NCLEX-PN - Quiz Questions with Answers

Basic Care and Comfort

1.

Your patient with heart failure has been responding well to treatments that include medications such as an ACE inhibitor and a loop diuretic. Today, the client is complaining about leg weakness and is refusing to ambulate. What is most likely occurring with this client?

Hypokalemia

Hyperkalemia

Hyponatremia

Hypernatremia

Correct answer: Hypokalemia

Hypokalemia, or low potassium, often occurs as the result of treatments with loop diuretics like furosemide (Lasix). The signs and symptoms of hypokalemia include muscular weakness, pain and cramping, as well as serious cardiac dysrhythmias. Clients taking loop diuretics should be closely monitored for hypokalemia and also given potassium supplementation when indicated.

2.

Your patient is scheduled to undergo a radical mastectomy due to breast cancer. You are teaching the patient the recommended post-op exercises. The client asks you why the exercises are necessary during healing and states that she is afraid the exercises will be painful. What is the **correct** rationale for performing arm exercises after a mastectomy?

"The exercises help you to regain the use of your arm, which will be affected by the surgery, and also prevent your shoulder from becoming stiff and painful."

"Arm exercises will eliminate postoperative swelling at the incision site."

"Arm exercises increase circulation in the breast and promote healing."

"The performance of arm exercises actually prevents postoperative pain."

Correct answer: Arm exercises help to prevent the shoulder from becoming stiff and help patients regain the full use of their arm following mastectomy.

These exercises will not reduce swelling at the incision site, nor are they performed to improve circulation in the breast. Arm exercises will not reduce postoperative discomfort.

3.

A patient has been admitted to the emergency department with a compound fracture of the tibia after a car accident. Which of the following interventions should the nurse implement immediately?

Select all that apply.

- **Splint the extremity**
- **Cover the wound with a sterile dressing**
- **Check the neurovascular status of the extremity**
- Assist the patient to perform RICE (rest, ice compression, and elevation) of the affected extremity
- Apply skin traction preoperatively

A compound (open) fracture occurs when bone is exposed to air through a break in the skin, and soft tissue injury and infection are common. Immediate interventions include covering the wound with a sterile dressing and immobilizing the affected extremity with a splint or cast. Check the neurovascular status of the extremity and prepare the patient for reduction, fixation, traction, and casting to allow proper healing of the bone.

Skeletal and skin traction may be applied postoperatively (skin traction is applied preoperatively with a fractured hip to reduce fracture, immobilize the bone, and help with muscle spasms). Management of a sprain (not a fracture) involves RICE, to reduce swelling and provide joint support.

4.

Your patient has a broken leg. You are teaching them about proper positioning of crutches. Choose the **incorrect** statement:

"Your elbows should be straight when you use the handgrips."

"The handgrips should be even with the top of your hipline."

"The crutches should reach to 1 to 1 1/2 inches below your armpits when you are standing upright."

"You should be using your hands, rather than your armpits, to absorb your weight."

Correct answer: "Your elbows should be straight when you use the handgrips."

Elbows should be slightly bent when using the handgrips. All other statements are correct.

5.

Which of the following is **true** regarding the use of a gait belt?

Ensure you can place three or four fingers between the belt and the patient

Tie the end of the gait belt in a knot

Tighten the gait belt as tight as it will go

Place the gait belt below the patient's hips

Correct answer: Ensure you can place three or four fingers between the belt and the patient

A gait belt is used as an assistive device to help promote steadiness while transferring a patient from one position to another. While the belt should be tight, the nurse should still be able to place three or four fingers between the gait belt and the patient. The belt should not be too loose or it will not serve its purpose. It should be placed above the patient's hips, near the waistline.

6.

All of the following are considered types of tube feeding **except**:

Intermittent

Bolus

Continuous

Cyclical

Correct answer: Intermittent

Tube feedings are administered through a gastrointestinal tube, for the patient who cannot take food by mouth. Tube feedings can be administered continuously (around the clock), cyclically (over 8 hours during the day or at night), or as a bolus feed (all at once over 30 or 60 minutes). The different types of feeds depend on the patient and their individual needs.

7.

The licensed practical nurse is assessing a patient's skin turgor and finds that it takes longer than normal for the skin to return to its place after being gently pinched. What are the possible indications of this assessment finding?

Select all that apply.

