt intervention can prevent swelling of the airway from edema. Although many other people are displaying volume loss, shock, pain, and head trauma, the airway is always the first consideration.

10. A new graduate nurse is assigned to take care of a patient with acquired immune deficiency syndrome (AIDS). The new graduate refuses to enter the patient's room and asks to be assigned to another patient. How should the nurse best respond to this situation?

a. "As a new graduate nurse it is important to gain exposure to all patient types. This will be a good opportunity for you."
b. "Regardless of personal view, it is our duty as nurses to take care of the sick and suffering."
c. "I noticed that you seem uncomfortable with this patient assignment."
d. "We will assign you to a different patient."

c. Therapeutic communication involves open-ended questions and restating what the person has shared. This allows them to reflect and expand on their feelings. Abrasive, dismissive, or judgmental responses are not helpful.

11. After reviewing voicemails left from home care patients, which message will the home health care nurse return first?

a. A patient with coronary artery disease who is complaining of pain along his shoulders and bicep.
b. A patient with osteoarthritis reporting warmth and tenderness in her left knee.
c. A patient complaining of sudden swelling, warmth, and 8/10 pain in both lower legs.
d. A patient reporting rebound abdominal pain and a fever.

a. The patient is displaying symptoms of a heart attack. Although immediate intervention must take place with bilateral deep vein thrombosis and appendicitis, a myocardial infarction presents a greater risk of mortality.

12. The nurse plans to administer carbamazepine 100 mg to a patient for the off-label indication of restless leg syndrome. What is the most important laboratory test that the nurse should perform?

a.White blood cell and platelet count.
b.Thyroid stimulating hormone.
c.Arterial blood gas.
d.Serum potassium.

a. Carbamazepine can cause aplastic anemia, a disease in which the bone marrow and blood stem cells are damaged. This causes a deficiency in white blood cells, platelets, and red blood cells. Screening for deficits in platelets, red blood cells, and red blood cells prior to initiation of therapy is important.

13. The nurse cares for a patient who takes metformin daily. The patient complains of muscle pain, nausea, and feeling tired. What laboratory test should the nurse perform first?

a.Complete blood count.
b.Liver function test.
c.C-reactive protein.
d.Arterial blood gas.

d. Metformin causes lactic acidosis by reducing pyruvate dehydrogenase activity and mitochondrial transport of reducing agents, and thus enhances anaerobic metabolism. The quickest way to assess for lactic acidosis is an arterial blood gas. Acidosis is characterized by an arterial pH < 7.35.

14. Before the nurse administers dilaudid 8 mg PO, which vital sign is it most important to assess?

a.Blood pressure.
b.Heart rate.
c.Respiratory rate.
d.Temperature.

c. Opioid analgesics depress the respiratory reflex by a direct effect on brain stem respiratory centers. The mechanism of respiratory depression also involves a reduction in the responsiveness of the brain stem respiratory centers to increases in carbon dioxide. The respiratory rate should be monitored before and throughout the administration of all opioids and opiates.

15. The nurse observes a patient at the community clinic as she prepares her daily medications. The nurse knows that teaching has been effective when the patient states:

a.“I can crush enteric coated aspirin to make them easier to swallow.”
b.“If I forget to take a dose of my medication, I can take twice the amount next time.”
c.“I share medications with my wife when she runs out.”
d.“I’ll talk to my physician about switching to a generic if I can’t afford the medication.”

d. Enteric coated medications are designed to be released slowly into the bloodstream. Crushing can alter this mechanism. Sharing medications can lead to errors of over or under-dose. Doubling medications can lead to overdose.

16. The nurse evaluates the effectiveness of warfarin therapy in the patient. What serum test will be most accurate in assessing the therapeutic value of warfarin?

a.Partial thromboplastin time (PTT).
b.International normalized ratio (INR).
c.Complete metabolic panel (CMP).
d.Platelet count.

b. INR is used to determine the clotting tendency of a patient's blood. It is a standardized measurement of time that indirectly assesses warfarin doses, liver damage, and vitamin K status. The target range for INR in warfarin use is 2-3.

17. Which of the following is considered a contraindication for the administration of metoprolol?

a.Hypertension.
b.Increased urine output.
c.Decreased respiratory rate.
d.Bradycardia.

d. Metoprolol blocks the response of beta-adrenergic stimulation. It is cardioselective for beta 1 at low doses. It decreases heart rate, so if a patient has a heart rate of less than 60 beast/min, it is not safe to administer.

18. The patient reports to the nurse that the last time he had an intravenous pyelogram performed he had an anaphylactic response from the contrast dye. The nurse knows that an anaphylactic response includes all of the following except:

a.Sedation.
b.Hives.
c.Shortness of breath.
d.Angioedema.

a. Anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death. It is typically caused by insect stings, foods, or medications. Anaphylaxis is caused by the release of inflammatory mediators from white blood cells.

