1. A 43-year-old African American male is admitted with sickle cell anemia. The nurse plans to assess circulation in the lower extremities every two hours. Which of the following outcome criteria would the nurse use?

A. Body temperature of 99°F or less

B. Toes moved in active range of motion

C. Sensation reported when soles of feet are touched

D. Capillary refill of < 3 seconds

Explanation: It is important to assess the extremities for blood vessel occlusion in the client with sickle cell anemia because a change in capillary refill would indicate a change in circulation. Body temperature, motion, and sensation would not give information regarding peripheral circulation; therefore, answers A, B, and C are incorrect.

2. A 30-year-old male from Haiti is brought to the emergency department in sickle cell crisis. What is the best position for this client?

A. Side-lying with knees flexed

B. Knee-chest

C. High Fowler's with knees flexed

D. Semi-Fowler's with legs extended on the bed

Explanation: Placing the client in semi-Fowler's position provides the best oxygenation for this client. Flexion of the hips and knees, which includes the kneechest position, impedes circulation and is not correct positioning for this client.

3. A 25-year-old male is admitted in sickle cell crisis. Which of the following interventions would be of highest priority for this client?

A. Taking hourly blood pressures with mechanical cuff

B. Encouraging fluid intake of at least 200mL per hour

C. Position in high Fowler's with knee gatch raised

D. Administering Tylenol as ordered

Explanation: It is important to keep the client in sickle cell crisis hydrated to prevent further sickling of the blood. Answer A is incorrect because a mechanical cuff places too much pressure on the arm. Answer C is incorrect because raising the knee gatch impedes circulation. Answer D is incorrect because Tylenol is too mild an analgesic for the client in crisis.

4. Which of the following foods would the nurse encourage the client in sickle cell crisis to eat?

A. Steak

B. Cottage cheese

C. Popsicle

D. Lima beans

Explanation: Hydration is important in the client with sickle cell disease to prevent thrombus formation. Popsicles, gelatin, juice, and pudding have high fluid content. The foods in answers A, B, and D do not aid in hydration.

5. A newly admitted client has sickle cell crisis. He is complaining of pain in his feet and hands. The nurse's assessment findingsinclude a pulse oximetry of 92. Assuming that all the following interventions are ordered, which should be done first?

A. Adjust the room temperature

B. Give a bolus of IV fluids

C. Start O2

D. Administer meperidine (Demerol) 75mg IV push

Explanation: The pulse oximetry indicates that oxygen levels are low; thus, oxygenation takes precedence over pain relief. Answer A is incorrect because although a warm environment reduces pain and minimizes sickling, it would not be a priority. Answer B is incorrect because although hydration is important, it would not require a bolus. Answer D is incorrect because Demerol is acidifying to the blood and increases sickling.

6. The nurse is instructing a client with iron-deficiency anemia. Which of the following meal plans would the nurse expect the client to select?

A. Roast beef, gelatin salad, green beans, and peach pie

B. Chicken salad sandwich, coleslaw, French fries, ice cream

C. Egg salad on wheat bread, carrot sticks, lettuce salad, raisin pie

D. Pork chop, creamed potatoes, corn, and coconut cake

Explanation: Egg yolks, wheat bread, carrots, raisins, and green, leafy vegetables are all high in iron, which is an important mineral for this client. Roast beef, cabbage, and pork chops are also high in iron, but the side dishes accompanying these choices are not; therefore, answers A, B, and D are incorrect.

7. Clients with sickle cell anemia are taught to avoid activities that cause hypoxia and hypoxemia. Which of the following activities would the nurse recommend?

A. A family vacation in the Rocky Mountains

B. Chaperoning the local boys club on a snow-skiing trip

C. Traveling by airplane for business trips

D. A bus trip to the Museum of Natural History

Explanation: Taking a trip to the museum is the only answer that does not pose a threat. A family vacation in the Rocky Mountains at high altitudes, cold temperatures, and airplane travel can cause sickling episodes and should be avoided; therefore, answers A, B, and C are incorrect.

8. The nurse is conducting an admission assessment of a client with vitamin B12 deficiency. Which finding reinforces the diagnosis of B12 deficiency?