- **Dehydration**
- **Extreme weight loss**
- The presence of pitting edema
- Jaundice
- Internal bleeding

A normal skin turgor (elasticity of the skin) test means that once the skin is gently pinched, it recoils almost immediately when released. If a patient is assessed to have poor skin turgor (it takes longer than 2 seconds for the pinched skin fold to return to normal), possible causes include dehydration, weight loss, heat exhaustion, or hypovolemic shock.

Pitting edema is assessed by the examiner applying pressure to a swollen area of skin (often feet, ankles, lower extremities), for about 10-15 seconds to check for lasting indentation. Jaundice and internal bleeding are not a cause of poor skin turgor.

8.

A new mother is breastfeeding her 2-month-old infant. She is concerned that the infant is "not getting enough to eat". The infant's weight is appropriate for its age and the infant appears well-nourished. The mother reports 4 to 5 wet diapers per day and 3 to 4 yellow loose stools. Which of the following responses will **best** provide the new mother with reassurance that her infant is getting enough nourishment?

"If your baby is urinating and stooling several times a day and is gaining weight, you can feel confident that he is getting enough nourishment."

"All new mothers worry about whether their baby is getting enough to eat."

"Are you sure the baby is feeding often enough?"

"I will send you to a lactation consultant if you are concerned."

Correct answer: "If your baby is urinating and stooling several times a day and is gaining weight, you can feel confident that he is getting enough nourishment."

Providing the mother with concrete feedback (number of wet and soiled diapers are adequate and weight is increasing) gives the mother positive feedback to focus on and teaches her what to watch for. Telling her that all new mothers worry does little to ease her anxiety. Asking her whether she is certain the baby is feeding often enough sounds critical and will not reassure an anxious mother. There is no need to consult a lactation consultant if the baby is doing well, unless the mother requires further reassurance.

9.

Your patient has an area on his coccyx measuring 2 cm by 2 cm. Yellow slough is present, as well as some granulation tissue. You can visualize subcutaneous fatty tissue but no bone or muscle is visible. The wound is 4 cm in depth and tunneling is present at 2:00. This wound **most** likely represents what stage of pressure ulcer?

Stage III

Stage II

Stage I

Stage IV

Correct answer: Stage III

Stage III pressure ulcers involve full thickness tissue loss. Bone, tendons, muscle or other structures are not visible. Slough may be present. Undermining/tunneling may be present. Depth will vary by anatomic location.

10.

The nurse is caring for a patient with kidney disease. The nurse understands this patient is at high risk for which of the following conditions related to renal insufficiency?

Select all that apply.

- **Fluid volume excess**
- **Potassium imbalances**
- **Sodium imbalances**
- Fluid volume deficit
- Diabetes mellitus

A patient with kidney damage or failure is at high risk for fluid volume excess due to the inability of the kidney(s) to properly filter fluids out of the body. In addition, there will be electrolyte imbalances present (including potassium and sodium) as the kidneys are not functioning properly. Diuretics and/or dialysis is often indicated for kidney failure.

Though untreated or poorly managed diabetes could cause kidney disease, the patient with kidney disease is not at high risk for the development of diabetes.

11.

The purpose of inserting a chest tube is to:

Restore negative pressure in the intrapleural space

Provide positive pressure within the thoracic cavity

Provide positive expiratory pressure

Provide pain relief from increased intrathoracic pressure

Correct answer: Restore negative pressure in the intrapleural space

Insertion of a chest tube is an invasive procedure designed to restore negative pressure in the intrapleural space. When the normally negative pressure of the intrapleural space is disrupted, it causes the lung to collapse and a patient to develop respiratory symptoms. Therefore, the tube is placed to restore negative pressure until the underlying condition can heal. Conditions that commonly necessitate a chest tube include a pneumothorax, blunt chest trauma, empyema, or hemothorax.

12.

How often and why should you reposition an incontinent comatose client in the bed?

You should reposition the client at least every two hours to minimize the risk for skin breakdown secondary to maceration

You should reposition the client every hour to minimize the risk for skin breakdown secondary to shearing

You should reposition the client every hour to minimize the risk for skin breakdown secondary to friction

You should reposition the client every two hours to minimize the risk for skin breakdown secondary to friction

---

Correct answer: You should reposition the client at least every two hours to minimize the risk for skin breakdown secondary to maceration

Skin breaks down for a number of reasons, including moisture, which macerates the skin. Incontinence is a major risk factor associated with skin breakdown, so incontinent patients, and other clients at risk, should be repositioned at least every two hours. Friction and shearing are also factors that lead to skin breakdown; however, incontinence does not lead to these forces. Instead, improperly pulling patients up in bed produces these high risk forces.