19. The nurse educates the patient who has recently been prescribed escitalopram for depression. The nurse should include what common side effect in the teaching?

a.Hyperglycemia.
b.Anemia.
c.Diarrhea.
d.Weight gain.

d. Up to 25% of patients on antidepressants gain weight. It is theorized that antidepressants trigger food cravings, particularly for carbohydrates. The drugs may also affect metabolism. Also, some postulate that when the patient becomes less depressed, the patient may regain appetite.

20. Which of the following would be considered an advantage of intramuscular injection over subcutaneous injection?

a.Less painful.
b.Easier self-injection.
c.More injection sites to choose.
d.Absorbs into bloodstream more quickly.

d. Intramuscular injections are more painful with less anatomical sites to choose from. However, intramuscular injections are deposited in tissue with better blood supply, making their absorption time lower.

21. The nurse cares for several patients in the intensive care unit. Which medication should the nurse administer first?

a. Mannitol 0.5-1.5 gm/kg IV for a patient suffering from a closed head injury and intracranial pressure (ICP) of 22 mmHg.
b. Insulin regular 10 units subcutaneously for a type 2 diabetic patient with a blood glucose of 205.
c. Propranolol 40 mg PO for a patient with chronic hypertension and a blood pressure of 177/96.
d. Amoxicillin 1000 mg IV for a patient diagnosed with a lower respiratory tract infection, expectorating copious green sputum, and a temperature of 101 F (38.5C).

a. Mannitol is an osmotic diuretic used to treat intracranial hypertension (ICP). Severe intracranial hypertension is considered >20 mmHg. Immediate action is required as permanent brain tissue damage and herniation may take place.

22. Which category of drugs is used to treat certain types of malignancies?

a.Alkylates.
b.Androgens.
c.Surfactants.
d.Anticholinergics.

a. Alkylation is the transfer of an alkyl group from one molecule to another. In medicine, alkylation of DNA is used in chemotherapy to damage the DNA of cancer cells. The class of drugs is called alkylating anti-neoplastic agents.

23. The nurse administers fentanyl 25 mcg IV to a patient for pain. Which is the best way for the nurse to dispose of the remaining 0.75 mL of fluid?

a.Put the vial in the trash.
b.Seal the medication in plastic bag and return to pharmacy.
c.Pour the liquid in the sink drain.
d.Return the remaining dose to the medication-dispensing machine.

c. Each hospital has specific policies that may include putting the vial in the sharps container or flushing the liquid down the toilet. More commonly, putting the medication in the trash is a sharps risk and creates access for drug seekers. Sending the drug to pharmacy or returning it to the medication administration machine is rarely done as multi-dose vials have fallen out of favor due to infection potential.

24. The nurse cares for a patient taking a fluticasone/salmeterol powder inhaler BID that contains a corticosteroid. The nurse knows that teaching has been effective when the patient states:

a.“I will shake the inhaler before using it.”
b.“This inhaler will act quickly to treat my shortness of breath.”
c.“I will use a spacing-chamber to increase the dose I receive.”
d.“I will rinse my mouth out after taking this medication.”

d. Powder inhalers should not be shaken as this can reduce the dose. Spacers are only used with metered-dose inhalers. Corticosteroids are not emergency inhalers. They are maintenance medications so their effect is not immediate. Thrush, or oral candidiasis, is a yeast/fungal infection of the mouth that occurs with corticosteroid use. The patient should rinse out their mouth after using.

25. The nurse auscultates the heart of a patient diagnosed with mitral valve regurgitation. What should the nurse expect to hear?

a.High-pitched blowing at base.
b.Mitral click.
c.Diastolic murmur beneath right clavicle.
d.Low-pitched diastolic murmur at the apex.

d. Mitral valve regurgitation, or mitral insufficiency, is a disorder of the heart in which the mitral valve does not close properly when the ventricles contract. This causes a backward flow of blood into the atrium heard during diastole.

26. The nurse cares for a patient in the intensive care unit. The patient is suspected of having valvular dysfunction. What is the best way to assess the patient's status?

a.Angiogram.
b.Echocardiogram.
c.Plethysmograph.
d.Pulmonary function test.

b. Coronary angiogram and cardiac catheterization are not generally used to diagnose valve issue. The most common method is echocardiogram. Echocardiography uses a hand-held probe that generates sound waves that bounce off of structures in the heart to create 2 and 3-dimensional images. It is routinely used in the diagnosis, management, and follow-up of patients with heart disease.

27. The nurse cares for a patient in the neuroscience intensive care unit. The patient is diagnosed with a tumor and experiences a loss of visual capabilities, an inability to identify colors, and hallucinations. The nurse knows that the tumor is affecting what area of the brain?

a.Frontal lobe.
b.Temporal lobe.
c.Occipital lobe.
d.Parietal lobe.

c. Occipital lobe tumors cause deficits in almost all cases. Visual hallucinations without seizures are strongly suggestive of occipital lobe lesions.