A. Enlarged spleen

B. Elevated blood pressure

C. Bradycardia

D. Beefy tongue

Explanation: The tongue of the client with B12 insufficiency is red and beefy. Answers A, B, and C incorrect because enlarged spleen, elevated BP, and bradycardia are not associated with B12 deficiency.

9. The body part that would most likely display jaundice in the darkskinned individual is the:

A. Conjunctiva of the eye

B. Soles of the feet

C. Roof of the mouth

D. Shins

Explanation: The oral mucosa and hard palate (roof of the mouth) are the best indicators of jaundice in dark-skinned persons. The conjunctiva can have normal deposits of fat, which give a yellowish hue; thus, answer A is incorrect. The soles of the feet can be yellow if they are calloused, making answer B incorrect; the shins would be an area of darker pigment, so answer D is incorrect.

10. The nurse is conducting a physical assessment on a client with anemia. Which of the following clinical manifestations would be most indicative of the anemia?

A. BP 146/88

B. Respirations 28 shallow

C. Weight gain of 10 pounds in six months

D. Pink complexion

Explanation: When there are fewer red blood cells, there is less hemoglobin and less oxygen. Therefore, the client is often short of breath, as indicated in answer B. The client with anemia is often pale in color, has weight loss, and may be hypotensive. Answers A, C, and D are within normal and, therefore, are incorrect.

11. The nurse is teaching the client with polycythemia vera about prevention of complications of the disease. Which of the following statements by the client indicates a need for further teaching?

A. “I will drink 500mL of fluid or less each day.”

B. “I will wear support hose.”

C. “I will check my blood pressure regularly.”

D. “I will report ankle edema.”

Explanation: The client with polycythemia vera is at risk for thrombus formation. Hydrating the client with at least 3L of fluid per day is important in preventing clot formation, so the statement to drink less than 500mL is incorrect. Answers B, C, and D are incorrect because they all contribute to the prevention of complications. Support hose promotes venous return, the electric razor prevents bleeding due to injury, and a diet low in iron is essential to preventing further red cell formation.

12. A 33-year-old male is being evaluated for possible acute leukemia. Which of the following findings is most likely related to the diagnosis of leukemia?

A. The client collects stamps as a hobby.

B. The client recently lost his job as a postal worker.

C. The client had radiation for treatment of Hodgkin’s disease as a teenager.

D. The client’s brother had leukemia as a child.

Explanation: Radiation treatment for other types of cancer can contribute to the development of leukemia. Some hobbies and occupations involving chemicals are linked to leukemia, but not the ones in these answers; therefore, answers A and B are incorrect. Answer D is incorrect because the incidence of leukemia is higher in twins, not siblings.

13. Where is the best site for examining for the presence of petechiae in an African American client?

A. The abdomen

B. The thorax

C. The earlobes

D. The soles of the feet

Explanation: Petechiae are not usually visualized on dark skin. The soles of the feet and palms of the hand provide a lighter surface for assessing the client for petichiae. Answers A, B, and C are incorrect because the skin may be too dark to make an assessment.

14. The client is being evaluated for possible acute leukemia. Which inquiry by the nurse is most important?

A. “Have you noticed a change in sleeping habits recently?”

B. “Have you had a respiratory infection in the last six months?”

C. “Have you lost weight recently?”

D. “Have you noticed changes in your alertness?”

Explanation: The client with leukemia is at risk for infection and has often had recurrent respiratory infections during the previous six months. Insomnolence, weight loss, and a decrease in alertness also occur in leukemia, but bleeding tendencies and infections are the primary clinical manifestations; therefore, answers A, C, and D are incorrect.

15. Which of the following would be the priority nursing diagnosis for the adult client with acute leukemia?

A. Oral mucous membrane, altered related to chemotherapy

B. Risk for injury related to thrombocytopenia

C. Fatigue related to the disease process

D. Interrupted family processes related to life-threatening illness of a family member

Explanation: The client with acute leukemia has bleeding tendencies due to decreased platelet counts, and any injury would exacerbate the problem. The client would require close monitoring for

hemorrhage, which is of higher priority than the diagnoses in answers A, C, and D, which are incorrect.

16. A 21-year-old male with Hodgkin's lymphoma is a senior at the local university. He is engaged to be married and is to begin a new job upon graduation. Which of the following diagnoses would be a priority for this client?