13.

You are providing care for a child with hemolytic uremic syndrome (HUS). The child has been anuric and will be receiving peritoneal dialysis treatment. You will include all the following interventions in the plan of care **except**:

Monitoring the arteriovenous (AV) fistula

Limiting fluids, as prescribed

Administering blood products to treat severe anemia

Instituting measures to prevent infection

Correct answer: Monitoring the arteriovenous (AV) fistula

HUS is thought to be associated with bacterial toxins, chemicals, and viruses that cause acute kidney injury in children, occurring primarily among infants and small children between the ages of 6 months and 5 years. Symptoms often include a triad of anemia, thrombocytopenia, and renal failure.

The child undergoing peritoneal dialysis for treating anuria will be placed on fluid restrictions and will also need adequate nutrition and measures taken to prevent infection. Blood products may be prescribed to treat severe anemia, but administered with caution to prevent fluid overload.

*Peritoneal dialysis does **not require** an AV fistula (only hemodialysis does).*

14.

Your client is receiving a continuous gastric tube feeding. The rate of the tube feeding is 75 mL per hour. You aspirate 45 mL of gastric contents. What should you do?

Return the measured residual and discontinue the feeding

Return the measured residual and continue the feeding

Continue the feeding and discard all of the residual

Discard the residual and discontinue the tube feeding

Correct answer: Return the measured residual and discontinue the feeding

*You should return the residual gastric contents back into the tube because it is less than 150 mL. Residual contents over 150 mL are **not** returned. You should also discontinue the tube feeding because the residual is more than 50% of the hourly rate. Half of 75 mLs is 34.5 mLs, and you have aspirated 45 mLs.*

15.

Your patient is in traction after fracturing his femur. He is awaiting surgery. The patient asks you what the purpose of traction is. How should you respond?

"Traction is used to reduce muscle spasms and immobilize the extremity."

"Traction will reduce unstable fractures over time."

"Traction is used to ensure the patient does not get out of bed."

"Traction serves no useful purpose."

Correct answer: "Traction is used to reduce muscle spasms and immobilize the extremity."

Traction can maintain the bone in proper alignment, realign the bone, immobilize the extremity and reduce muscle spasms. It is not applied to reduce pain; traction is often uncomfortable.

16.

The nurse is providing education to the parents of an infant diagnosed with truncus arteriosus. The nurse explains that this condition involves which of the following structural defects?

Select all that apply.

- **A single vessel arising from both ventricles**
- **A mixture of blood from both ventricles in the common great artery**
- Obstruction of blood flow from the left ventricle
- Obstruction of blood flow from the right ventricle
- Return of blood to the heart without entry to the left atrium

---

Truncus arteriosus is a mixed defect, meaning fully saturated systemic blood flow mixes with the desaturated blood flow, causing a desaturation of the systemic blood flow, pulmonary congestion, and decreased cardiac output. Structurally, it involves a single vessel (failure of the division into the pulmonary artery and the aorta in utero) that overrides both ventricles. Blood from both ventricles mixes in the common great artery, thus causing desaturation and hypoxia. A characteristic murmur is present, and the infant exhibits heart failure, cyanosis, poor growth and development, and intolerance to activity. Treatment involves surgical intervention.

Pulmonary stenosis involves obstruction of blood flow from the right ventricle. Total anomalous pulmonary venous connection (TAPVC) is a defect of the pulmonary veins. It involves the return of blood to the heart without entry into the left atrium and obstruction of blood flow from the left ventricle.

17.

A patient has recently been diagnosed with cirrhosis of the liver, and the nurse is providing nutrition education to this patient. The nurse determines that the patient has the best understanding of the dietary measures to follow if the patient states an intention to increase the intake of which of the following foods?

Select all that apply.

- **Cooked fish**
- **Eggs**
- **Whole grain cereal**
- Bacon
- Full-fat milk

The patient with cirrhosis of the liver needs to consume foods high in protein and supplemental vitamins (B complex, vitamins A, C, and K, folic acid, and thiamine). A protein-rich diet includes cooked fish (particularly salmon, tuna, and mackerel that contain high omega-3 fatty acids), eggs and egg whites, a variety of fruits and vegetables, low-fat or fat-free dairy products, and whole grains (just to name a few).