28. The nurse cares for a diabetic patient who has just arrived to the emergency department. The patient breathes deeply and in a labored pattern. How would the nurse best describe the breathing pattern?

a.Kussmaul respirations.
b.Cheyne-Stokes respirations.
c.Biot's respirations.
d.Steven-Johnson respirations.

a. Kussmaul breathing is a deep and labored pattern often associated with severe metabolic acidosis, particularly diabetic ketoacidosis. It is a form of hyperventilation to compensate for an acidotic serum state.

29. The most common cause of hospitalization for patients older than 75 years of age is:

a.Pneumonia.
b.Hypertension.
c.Heart failure.
d.Cancer.

c. Heart failure is common in the elderly. Approximately 6-10% of the population 65 years or older has heart failure. The common causes of heart failure include ischemic heart disease, valvular heart disease, hypertension, and cardiomyopathy.

30. The nurse supervises a nursing student caring for a patient in the intensive care unit recovering from the surgical removal of neck cancer. The patient has a tracheostomy. Which statement by the student nurse indicates teaching has been successful?

a.“I will cut a piece of gauze to fit around the tracheostomy site.”
b.“I will administer humidified oxygen to the patient.”
c.“I will clean the area around the tracheostomy with alcohol.”
d.“I will avoid suctioning until 48 hours after the surgery.”

b. Humidified oxygen is important for a patient whose upper airway has been bypassed. The function of the upper airway is to filter, humidify, and warm air. Alcohol is too abrasive on the skin. Cutting gauze can create loose strands that can become lodged in the airway. A drain sponge should be used. Suctioning can and should be performed regularly immediately following surgery.

31. The nurse administers an electrocardiogram. Which instruction should the nurse include for the patient?

a.“Lie on your stomach.”
b.“Try to move as little as possible.”
c.“Hold your breath when I tell you.”
d.“Make sure to uncross your legs.”

b. Patient movement while performing an ECG will disrupt the electrical pattern and cause interference. The patient is allowed to cross their legs, breath normally, and lie supine.

32. The nurse cares for a patient suffering from gastritis. The nurse should encourage the patient to drink a minimum of how many liters per day?

a.1 L.
b.1.5 L.
c.2 L.
d.2.5 L.

b. Diets for gastritis are aimed at sparing the gastrointestinal tract from irritation, reducing inflammation, and improving the healing of the mucosa. Sufficient hydration is important. Common causes of gastritis include Helicobacter pylori and NSAIDs.

33. The triage phone nurse receives a call from the parent of a child reporting fever, drooling, and difficulty swallowing. What should the nurse instruct the parent to do first?

a.“Apply a cold compress to the neck.”
b.“Inspect the back of the throat for redness.”
c.“Apply a warm compress to the neck.”
d.“Come into the hospital right away.”

d. Epiglottitis most commonly affects children and is caused by a bacterial infection of the epiglottis. Drooling and difficulty swallowing signal a potential progression toward upper airway obstruction, which is a medical emergency. Inspecting the child's mouth or throat could further irritate the area causing rapid swelling.

34. The nurse cares for a patient on medical-surgical unit who returned from an abdominal surgery yesterday. The nurse is most concerned about:

a.Aspiration associated with surgical injury to the lower esophageal sphincter.
b.Recurrent pneumothorax from surgical trauma.
c.Respiratory infection from shallow respirations due to incisional pain.
d.General anesthetic withdrawal causing delirium and self-injury.

c. Patients recovering from abdominal surgeries may take shallow breaths due to incisional pain. Encouraging deep breathing, coughing, and use of an incentive spirometer can help. Aspiration, pneumothorax, and delirium are not risks.

35. The nurse cares for a patient with AIDS diagnosed with toxoplasmosis. What laboratory data best illustrates the lowered immunity of this patient?

a.T-cell count of 200.
b.CD4 count of 100.
c.T-cell count of 750.
d.CD4 count of 200.

b. T-cell and CD4 (T-lymphocytes) are different names for the same lymphocyte that plays a central role in cell-mediated immunity. Acquired immunodeficiency syndrome is characterized by a count below 200 cells per microliter.

36. The nurse assesses the vital signs of a 6-month-old at the outpatient clinic. The respiratory rate is 45 breaths per minute. What should the nurse do next?

a.Administer a simple facemask at 8 L/min.
b.Sit the patient upright and recheck the respiratory rate.
c.Alert physician and prepare for transport to hospital.
d.Document findings and continue with the assessment.

d. The normal range for vital signs changes as a patient ages. For children under 1 year of age, a respiratory rate of 30-60 breaths per minute is a normal finding. The heart rate range is 100-160 beats/min.

37. The nurse counsels a patient with a herniated lower lumbar spinal disk at the community clinic regarding lifting technique. Which muscle should the nurse encourage the patient to utilize while lifting objects?

a.Quadriceps.
b.Rectus abdominis.
c.Erector spinae.
d.Latissimus dorsi.

a. Lifting with the legs as opposed to the back is important for patients with lower back pain. Using solely the back to lift objects can create unnecessary strain and risk further injury.