A. Sexual dysfunction related to radiation therapy

B. Anticipatory grieving related to terminal illness

C. Tissue integrity related to prolonged bed rest

D. Fatigue related to chemotherapy

Explanation: Radiation therapy often causes sterility in male clients and would be of primary importance to this client. The psychosocial needs of the client are important to address in light of the age and life choices. Hodgkin's disease, however, has a good prognosis when diagnosed early. Answers B, C, and D are incorrect because they are of lesser priority.

17. A client has autoimmune thrombocytopenic purpura. To determine the client's response to treatment, the nurse would monitor:

A. Platelet count

B. White blood cell count

C. Potassium levels

D. Partial prothrombin time (PTT)

Explanation: Clients with autoimmune thrombocytopenic purpura (ATP) have low platelet counts, making answer A the correct answer. White cell counts, potassium levels, and PTT are not affected in ATP; thus, answers B, C, and D are incorrect.

18. The home health nurse is visiting a client with autoimmune thrombocytopenic purpura (ATP). The client's platelet count currently is 80,000. It will be most important to teach the client and family about:

A. Bleeding precautions

B. Prevention of falls

C. Oxygen therapy

D. Conservation of energy

Explanation: The normal platelet count is 120,000–400,000. Bleeding occurs in clients with low platelets. The priority is to prevent and minimize bleeding. Oxygenation in answer C is important, but platelets do not carry oxygen. Answers B and D are of lesser priority and are incorrect in this instance.

19. The client has surgery for removal of a Prolactinoma. Which of the following interventions would be appropriate for this client?

A. Place the client in Trendelenburg position for postural drainage.

B. Encourage coughing and deep breathing every two hours.

C. Elevate the head of the bed 30°.

D. Encourage the Valsalva maneuver for bowel movements.

Explanation: A prolactinoma is a type of pituitary tumor. Elevating the head of the bed 30° avoids pressure on the sella turcica and helps to prevent headaches. Answers A, B, and D are incorrect because Trendelenburg, Valsalva maneuver, and coughing all increase the intracranial pressure.

20. The client with a history of diabetes insipidus is admitted with polyuria, polydipsia, and mental confusion. The priority intervention for this client is:

A. Measure the urinary output.

B. Check the vital signs.

C. Encourage increased fluid intake.

D. Weigh the client.

Explanation: The large amount of fluid loss can cause fluid and electrolyte imbalance that should be corrected. The loss of electrolytes would be reflected in the vital signs. Measuring the urinary output is important, but the stem already says that the client has polyuria, so answer A is incorrect. Encouraging fluid intake will not correct the problem, making answer C incorrect. Answer D is incorrect because weighing

the client is not necessary at this time.

21. A client with hemophilia has a nosebleed. Which nursing action is most appropriate to control the bleeding?

A. Place the client in a sitting position.

B. Administer acetaminophen (Tylenol).

C. Pinch the soft lower part of the nose.

D. Apply ice packs to the forehead.

Explanation: C is correct because direct pressure to the nose stops the bleeding. Answers A, B, and D are incorrect because they do not stop bleeding.

22. A client has had a unilateral adrenalectomy to remove a tumor. The most important measurement in the immediate post-operative period for the nurse to take is:

A. The blood pressure

B. The temperature

C. The urinary output

D. The specific gravity of the urine

Explanation: Blood pressure is the best indicator of cardiovascular collapse in the client who has had an adrenal gland removed. The remaining gland might have been suppressed due to the tumor activity. Temperature would be an indicator of infection, decreased output would be a clinical manifestation but would take longer to occur than blood pressure changes, and specific gravity changes occur with other disorders; therefore, answers B, C, and D are incorrect.

23. A client with Addison's disease has been admitted with a history of nausea and vomiting for the past three days. The client is receiving IV glucocorticoids (Solu-Medrol). Which of the following interventions would the nurse implement?

A. Glucometer readings as ordered

B. Intake/output measurements

C. Evaluating the sodium and potassium levels

D. Daily weights

Explanation: IV glucocorticoids raise the glucose levels and often require coverage with insulin. Answer B is not necessary at this time, sodium and potassium levels would be monitored when the

client is receiving mineral corticoids, and daily weights is unnecessary; therefore, answers B, C, and D are incorrect.