The patient with cirrhosis of the liver should follow a low-sodium diet, and bacon is very high in sodium.

18.

The nurse has just started her shift and is assessing a newborn who is roughly four hours post-delivery. Which of the following findings are **not** considered normal newborn variations and would require further follow-up by the RN and primary health care provider (PHCP)?

Select all that apply.

- **Low-set ears**
- **Harlequin sign**
- **Slight tremors**
- Epstein pearls
- Acrocyanosis
- The presence of vernix caseosa

Low-set ears can be associated with Down's syndrome, renal anomalies, or other genetic or chromosomal syndromes. Harlequin sign is a deep pink or red color to the skin that develops over one side of the newborn's body, while the other side remains normal in color. This may indicate shunting of blood that occurs with a cardiac problem or may indicate sepsis. Slight tremors, though often a common finding indicating an immature neuromuscular system, should never be ignored because this could be a sign of hypoglycemia or drug withdrawal.

Epstein pearls are small, white cysts which may be present on the hard palate and are considered a normal finding. However, the presence of thrush (which is white patchy areas on the tongue or gums that cannot be removed with a washcloth) is not a normal finding and would need to be reported to the RN. Acrocyanosis (blue extremities) is normal in the first few hours after birth and may be noted intermittently for the next 7 to 10 days. Vernix caseosa is a cheesy white substance on the entire body (more prominent between folds) that protects the baby during fetal development. It is common in infants at birth, and generally can be gently washed off with the first few sponge baths.

19.

Improper patient positioning may lead to all of the following **except**:

Cardiac dysrhythmias

Pleural effusion

Pressure ulcer

Muscle contracture

Correct answer: Cardiac dysrhythmias

Improper positioning or alignment of an immobile patient can have a number of negative consequences. Patients may develop pressure ulcers as a result of positioning, in addition to pleural effusions, muscle contractures, and muscle spasms. Patients who are bed-bound should be turned and repositioned at least every two hours, and their correct anatomic alignment should be maintained.

20.

How should you assist a client to the chair when he has left-sided weakness as the result of a cerebrovascular accident?

Place the chair on the unaffected side

Place the chair on the affected side

Place the chair at the foot of the bed

This client should not be transferred to a chair because of the risk of a fall

---

Correct answer: Place the chair on the unaffected side

You should place the chair on the unaffected side so that the client can assist you with the transfer to the chair.

Out-of-bed activity should be encouraged for all clients when medically indicated, so there is no reason to keep the client in bed because of one-sided weakness or paralysis.

21.

Which of the following interventions would help an elderly woman who has just has hip surgery to begin resuming activity?

Placing an overhead trapeze on the bed

Assisting the patient to ambulate in the hallways

Assisting the patient to sit up in a chair for 2 hours twice daily

Having her family visit daily

Correct answer: Placing an overhead trapeze on the bed

An overhead trapeze allows the patient to position herself in the bed more comfortably, and also builds upper body strength in preparation for ambulation. A patient who has just had hip surgery won't be capable of walking in the halls, nor will she be able to sit in a chair right after surgery, as doing so will flex the hip at a 90 degree angle. Asking the family to visit may improve the patient's mood but won't facilitate the resumption of activity.

22.

The licensed practical nurse is caring for a laboring mother who is full-term, and notes the fetal heart rate has been at 180 beats per minute for over 10 minutes. What should the nurse do?

Select all that apply.

- **Notify the RN and the primary health care provider (PHCP)**
- **Change the mother's position**
- **Administer oxygen**
- **Obtain vital signs**
- Continue to monitor as this is a normal finding
- Perform a cervical check on the mother to assess progress

If a fetus is term or near-term, the fetal heart rate should be between 110 and 160 beats per minute. If it is noted to be less than (fetal bradycardia) or greater than (fetal tachycardia) this normal range, the LPN should change maternal positioning, administer oxygen, and check the mother's vital signs. In addition, notify the RN immediately and the PHCP.

The LPN should not assess cervical progress unless ordered by the RN or PHCP (performing one or more of the above interventions should, hopefully, resolve the fetal tachycardia).

23.

A 90-year-old male is admitted to the step down unit after suffering a myocardial infarction. Upon assessing him, you note an area of skin breakdown on his coccyx that is about 5 x 2 cm and looks like a blister that has broken open. It appears pinkish in color. You consider this which stage of pressure ulcer?