38. The nurse cares for a patient who has just returned from a cardiac catheterization. Which finding would alert the nurse to contact the physician immediately?

a.Unable to palpate dorsalis pedis pulse.
b.Weak ulnar pulse.
c.Bounding brachial pulse.
d.Visible abdominal aortic pulse.

a. Cardiac catheterizations typically utilize the femoral artery to feed a catheter toward the heart for examination. When the introducer sheath is removed, an occlusive pressure dressing is placed. There is a risk of thrombus to the puncture site, which would manifest as the inability to palpate a distal pulse, such as the dorsalis pedis or posterior tibial. A visible abdominal aortic pulse is a normal finding on patients with less abdominal girth.

39. The nurse cares for a patient with a chest tube in place after gunshot wound to the chest. Which finding should alert the nurse to contact the physician?

a. Intermittent bubbling in the water-seal chamber.
b. Subcutaneous emphysema.
c. Tidaling in the water-seal chamber.
d. Blood in the collection chamber.

b. Subcutaneous emphysema is the collection of air underneath the skin. It creates a crackling sensation when palpated. Although subcutaneous emphysema can be an expected finding in some patients, the physician should be made aware. Blood is not an abnormal finding. Tidaling is normal with respiratory fluctuations of pressure in the chest cavity. Intermittent bubbling is expected when there is air in the pleural space.

40. The nurse cares for a patient with systemic erythematous lupus (SLE). Which laboratory finding should be reported immediately?

a.Serum potassium 6 mEq/L.
b.Hemoglobin 10.1 mg/dl.
c.Platelet count of 110,000/L.
d.Creatinine 1.5 mg/dL.

a. An elevated potassium can be potentially life-threatening as it interferes with cardiac conduction. Repolarization abnormalities, such as peaked T waves, are early signs. When potassium exceeds 6.5 mEq/L there is progressive paralysis of the atria. Conduction abnormalities occur at 7 mEq/L, and cardiac arrest when potassium exceeds 9.

41. The nurse cares for an 18-year-old patient without chronic respiratory pathology and a respiratory rate of 30 breath/min. Which of the following arterial blood gases results would prompt the nurse to contact the physician?

a.pH 7.35, $PaCO_2$ 30, HCO_3 20.
b.pH 7.45, $PaCO_2$ 50, HCO_3 30.
c.pH 7.31, $PaCO_2$ 55, HCO_3 28.
d.pH 7.48, $PaCO_2$ 55, HCO_3 30.

c. The arterial blood gas shows an uncompensated respiratory acidosis. The patient is hyperventilating and the PaCO2 is still elevated. Respiratory failure is likely if the patient is not treated.

42. The nurse provides discharge instruction to a patient after an extracapsular cataract extraction surgery. Which of the following should the nurse include in the teaching?

a.“Wash the iodine solution off of your face in the shower when you get home.”
b.“Avoid lifting heaving objects for a few days.”
c.“Avoid fiber containing foods and decrease fluid intake to avoid increasing eye pressure.”
d.“You may resume driving the same day as discharge.”

b. To avoid straining and increasing eye pressure, heavy lifting should be avoided as well as straining while defecating. Increase fluid and fiber to facilitate passage of stool. Avoid direct contact with face or eye, especially from a shower stream. Sight may be impaired for several days so driving should be avoided.

43. The nurse cares for a patient after a bronchoscopy with needle biopsy to investigate a nodule identified on chest x-ray. Which finding requires immediate intervention by the nurse?

a. The patient complains of throat pain and has a hoarse voice.
b. The patient coughs up blood-tinged sputum.
c. The patient's trachea deviates to one side.
d. The patient is drowsy, moaning, and complains of thirst.

c. A deviated trachea is a cardinal sign of pneumothorax. With needle biopsies, a rare complication can occur where the lung becomes punctured, pressure accumulates in the pleural space during spontaneous respirations, and compression of the heart and lungs creates respiratory distress and hemodynamic collapse. Immediately notify the physician and prepare to insert a chest tube.

44. The nurse cares for an alcoholic patient admitted with pneumonia. The nurse anticipates delirium tremens from alcohol withdrawal during what stage of admission?

a.Within the first 8 hours of admission.
b.During first 24 hours.
c.On the second or third day.
d.Four days to one week after admission.

c. Delirium tremens is an acute episode of delirium caused by withdrawal from alcohol. Symptoms include agitation, hallucinations, sweating, and signs of autonomic hyperactivity. It has a significant mortality rate and occurs around day 3 following cessation of drinking. Benzodiazepines are the treatment of choice.

45. The nurse performs a preoperative assessment on a patient with cirrhotic liver disease who is planning to undergo an elective total knee replacement surgery. Which laboratory finding would be considered a contraindication to elective surgery in this patient?

a.Blood ammonia of 100 umol/L.
b.Total bilirubin 25 umol/L.
c.Serum albumin 5 g/dL.
d.Hemoglobin 11 g/dL.

a. Hemodynamic instability in the perioperative period can worsen liver disease. Coagulopathies can create excessive bleeding. The decreased hepatic perfusion at baseline makes the cirrhotic liver more susceptible to hypoxemia and hypotension in the operating room. An elevated ammonia is a sign of worsening liver disease.