24. A client had a total thyroidectomy yesterday. The client is complaining of tingling around the mouth and in the fingers and toes. What would the nurses' next action be?

A. Obtain a crash cart.

B. Check the calcium level.

C. Assess the dressing for drainage.

D. Assess the blood pressure for hypertension.

Explanation: The parathyroid glands are responsible for calcium production and can be damaged during a thyroidectomy. The tingling can be due to low calcium levels. The crash cart would be needed in respiratory distress but would not be the next action to take; thus, answer A is incorrect. Hypertension occurs in thyroid storm and the drainage would occur in hemorrhage, so answers C and D are incorrect.

25. A 32-year-old mother of three is brought to the clinic. Her pulse is 52, there is a weight gain of 30 pounds in four months, and the client is wearing two sweaters. The client is diagnosed with hypothyroidism. Which of the following nursing diagnoses is of highest priority?

A. Impaired physical mobility related to decreased endurance

B. Hypothermia r/t decreased metabolic rate

C. Disturbed thought processes r/t interstitial edema

D. Decreased cardiac output r/t bradycardia

Explanation: The decrease in pulse can affect the cardiac output and lead to shock, which would take precedence over the other choices; therefore, answers A, B, and C are incorrect.

26. The client presents to the clinic with a serum cholesterol of 275mg/dL and is placed on rosuvastatin (Crestor). Which instruction should be given to the client taking rosuvastatin (Crestor)?

A. Report muscle weakness to the physician.

B. Allow six months for the drug to take effect.

C. Take the medication with fruit juice.

D. Report difficulty sleeping.

Explanation: The client taking antilipidemics should be encouraged to report muscle weakness because this is a sign of rhabdomyolysis. The medication takes effect within one month of beginning therapy, so answer B is incorrect. The medication should be taken with water because fruit juice, particularly grapefruit, can decrease the effectiveness, making answer C incorrect. Liver function studies should be checked before beginning the medication, not after the fact, making answer D incorrect.

27. The client is admitted to the hospital with hypertensive crises. Diazoxide (Hyperstat) is ordered. During administration, the nurse should:

A. Utilize an infusion pump.

B. Check the blood glucose level.

C. Place the client in Trendelenburg position.

D. Cover the solution with foil.

Explanation: Hyperstat is given IV push for hypertensive crises, but it often causes hyperglycemia. The glucose level will drop rapidly when stopped. Answer A is incorrect because the hyperstat is

given by IV push. The client should be placed in dorsal recumbent position, not Trendelenburg position, as stated in answer C. Answer D is incorrect because the medication does not have to be covered with foil.

28. The six-month-old client with a ventral septal defect is receiving Digitalis for regulation of his heart rate. Which finding should be reported to the doctor?

A. Blood pressure of 126/80

B. Blood glucose of 110mg/dL

C. Heart rate of 60bpm

D. Respiratory rate of 30 per minute

Explanation: A heart rate of 60 in the baby should be reported immediately. The dose should be held if the heart rate is below 100bpm. The blood glucose, blood pressure, and respirations are within normal limits; thus, answers A, B, and D are incorrect.

29. The client admitted with angina is given a prescription for nitroglycerine. The client should be instructed to:

A. Replenish his supply every three months.

B. Take one every 15 minutes if pain occurs.

C. Leave the medication in the brown bottle.

D. Crush the medication and take with water.

Explanation: Nitroglycerine should be kept in a brown bottle (or even a special air- and water-tight, solid or plated silver or gold container) because of its instability and tendency to become less potent when exposed to air, light, or water. The supply should be replenished every six months, not three

months, and one tablet should be taken every five minutes until pain subsides, so answers A and B are incorrect. If the

pain does not subside, the client should report to the emergency room. The medication should be taken sublingually and should not be crushed, as stated in answer D.

30. The client is instructed regarding foods that are low in fat and cholesterol. Which diet selection is lowest in saturated fats?

A. Macaroni and cheese

B. Shrimp with rice

C. Turkey breast

D. Spaghetti with meat sauce

Explanation: Turkey contains the least amount of fats and cholesterol. Liver, eggs, beef, cream sauces, shrimp, cheese, and chocolate should be avoided by the client; thus, answers A, B, and D are incorrect. The client should bake meat rather than frying to avoid adding fat to the meat during cooking.