II

I

III

IV

Correct answer: II

Stage II pressure ulcers typically appear as a "shallow crater." The outer layer of skin, called the epidermis, and part of the underlying layer of skin, called the dermis, are damaged. The wound may be shallow and pinkish or red. The wound may look like a fluid-filled blister or a ruptured blister. The description of the man's wound is consistent with a stage II pressure ulcer.

24.

You are caring for a 22-year-old female with acute myelogenous leukemia. She is currently receiving chemotherapy and as a result, has severe stomatitis. In teaching her proper oral care, you reinforce which of the following?

Avoid alcohol-based mouthwashes and toothpaste

Drink hot liquids to promote comfort

Remove any blistering or patches that you see

Avoid brushing your teeth daily

Correct answer: Avoid alcohol-based mouthwashes and toothpaste

Stomatitis is an inflammation of the mucous lining of the mouth, which may involve the cheeks, gums, tongue, lips, and roof or floor of the mouth. It may lead to severe pain and, in cases where a patient cannot eat, may result in nutritional deficiencies. Good hygiene is critical to treating stomatitis. Alcohol-based mouthwashes and toothpaste should be avoided, and a soft-bristled toothbrush should be used. Alcohol-based washes can disrupt the normal protective flora in the mouth. Additionally, white patches or blistering should never be removed; and tepid, not hot, liquids can provide comfort.

25.

A client with prostate cancer is complaining of bladder fullness and discomfort. What would you do to increase the client's level of comfort despite his urinary retention?

Perform Crede massage

Encourage Kegel exercises

Perform prostate massage

Encourage active range of motion

Correct answer: Perform Crede massage

Crede massage is used if the client has a flaccid bladder. It includes the manual pressing on the bladder to promote bladder emptying. Some other interventions for urinary retention include maintaining adequate fluid intake, maintaining normal voiding habits, and the use of a cholinergic drug to stimulate bladder contractions.

26.

Your patient has been sitting on the commode for 30 minutes, straining to have a bowel movement. You note that hardened stool is partway out of the rectum. The patient complains of inability to push the stool out. You should:

Disimpact the patient after donning gloves and applying lubricant

Give the patient an oral laxative

Insert a suppository

Give the patient a fleet enema

Correct answer: Disimpact the patient after donning gloves and applying lubricant

A patient who has been straining for 30 minutes and has been unable to successfully pass hardened stool is impacted. Disimpacting the patient will provide immediate relief. Ample lubricant should be used. Disimpaction may result in a vasovagal response. In some institutions, nurses may need a physician's order to disimpact.

An oral laxative may take several hours to work and may cause abdominal pain. Inserting a suppository or giving a fleet enema may be impossible if stool is in the way.

27.

Your patient is incontinent of both urine and stool. Her perineal area and groin are reddened and irritated. Which of the following measures will prevent further skin breakdown in this patient?

All of these

Frequent changing of incontinence products

Gentle cleansing of the skin with nonperfumed soap or an approved emollient product

Sparing application of barrier cream, layered on in the direction of hair growth

---

Correct answer: All of these

Keeping the skin clean and dry is key to preventing skin breakdown in incontinent patients. Perfumed soaps should be avoided. Emollients can help to moisturize the skin. Barrier creams form a thin layer to protect the skin from urine and stool. They should be applied in a thin layer and should not be massaged in.

28.

You are discussing plans for future treatment options with a patient who has symptomatic polycystic kidney disease (PCKD). Which treatment would **not** be included in this discussion?

Peritoneal dialysis

Hemodialysis

Kidney transplant

Bilateral nephrectomy

Correct answer: Peritoneal dialysis

PCKD is a genetic familial disease involving cyst formation and hypertrophy of the kidneys, which leads to cystic rupture, infection, formation of scar tissue, and damaged nephrons. There is no specific treatment to stop the progression of the destructive cysts, and the ultimate result of this disease is chronic kidney disease (CKD).

*Treatment options include hemodialysis or renal transplantation. Patients usually undergo bilateral nephrectomy to remove the large, painful, cyst-filled kidneys. Peritoneal dialysis is **not** a treatment option, due to the obstructive nature of the cysts.*

29.