46. Diabetic patients are at greater risk while undergoing surgery for all of the following except:

a.Infection.
b.Hypoglycemia.
c.Malignant hyperthermia.
d.Stroke.

c. Malignant hyperthermia is a rare life-threatening condition that is triggered by exposure to inhaled anesthetics and muscle relaxants. Diabetics are no more susceptible to this than other patients. Stroke from vascular disease, infection from elevated glucose, and hypoglycemia are all more likely in diabetic patients.

47. The nurse encourages postoperative physical exercise to accomplish all of the following except:

a.Prevent venous stasis.
b.Mobilize microthrombi.
c.Increase bowel motility.
d.Stimulate respiratory function.

b. Postoperative exercises stimulate deeper respirations to avoid atelectasis, mobilizes the gut, and prevent blood clots through increased circulation. The goal of postoperative body movement is not to transform thrombi into emboli.

48. The nurse provides preoperative instructions to the patient several days before surgery. The patient asks why she is instructed to bath prior to arriving at the hospital on the day of surgery. The nurse's best response is:

a. "You will experience sweating during the perioperative period so we want you to start out clean."
b. "Your hair will placed under a cap and this will help to avoid tangles."
c. "The fumes from the human body react with the cautery we use in the operating room."
d. "It will reduce the number of microorganisms and lessen the chance of infection."

d. Because the skin is not sterile, reducing the number of germs on the patient's skin by washing before surgery can help to avoid infection. Although a preparation solution will be applied to the incision site in the operating room, any visibly soiled areas that are washed with soap and water is useful.

49. The nurse cares for a pregnant patient during the second stage of labor. Which of the following interventions should the nurse perform?

a.Position the patient's legs in the stirrups for the lithotomy position.
b.Allow the mother to bond with the infant.
c.Perform a cleansing enema.
d.Apply an ice pack to the perineum.

a. The second stage of labor begins when the cervix is completely effaced and dilated and ends when the infant is born. Once dilation and effacement are complete, the patient is instructed to push with each contraction to bring the presenting part of the anatomy down into the pelvis.

50. The nurse cares for a patient with scleroderma. Which vital sign obtained by the nurse might be considered unreliable?

a.Heart rate.
b.Blood pressure.
c.Oxygen saturation.
d.Respiratory rate.

c. Oxygen saturation (SpO2) is a meaningful measurement of pulmonary status, which is of particular importance in this patient population as they suffer from pulmonary hypertension and other complications. Due to the connective tissue disorder and poor peripheral circulation, SpO2 measurement may need to be correlated with arterial blood gas samples because of their unreliability.

51. The nurse assists with endotracheal intubation on a patient in the pulmonary unit suffering from respiratory failure. After insertion of the endotracheal tube, where would breath sounds most likely be heard if the tube was successfully inserted and advanced too far?

a.Stomach.
b.Right lung.
c.Left lung.
d.Trachea.

b. The right main stem bronchus branches from the trachea at a 20-30 degree angle from the medial axis of the trachea while the angle of the left main stem bronchus is 40-50 degrees. Because of this angle, the path of least resistance for a tube inserted too deeply would be the right lung. After cuff inflation and lung isolation, breath sounds may only be heard on the right side.

52. The nurse assesses the vital signs of a 9-year-old pediatric patient. Which of the following would be most concerning?

a.SpO2 94%.
b.Respiratory rate 24 breaths/min.
c.Heart rate 110 beats/min.
d.Blood pressure 89/53 mmHg.

a. Vital signs vary by age. The acceptable heart rate and respiratory ranges decrease with age and the blood pressure increases. The pulmonary system of pediatrics should function without deficit so any oxygen saturation less the 95% is cause for concern.

53. The recovery room nurse takes report on an elderly patient. The nurse knows that the patient is at greater risk for prolonged effects from anesthesia because of all of the following except:

a.Slower circulation time.
b.Increased fatty tissue.
c.Decreased liver size.
d.Increased blood pressure.

d. Slower circulation time will slow down the speed of metabolism of anesthetic drugs as will the reduced liver size. Inhaled anesthesia deposits in fat tissue where it is released mores slowly than other tissue, which can prolong the effects. Increased blood pressure has no influence on anesthetic clearance.

54. The nurse cares for a patient new to the outpatient chemotherapy clinic. The nurse should include all of the following instructions concerning the next 48 hours except:

a.“After using the toilet, close the lid and flush twice.”
b.“Avoid kissing loved ones, especially children.”
c.“Use condoms with your partner.”
d.“If any bodily fluids get on your clothes, wash them separately from your family’s.”

b. Chemotherapy medication is released from the body through urine, stool, vomit, and blood for 48 hours after treatments. Visiting, sitting with, kissing, and hugging will not contaminate others. Any bodily fluids must be isolated from contact with others.