31. The client is admitted with left-sided congestive heart failure. In assessing the client for edema, the nurse should check the:

A. Feet

B. Neck

C. Hands

D. Sacrum

Explanation: The jugular veins in the neck should be assessed for distension. The other parts of the body will be edematous in right-sided congestive heart failure, not left-sided; thus, answers A, C, and D are incorrect.

32. The nurse is checking the client's central venous pressure. The nurse should place the zero of the manometer at the:

A. Phlebostatic axis

B. PMI

C. Erb's point

D. Tail of Spence

Explanation: The phlebostatic axis is located at the fifth intercostals space midaxillary line and is the correct placement of the manometer. The PMI or point of maximal impulse is located at the fifth intercostals space midclavicular line, so answer B is incorrect. Erb's point is the point at which you can hear the valves close simultaneously, making answer C incorrect. The Tail of Spence (the upper outer quadrant of

the breast) is the area where most breast cancers are located and has nothing to do with placement of a manometer; thus, answer D is incorrect.

33. The physician orders lisinopril (Zestril) and furosemide (Lasix) to be administered concomitantly to the client with hypertension. The nurse should:

A. Question the order.

B. Administer the medications.

C. Administer separately.

D. Contact the pharmacy.

Explanation: Zestril is an ACE inhibitor and is frequently given with a diuretic such as Lasix for hypertension. Answers A, C, and D are incorrect because the order is accurate. There is no need to question the order, administer the medication separately, or contact the pharmacy.

34. The best method of evaluating the amount of peripheral edema is:

A. Weighing the client daily

B. Measuring the extremity

C. Measuring the intake and output

D. Checking for pitting

Explanation: The best indicator of peripheral edema is measuring the extremity. A paper tape measure should be used rather than one made of plastic or cloth, and the area should be marked with a pen, providing the most objective assessment. Answer A is incorrect because weighing the client will not indicate peripheral edema. Answer C is incorrect because checking the intake and output will not indicate peripheral edema. Answer D is incorrect because checking for pitting edema is less reliable than measuring with a paper tape measure.

35. A client with vaginal cancer is being treated with a radioactive vaginal implant. The client's husband asks the nurse if he can spend the night with his wife. The nurse should explain that:

A. Overnight stays by family members is against hospital policy.

B. There is no need for him to stay because staffing is adequate.

C. His wife will rest much better knowing that he is at home.

D. Visitation is limited to 30 minutes when the implant is in place.

Explanation: Clients with radium implants should have close contact limited to 30 minutes per visit. The general rule is limiting time spent exposed to radium, putting distance between people and the radium source, and using lead to shield against the radium. Teaching the family member these principles is extremely important. Answers A, B, and C are not empathetic and do not address the question; therefore, they are incorrect.

36. The nurse is caring for a client hospitalized with a facial stroke. Which diet selection would be suited to the client?

A. Roast beef sandwich, potato chips, pickle spear, iced tea

B. Split pea soup, mashed potatoes, pudding, milk

C. Tomato soup, cheese toast, Jello, coffee

D. Hamburger, baked beans, fruit cup, iced tea

Explanation: The client with a facial stroke will have difficulty swallowing and chewing, and the foods in answer B provide the least amount of chewing. The foods in answers A, C, and D would require more chewing and, thus, are incorrect.

37. The physician has prescribed Novalog insulin for a client with diabetes mellitus. Which statement indicates that the client knows when the peak action of the insulin occurs?

A. "I will make sure I eat breakfast within 10 minutes of taking my insulin."

B. "I will need to carry candy or some form of sugar with me all the time."

C. "I will eat a snack around three o'clock each afternoon."

D. "I can save my dessert from supper for a bedtime snack."

Explanation: Novalog insulin onsets very quickly, so food should be available within 10–15 minutes of taking the insulin. Answer B does not address a particular type of insulin, so it is incorrect. NPH

insulin peaks in 8–12 hours, so a snack should be eaten at the expected peak time. It may not be 3 p.m. as stated in answer C. Answer D is incorrect because there is no need to save the dessert until bedtime.