The licensed practical nurse is providing instruction to a patient's son who will be caring for their mother at home. The patient's mother is incontinent of both bladder and bowel and therefore the LPN reminds the son to:

Cleanse the perineum from front to back

Cleanse the perineum with water only

Cleanse the perineum in the back first, then with a different cloth in the front

Wash around the skin folds

Correct answer: Cleanse the perineum from front to back

Female patients, including patients who are incontinent of either bladder or bowel, should always be washed with soap and water from the front area to the back area. Washing from the perineum to the buttocks reduces the risk of transmitting bacteria from the back area into the urinary meatus. If bacteria does enter the urinary meatus, it may lead to a urinary tract infection and significant discomfort for the patient.

30.

Which of the following is the **most** accurate method of pain assessment?

Client's self reports of pain intensity

Observation of facial expressions

Observation of bodily movement including guarding

Review of the client's past medical history

Correct answer: Client's self reports of pain intensity

Research indicates that the most accurate and reliable way to assess pain is through the client's self reports of pain.

Although facial expressions and bodily movements are indicators of pain, the most reliable indicator of pain and its intensity is the patient's own words about his pain and its intensity.

31.

Your patient has swelling of the leg and pain, tenderness, warmth, and redness of the calf. This client has recently returned home after traveling to Paris to visit family members.With what is this patient most likely affected?

Deep vein thrombosis

Peripheral edema

Heart failure

Hepatotoxicity

Correct answer: Deep vein thrombosis

Deep vein thrombosis may be asymptomatic or accompanied with swelling of the leg and pain, tenderness, warmth, and redness of the calf. Deep vein thrombosis is a serious complication of immobility and airplane travel that must be treated with anticoagulants in order to prevent life-threatening pulmonary emboli.

32.

The licensed practical nurse is caring for a patient who is unconscious. The LPN provides oral care to the unconscious patient:

Every two hours

Daily

Every shift

Every thirty minutes

Correct answer: Every two hours

For the patient who is unconscious, mouth breathing is common. Therefore, in order to maintain the integrity of the oral cavity and mucous membranes, oral care should be given every 2 hours and as needed in between. Providing adequate oral care also reduces the chance of infection due to dryness, cracking, or sores. Suction should be available at the bedside while providing oral care to the unconscious patient, in order to reduce the likelihood of aspiration.

33.

You are teaching a new aide how to assist a patient onto and off of a bedpan. She asks you why it is important to support the patient's lower back when removing the bedpan. Choose the **best** response:

"To prevent injury to the skin from friction."

"To prevent spilling the contents of the bedpan."

"It is not necessary to support the patient's lower back."

"It gives you leverage so that you can pull the bedpan out more easily."

Correct answer: "To prevent injury to the skin from friction."

Before removing a bedpan, you should lower the head of the bed, then ask the patient to raise his/her buttocks off the bed. Supporting the lower back, gently remove the bedpan to avoid injury to the skin caused by friction.

34.

Your patient has a fractured jaw and is scheduled for fixation surgery. When the patient returns from surgery, you should anticipate positioning the client in which of the following positions?

Side-lying position with the head slightly elevated

High Fowler's

Supine

Prone with the head turned to the side

Correct answer: Side-lying position with the head slightly elevated

The patient should be placed in a side-lying position with the head slightly elevated. The other positions might be dangerous should the patient vomit--aspiration may occur.

35.

You are caring for a group of residents, and two of these residents are incontinent of urine. Mrs. B is incontinent of urine when she giggles and coughs, and Mr. T is a confused, agitated incontinent client who is under a lot of stress as the result of his recent cognitive impairments. Which of these clients would most likely benefit from a bladder training program?

Mr. T because he is most likely affected with functional incontinence and has no present control

Mrs. B because she is far less confused than Mr. T

Mr. T because he is most likely affected with stress incontinence

Neither resident is a candidate for a bladder training program

---

Correct answer: Mr. T because he is most likely affected with functional incontinence and has no present control

Mr. T is most likely affected with functional incontinence. This type of incontinence occurs most frequently among those who have cognitive dysfunction or a severe physical disease. Complete uncontrollable bladder emptying occurs. Although a bladder training program may not be completely successful for this client, it may help somewhat. Mrs. B is most likely affected with stress incontinence, which occurs after a person coughs or laughs. There is only a small amount of urinary leakage when the abdominal pressure increases during these laughing or coughing episodes. Stress incontinence results from weakened pelvic floor muscles, and it is not treated with a bladder training program.

36.

Your patient is experiencing severe abdominal pain. Which of the following positions is **best** to relieve abdominal pressure?