55. The nurse cares for a patient admitted with persistent bloody cough, night sweats, and multiple infiltrates and nodules identified on chest x-ray. Which type of infection precaution is best for this patient?

a.Droplet.
b.Contact.
c.Standard.
d.Airborne.

d. Night sweats, weight loss, bloody sputum, country of origin, and nodules on chest x-ray are symptoms of tuberculosis. Tuberculosis is spread through bacteria suspended in air for a much longer time than droplets. An N95 mask or disposable respirator is essential.

56. The nurse cares for a patient in the post-anesthesia care unit. What would be the priority nursing assessment after a lumbar laminectomy and discectomy to ensure safety?

a.Check femoral pulses.
b.Perform neurological assessment.
c.Assess for muscle spasms.
d.Ensure patient voids within 2 hours.

b. After a spine surgery, strength and sensation assessments, as compared with preoperative status, should be evaluated. Special attention must be paid to neurological assessment and correlation with lower extremity function.

57. The nurse assesses a 6-year-old child taken to the emergency department. The parents state that the child had a sore throat and loss of appetite for a couple of days and today they measured a temperature of 102 F (38.8C). What should the nurse suspect?

a.Chicken pox.
b.Measles.
c.Croup.
d.Pertussis.

a. Chicken pox can have several symptoms that precede a fever such as loss of appetite, headache, and cough. The characteristic rash with chicken pox is papules (pink bumps) and vesicles (fluid-filled blisters).

58. The nurse cares for a pediatric patient diagnosed with a varicella zoster infection. What type of isolation precautions should the nurse initiate?

a.Airborne if the lesions are blistered and wet.
b.Contact if the lesions are dry and crusted.
c.Airborne and contact.
d.Droplet.

c. Patients with varicella zoster or chicken pox should be placed in airborne and contact precautions. Once the fluid filled vesicles have burst, dried, and crusted, the patient may be allowed off precautions.

59. The nurse starts an infusion of dextrose 5% in ¼% normal saline. The nurse should assess for what symptom as an indication of fluid volume overload?

a.Nausea and vomiting.
b.Increased respiratory rate.
c.Abdominal distention.
d.Hypothermia.

b. Increased respiratory rate, crackles, and additional signs of fluid overload can be indications. Water weight and fluid shift differences make a child more prone to dyspnea and excess fluid intake.

60. The nurse counsels a patient who is 5 months pregnant during a regular prenatal visit. What regular activity should the nurse caution the patient against performing?

a.Eating pork.
b.Pumping gas for the car.
c.Planting flowers in the garden with gloves.
d.Cleaning the cat's litter box.

d. If the mother contracts toxoplasmosis during pregnancy, it can be passed to the fetus. Most infected infants do not have symptoms at birth but can develop serious symptoms later in life, such as blindness or mental disability. Cats become infected by eating rodents or birds. This can be passed through feces from a litter box.

61. During orientation, the nurse speaks with a newly hired CNA about regular vaccination practices. The CNA states that she received an influenza vaccination last year so she doesn't need another one. Which is the best response by the nurse?

a."If you start to show symptoms, then you should get a shot."
b."It's important because if you get the vaccine you won't get the flu or pass it to others."
c."The virus can change from year-to-year so it's important to get it every year."
d."The vaccine will work right away so it's important to get it now."

c. There is a possibility of getting the flu even if vaccinated. Sometimes the similarity between the viruses used to make the vaccine and those circulating in the community are different. Vaccines take about 2 weeks to take effect. The vaccine will not prevent symptoms in someone who's already infected. The dominant flu strain changes regularly so receiving a new flu shot is important.

62. The occupational health nurse performs PPD tuberculosis skin tests on newly hired employees. Which level of prevention does this represent?

a.Primary prevention.
b.Collateral prevention.
c.Secondary prevention.
d.Tertiary prevention.

c. Secondary prevention aims to reduce the impact of a disease or injury through detection. Primary prevention serves to prevent and tertiary prevention treats or helps a patient to recover from a disease.

63. The nurse is assigned to receive a patient returning from surgery for a shoulder repair. Which roommate should the nurse assign this patient to?

a.A patient with diarrhea admitted this morning.
b.A patient with cystic fibrosis receiving postural drainage.
c.A patient with Crohn's disease receiving azathioprine.
d.A patient with azotemia receiving IV fluids.

d. A patient prone to post-surgical infection should be placed with a non-infectious patient. The patient with diarrhea could be experiencing a gastrointestinal infection. The patient with cystic fibrosis may have pneumonia and the patient with Crohn's disease is receiving an immunosuppressant drug and is more prone to infections.