38. The nurse is teaching basic infant care to a group of first-time parents. The nurse should explain that a sponge bath is recommended for the first two weeks of life because:

A. New parents need time to learn how to hold the baby.

B. The umbilical cord needs time to separate.

C. Newborn skin is easily traumatized by washing.

D. The chance of chilling the baby outweighs the benefits of bathing.

Explanation: The umbilical cord needs time to dry and fall off before putting the infant in the tub. Although answers A, C, and D might be important, they are not the primary answer to the question.

39. A client with leukemia is receiving Trimetrexate. After reviewing the client's chart, the physician orders Wellcovorin (leucovorin calcium). The rationale for administering leucovorin calcium to a client receiving Trimetrexate is to:

A. Treat iron-deficiency anemia caused by chemotherapeutic agents

B. Create a synergistic effect that shortens treatment time

C. Increase the number of circulating neutrophils

D. Reverse drug toxicity and prevent tissue damage

Explanation: antagonists. Leucovorin is a folic acid derivative. Answers A, B, and C are incorrect because Leucovorin does not treat iron deficiency, increase neutrophils, or have a synergistic effect.

40. A four-month-old is brought to the well-baby clinic for immunization. In addition to the DPT and polio vaccines, the baby should receive:

A. Hib titer

B. Mumps vaccine

C. Hepatitis B vaccine

D. MMR

Explanation: The Hemophilus influenza vaccine is given at four months with the polio vaccine. Answers B, C, and D are incorrect because these vaccines are given later in life.

41. The physician has prescribed Nexium (esomeprazole) for a client with erosive gastritis. The nurse should administer the medication:

A. 30 minutes before a meal

B. With each meal

C. In a single dose at bedtime

D. 30 minutes after meals

Explanation: Proton pump inhibitors should be taken prior to the meal. Answers B, C, and D are incorrect times for giving proton pump inhibitors like Nexium.

42. A client on the psychiatric unit is in an uncontrolled rage and is threatening other clients and staff. What is the most appropriate action for the nurse to take?

A. Call security for assistance and prepare to sedate the client.

B. Tell the client to calm down and ask him if he would like to play cards.

C. Tell the client that if he continues his behavior he will be punished.

D. Leave the client alone until he calms down.

Explanation: If the client is a threat to the staff and to other clients the nurse should call for help and prepare to administer a medication such as Haldol to sedate him. Answer B is incorrect because simply telling the client to calm down will not work. Answer C is incorrect because telling the client that if he continues he will be punished is a threat and may further anger him. Answer D is incorrect because if the

client is left alone, he might harm himself.

43. When the nurse checks the fundus of a client on the first postpartum day, she notes that the fundus is firm, is at the level of the umbilicus, and is displaced to the right. The next action the nurse should take is to:

A. Check the client for bladder distention.

B. Assess the blood pressure for hypotension.

C. Determine whether an oxytocic drug was given.

D. Check for the expulsion of small clots.

Explanation: If the fundus of the client is displaced to the side, this might indicate a full bladder. The next action by the nurse should be to check for bladder distention and catheterize, if necessary. The answers in B, C, and D are actions that relate to postpartal hemorrhage.

44. A client is admitted to the hospital with a temperature of 99.8°F, complaints of blood-tinged hemoptysis, fatigue, and night sweats. The client's symptoms are consistent with a diagnosis of:

A. Pneumonia

B. Reaction to antiviral medication

C. Tuberculosis

D. Superinfection due to low CD4 count

Explanation: A low-grade temperature, blood-tinged sputum, fatigue, and night sweats are symptoms consistent with tuberculosis. If the answer in A had said pneumocystis pneumonia, answer A would have been consistent with the symptoms given in the stem, but just saying pneumonia isn't specific enough to diagnose the problem. Answers B and D are not directly related to the stem.

45. The client is seen in the clinic for treatment of migraine headaches. The drug Imitrex (sumatriptan succinate) is prescribed for the client. Which of the following in the client's history should be reported to the doctor?

A. Diabetes

B. Prinzmetal's angina

C. Cancer

D. Cluster headaches

Explanation: If the client has a history of Prinzmetal's angina, he should not be prescribed triptan preparations because they cause vasoconstriction and coronary spasms. There is no contraindication for taking triptan drugs in clients with diabetes, cancer, or cluster headaches, making answers A, C, and D incorrect.