64. The nurse works in a unit that has no more single-occupancy rooms remaining and the hospital is at capacity. The nurse is assigned to place a newly admitted patient with pertussis. Which roommate is the best choice to place the newly admitted with?

a.A patient admitted 12 hours ago with meningitis.
b.A patient recovering from a total knee replacement.
c.A patient with chicken pox in a negative airflow room.
d.A patient with clostridium difficile on day three of vancomycin therapy.

a. Pertussis and meningitis are both spread through droplet transmission. The distance that droplets can be suspended in air after emanating from a patient, requiring masks, is 3-5 feet. As long as the nurse can ensure that the patients remain this distance apart, they can share a room.

65. The nurse performs health education for the parents of an 18-month-old infant. Which instructions should the nurse include about regular screening?

a.Screen for lead poisoning at 36 months.
b.Regular dental visits begin at 24 months.
c.Check for iron-deficiency at 12 months.
d.Hearing screening tests at 48 months.

b. Regular dental visits should begin at 24 months. Iron-deficiency screenings should be performed at 6 months, especially if formula-fed. Hearing should be screened at birth and lead poisoning should be checked at 18 - 36 months.

66. The nurse cares for a patient set to undergo a lower-extremity venogram. Which of the following should the nurse alert the procedure team to?

a.Allergy to lobster.
b.History of reactive bowel disease.
c.Patient becomes dyspneic when prone.
d.Allergy to egg whites.

a. Venograms require contrast dye to image the vessels of the lower extremities. The contrast dye shares a cross-sensitivity to shellfish as it is composed of iodine. The care team should be alerted to avoid an allergic reaction.

67. The nurse must assign a patient with AIDS and a CD4 cell count of 150 cells/mm to a roommate. Which roommate is the best choice for this patient?

a.A patient preparing for chest tube insertion for an empyema.
b.A patient with COPD exacerbation on prednisone.
c.A diabetic 2 days after surgery for osteomyelitis.
d.A patient recently diagnosed with Huntington's disease.

d. Huntington's disease is a neurodegenerative genetic disorder that affects muscle coordination. Since the AIDS patient is immunocompromised, placement with a patient experiencing a pleural infection, another immunocompromised patient on steroids, and a patient recovering from a bone infection would not be appropriate.

68. Which of the following substances, when consumed during pregnancy, can cause the fetus to exhibit periventricular cysts?

a.Nicotine.
b.Cocaine.
c.Alcohol.
d.Raw meats.

b. Cocaine can cause cerebral anatomical anomalies identified on MRI including hemorrhage, grey matter reduction, and cysts. Alcohol reduces the size of the cerebellum and basal ganglia. Nicotine primarily affects dopamine and acetylcholine neurons.

69. In preparing a lecture on bioterrorism for the hospital disaster response committee, the nurse must discuss infectious diseases that could be used during an attack. Which of the following agents is not contagious?

a.Brucellosis.
b.Q fever.
c.Ricin.
d.Plague.

c. Ricin is a protein cytotoxin derived from the beans of the castor plant and is not contagious. Q fever is caused by rickettsia from cattle, sheep, and goats. Brucellosis is a zoonotic disease typically transmitted through the consumption of raw meat. The plague is naturally spread through rodents or their fleas. Standard precautions are used for the bubonic plague and droplet for the pneumonic strain.

70. The nurse cares for a patient with congestive heart failure who is being treated with spironolactone. The patient has developed hyperkalemia from overuse of this medication. What is the most important nursing intervention for the patient?

a. Notify the physician and advocate for salbutamol and sodium bicarbonate.
b. Administer calcium chloride and kayexalate as ordered.
c. Request an ECG.
d. Review diet for excess sources of potassium and encourage fluid intake.

c. Arrhythmias are a potentially fatal result of hyperkalemia. The first step in the nursing process is assessment of the patient. An ECG will help to evaluate the patient's heart rhythms to direct appropriate treatment.

71. The nurse performs dietary education for an obese patient at the outpatient clinic. Which of the following are not effective nursing assessments to evaluate the patient's knowledge of nutrition as it relates to body requirements?

a. Assess patient's ability to read food labels.
b. Assess patient's ability to identify appropriate food portions.
c. Assess patient's ability to estimate body weight.
d. Assess patient's ability to plan a menu.

c. Patients may be unaware of their actual weight. The nurse should encourage the patient to weigh at the same time of day or same day of the week with the same clothing and using the same scale. Charting progress can be an important motivational factor.

72. An elderly patient has been walking infrequently and taking his meals in bed. Which complication of immobility would indicate to the nurse that there is an impairment?

a. Increased urine output.
b. An increase in blood pressure and decrease in heart rate upon standing.
c. Decreased hematocrit.
d. Impaired ability to coagulate.

a. When a patient is supine, the shift of blood from the legs into the thorax increases atrial stretch, stimulating the release of ANP, causing diuresis. This dehydration causes orthostatic hypotension, which creates an increase in heart rate and drop in blood pressure upon standing. This also creates hypercoagulability, blood clots, and an increased hematocrit.

73. The nurse cares for a patient 24 hours after a cardiac artery bypass graft (CABG). What is the best nursing intervention that the nurse can perform to lessen the patient's pain during coughing and deep breathing exercises?

a. Administer pain medication.
b. Offer the patient a pillow to hug.
c. Have patient transfer to a chair.
d. Remove epicardial pacing wires.

b. Coughing and deep breathing is important for patients with cardiothoracic surgeries. The patient is less likely to cough if it causes pain so helping the patient to splint the incision will reduce tension. Administering pain medication may help, but it threatens to lesson the patient's drive to both deep breath and cough. Pain medication should not be the first intervention. Pulling the pericardial pacer wires is a painless procedure that typically creates a 'pulling' or 'tugging' sensation.

74. The nurse cares for a patient in the neurology unit. As the patient recovers from a traumatic car accident that permanently disabled his left leg, the nurse teaches him how to properly use a walker. Which technique by the patient characterizes effective use of a walker?

a. The patient's arms are at a 90 degree angle while grasping the walker.
b. The patient advances the walker followed by the left leg.
c. When rising from a seated position, the patient uses the walker for support.
d. The patient observes his feet to ensure proper technique.

b. The walker should be advanced followed by the injured leg for support. Looking down creates a tripping risk. Always look forward. Using the walker for support while rising from a seated position can cause it to tip. Use the chair to push off. The walker handles should reach the waste, creating an approximately 30 degree angle at the elbows.

75. The nurse suspects urinary retention in a patient with diabetes. Which of the following is the most accurate way to assess urinary retention?

a. Observe elimination patterns.
b. Palpate lower abdomen for distention.
c. Catheterize and measure residual volume.
d. Perform bladder ultrasound.

c. Retention of urine in the bladder predisposes the patient to urinary tract infections. The most direct measure is to catheterize the patient for residual urine. While bladder scanning and abdominal palpation can be symptoms, the actual diagnosis involves direct measurement of volume.

76. The nurse cares for a pediatric patient with cerebral palsy admitted with fluid overload related to neurogenic bladder. What physiological alterations would the nurse not anticipate?

a. Decreased sodium.
b. Decreased ANP release.
c. Decreased serum osmolality.
d. Decreased potassium.

b. Fluid overload can cause dilution of electrolytes, especially sodium and potassium. Serum osmolality would decrease secondary to decreased solute in proportion to plasma volume. Serum atrial natriuretic peptide (ANP) would increase in response to increased blood volume and atrial stretch.

77. The nurse performs discharge teaching for a patient placed on a low-sodium diet following a recent diagnosis of hypertension. Which dietary recommendations would be most suitable for this patient?

a. Seared salmon with watermelon and apricots.
b. Turkey bacon with peanut butter toast.
c. Chicken noodle soup with a side of frozen vegetables.
d. Cottage cheese with a bagel.

a. Cottage cheese, frozen vegetables, refined flour, peanuts, and canned soups contain a large amount of sodium. Sodium can lead to water retention, which can create hypervolemia in patients with renal impairment.

78. The nurse administers intermittent nasogastric bolus tube feedings to the patient. The nurse prepares for the noon feedings by first:

a. Positioning the patient's head of the bed at greater than 30 degrees.
b. Flushing the nasogastric tube with 20 mL of warm water.
c. Filling the bolus syringe with a small amount of test feeding.
d. Measuring residual volume.

d. Tube feedings are contraindicated if the residual gastric volume is greater than 100-150 mL in an adult. With continuous tube feeding, a gastric residual volume greater than 2 times the hourly rate should cause the nurse to consider slowing or stopping the set rate.

79. Which of the following nursing interventions would be most helpful for the patient with reduced cognitive abilities to avoid aspiration during mealtime?

a. Auscultate bowel sounds.
b. Assess cough and gag reflex.
c. Turn off the television.
d. Keep suction available.

c. For patients with reduced cognitive abilities, removing distracting stimuli during mealtimes can help to avoid aspiration. This facilitates concentration on chewing and swallowing.

80. The nurse enters the room while the patient appears to sleep comfortably. With eyes closed, the patient requests pain medication. What should the nurse do next?

a. Elicit further details about the character and duration of the pain.
b. Help the patient with alternatives to pain medication such as deep breathing.
c. Encourage the patient to rest and observe for more definitive signs of pain.
d. Accept the patient's interpretation and report of pain.

d. Inquiring further about the pain and offering alternatives are valid responses but the nurse must first rely on the patient to be the most accurate source for reporting of pain. Pain is a subjective symptom with no true objective measurement. The patient is the expert when it comes to the experience of his or her own pain.

81. A meal tray is placed next to the bed of a patient recovering from a Billroth operation. Which food categories, if found on the meal tray, would not be in keeping with a gastrectomy diet?

a. Pork with pealed fruit.
b. Fish seasoned with salt.
c. Cereal & yogurt.
d. Steamed broccoli.

c. A gastrectomy diet is low in starches and sugar as these hyperosmolar foods can cause dumping syndrome. Many patients develop lactose malabsorption following this surgery, which can cause diarrhea and gas.

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