46. The client with suspected meningitis is admitted to the unit. The doctor is performing an assessment to determine meningeal irritation and spinal nerve root inflammation. A positive Kernig's sign is charted if the nurse notes:

A. Pain on flexion of the hip and knee

B. Nuchal rigidity on flexion of the neck

C. Pain when the head is turned to the left side

D. Dizziness when changing positions

Explanation: Kernig's sign is positive if pain occurs on flexion of the hip and knee. The Brudzinski reflex is positive if pain occurs on flexion of the head and neck onto the chest so answer B is incorrect. Answers C and D might be present but are not related to Kernig's sign.

47. The client with Alzheimer's disease is being assisted with activities of daily living when the nurse notes that the client uses her toothbrush to brush her hair. The nurse is aware that the client is exhibiting:

A. Agnosia

B. Apraxia

C. Anomia

D. Aphasia

Explanation: Apraxia is the inability to use objects appropriately. Agnosia is loss of sensory comprehension, anomia is the inability to find words, and aphasia is the inability to speak or understand, so answers A, C, and D are incorrect.

48. The client with dementia is experiencing confusion late in the afternoon and before bedtime. The nurse is aware that the client is experiencing what is known as:

A. Chronic fatigue syndrome

B. Normal aging

C. Sundowning

D. Delusions

Explanation: Increased confusion at night is known as “sundowning” syndrome. This increased confusion occurs when the sun begins to set and continues during the night. Answer A is incorrect because fatigue is not necessarily present. Increased confusion at night is not part of normal aging; therefore, answer B is incorrect. A delusion is a firm, fixed belief; therefore, answer D is incorrect.

49. The client with confusion says to the nurse, “I haven’t had anything to eat all day long. When are they going to bring breakfast?” The nurse saw the client in the day room eating breakfast with other clients 30 minutes before this conversation. Which response would be best for the nurse to make?

A. “You know you had breakfast 30 minutes ago.”

B. “I am so sorry that they didn’t get you breakfast. I’ll report it to the charge nurse.”

C. “I’ll get you some juice and toast. Would you like something else?”

D. “You will have to wait a while; lunch will be here in a little while.”

Explanation: The client who is confused might forget that he ate earlier. Don’t argue with the client. Simply get him something to eat that will satisfy him until lunch. Answers A and D are incorrect because the nurse is dismissing the client. Answer B is validating the delusion.

50. The doctor has prescribed Exelon (rivastigmine) for the client with Alzheimer's disease. Which side effect is most often associated with this drug?

A. Urinary incontinence

B. Headaches

C. Confusion

D. Nausea

Explanation: Nausea and gastrointestinal upset are very common in clients taking acetylcholinesterase inhibitors such as Exelon. Other side effects include liver toxicity, dizziness, unsteadiness, and clumsiness. The client might already be experiencing urinary incontinence or headaches, but they are not necessarily associated; and the client with Alzheimer's disease is already confused. Therefore, answers A, B, and C

are incorrect.

51. A client is admitted to the labor and delivery unit in active labor. During examination, the nurse notes a papular lesion on the perineum. Which initial action is most appropriate?

A. Document the finding.

B. Report the finding to the doctor.

C. Prepare the client for a C-section.

D. Continue primary care as prescribed.

Explanation: Any lesion should be reported to the doctor. This can indicate a herpes lesion. Clients with open lesions related to herpes are delivered by Cesarean section because there is a possibility of transmission of the infection to the fetus with direct contact to lesions. It is not enough to document the finding, so answer A is incorrect. The physician must make the decision to perform a

C-section, making answer C incorrect. It is not enough to continue primary care, so answer D is incorrect.

52. A client with a diagnosis of HPV is at risk for which of the following?

A. Hodgkin's lymphoma

B. Cervical cancer

C. Multiple myeloma

D. Ovarian cancer

Explanation: The client with HPV is at higher risk for cervical and vaginal cancer related to this STI. She is not at higher risk for the other cancers mentioned in answers A, C, and D, so those are incorrect.

53. During the initial interview, the client reports that she has a lesion on the perineum. Further investigation reveals a small blister on the vulva that is painful to touch. The nurse is aware that the most likely source of the lesion is:

A. Syphilis

B. Herpes

C. Gonorrhea

D. Condylomata

Explanation: A lesion that is painful is most likely a herpetic lesion. A chancre lesion associated with syphilis is not painful, so answer A is incorrect. Condylomata lesions are painless warts, so answer D is incorrect. In answer C, gonorrhea does not present as a lesion, but is exhibited by a yellow discharge.

54. A client visiting a family planning clinic is suspected of having an STI. The best diagnostic test for treponema pallidum is:

A. Venereal Disease Research Lab (VDRL)

B. Rapid plasma reagin (RPR)

C. Fluorescent treponemal antibody (FTA)

D. Thayer-Martin culture (TMC)

Explanation: Fluorescent treponemal antibody (FTA) is the test for treponema pallidum. VDRL and RPR are screening tests done for syphilis, so answers A and B are incorrect. The Thayer-Martin culture is done for gonorrhea, so answer D is incorrect.

55. A 15-year-old primigravida is admitted with a tentative diagnosis of HELLP syndrome. Which laboratory finding is associated with HELLP syndrome?

A. Elevated blood glucose

B. Elevated platelet count

C. Elevated creatinine clearance

D. Elevated hepatic enzymes

Explanation: The criteria for HELLP is hemolysis, elevated liver enzymes, and low platelet count. In answer A, an elevated blood glucose level is not associated with HELLP. Platelets are decreased, not elevated, in HELLP syndrome, as stated in answer B. The creatinine levels are elevated in renal disease and are not associated with HELLP syndrome, so answer C is incorrect.

56. The nurse is assessing the deep tendon reflexes of a client with preeclampsia. Which method is used to elicit the biceps reflex?

A. The nurse places her thumb on the muscle inset in the antecubital space and taps the thumb briskly with the reflex hammer.

B. The nurse loosely suspends the client's arm in an open hand while tapping the back of the client's elbow.

C. The nurse instructs the client to dangle her legs as the nurse strikes the area below the patella with the blunt side of the reflex hammer.

D. The nurse instructs the client to place her arms loosely at her side as the nurse strikes the muscle insert just above the wrist.

Explanation: Answer B elicits the triceps reflex, so it is incorrect. Answer C elicits the patella reflex, making it incorrect. Answer D elicits the radial nerve, so it is incorrect.

57. A primigravida with diabetes is admitted to the labor and delivery unit at 34 weeks gestation. Which doctor's order should the nurse question?

A. Magnesium sulfate 4gm (25%) IV

B. Brethine 10mcg IV

C. Stadol 1mg IV push every 4 hours as needed prn for pain

D. Ancef 2gm IVPB every 6 hours

Explanation: Brethine is used cautiously because it raises the blood glucose levels. Answers A, C, and D are all medications that are commonly used in the diabetic client, so they are incorrect.

58. A diabetic multigravida is scheduled for an amniocentesis at 32 weeks gestation to determine the L/S ratio and phosphatidyl glycerol level. The L/S ratio is 1:1 and the presence of phosphatidylglycerol is noted. The nurse's assessment of this data is:

A. The infant is at low risk for congenital anomalies.

B. The infant is at high risk for intrauterine growth retardation.

C. The infant is at high risk for respiratory distress syndrome.

D. The infant is at high risk for birth trauma.

Explanation: When the L/S ratio reaches 2:1, the lungs are considered to be mature. The infant will most likely be small for gestational age and will not be at risk for birth trauma, so answer D is incorrect. The L/S ratio does not indicate congenital anomalies, as stated in answer A, and the infant is not at risk for intrauterine growth retardation, making answer B incorrect.

59. Which observation in the newborn of a diabetic mother would require immediate nursing intervention?

A. Crying

B. Wakefulness

C. Jitteriness

D. Yawning

Explanation: Jitteriness is a sign of seizure in the neonate. Crying, wakefulness, and yawning are expected in the newborn, so answers A, B, and D are incorrect.

60. The nurse caring for a client receiving intravenous magnesium sulfate must closely observe for side effects associated with drug therapy. An expected side effect of magnesium sulfate is:

A. Decreased urinary output

B. Hypersomnolence

C. Absence of knee jerk reflex

D. Decreased respiratory rate

Explanation: The client is expected to become sleepy, have hot flashes, and be lethargic. A decreasing urinary output, absence of the knee-jerk reflex, and decreased respirations indicate toxicity, so answers A, C, and D are incorrect.