Dorsal recumbent

High Fowler's

Prone

Supine

Correct answer: Dorsal recumbent

The dorsal recumbent position is the supine position with the knees flexed. You can support the knees with pillows. This position relieves pressure on the abdomen. The other positions may increase intra-abdominal pressure, thus increasing pain.

37.

A patient is diagnosed with Lyme disease, and is in the first stage of the illness. Upon assessment, the nurse anticipates the patient will exhibit which of the following manifestations, characteristic to stage one of this disease?

Select all that apply.

- **Flu-like symptoms**
- **Ring-shaped rash that may appear anywhere on the body**
- Enlarged and inflamed joints
- Cardiac complications
- Joint pain
- Signs of neurological impairments

Lyme disease is an infection acquired from a tick bite (the spirochete Borrelia burgdorferi from the infected tick causes the illness). Ticks live in the woods and survive by attaching to a host. The infection with this bacterial organism stimulates inflammatory cytokines and autoimmune mechanisms. The typical ring-shaped rash of Lyme disease does not occur in all patients, but if the rash does occur, it can be anywhere on the body (not only at the site of the bite). Symptoms can occur several days to months following the bite. The first stage is characterized by a small red pimple that spreads into the typical ring-shaped rash, and flu-like symptoms (headache, stiff neck, muscle aches, and fatigue).
The second stage occurs several weeks following the bite. Joint pain, neurological, and cardiac complications occur. The third stage is characterized by enlarged and inflamed joints, progressing into arthritis (if left untreated).

38.

All of the following are correct principles for moving patients **except**:

Keep your elbows away from your body

Use smooth, coordinated movements

Lift with your leg muscles

Obtain additional help when necessary

Correct answer: Keep your elbows away from your body

When moving patients, it is critical that health care workers acknowledge proper moving techniques. One should move a patient with the leg muscles, and have the elbows kept close to the body--close to the center of gravity. Smooth, coordinated movements should be employed and additional help should be sought out as necessary.

39.

You are caring for a 58-year-old female who suffered an ischemic stroke, leaving her right side paralyzed. When helping her dress for the day, you do which of the following?

Dress the right side first

Dress the left side first

Request assistance from the nurse's aide for dressing

Request the patient wear button-down tops only

Correct answer: Dress the right side first

When dressing a patient who has weakness or paralysis on one side of the body, it is important to dress the affected or weak side first. When helping a patient to undress, you should employ the opposite rule of thumb and undress the unaffected side first, followed by the affected side. This technique helps to make the task easier.

40.

Of the following steps, which is **not** appropriate regarding the insertion of a Foley catheter?

Maintain the catheter bag on the side rail of the bed

Use aseptic technique when inserting the catheter

Check the balloon for patency

Expose the urinary meatus with the nondominant hand

Correct answer: Maintain the catheter bag on the side rail of the bed

When inserting a Foley catheter, aseptic technique must be used, since it is a sterile procedure. The Foley catheter balloon should be tested prior to insertion. The nondominant hand should be used to expose the urinary meatus, with the dominant hand being used to guide the catheter through the meatus and into the bladder. The catheter bag should be placed in a position that is lower than the level of the bladder. Therefore, placing the bag on the side rail of the bed would not be appropriate.

41.

All of the following are considered risk factors for pressure ulcers **except**:

Dry skin

Immobility

Malnutrition

Decreased sensory perception

Correct answer: Dry skin

There are a number of identifiable risk factors for pressure ulcers. These include immobility, friction and shearing forces, malnutrition, decreased activity, altered or decreased sensory perception, and increased moisture of the skin. Each of these factors is assessed with a scale known as the Braden scale for predicting pressure ulcer risk. Braden scales are completed by nursing staff for patients upon admission to a hospital or long-term-care facility, then typically every 24 hours through discharge.

42.

Your patient who has been on bedrest for several weeks has begun to develop contractures. Which of the following interventions will prevent the patient's contractures from worsening?

Range of motion exercises performed TID

Turning the patient every two hours from side to side

Massaging the extremities daily

Placing sheepskin booties on the patient's feet

Correct answer: Range of motion exercises performed TID

Range of motion exercises are performed to maintain joint mobility and prevent shortening of the muscles. Turning the patient every 2 hours may promote comfort but will not prevent contractures. Massaging the extremities may also promote comfort but will not prevent contractures. Sheepskin booties are designed to prevent heel pressure ulcers from forming when a patient is confined to bed.

43.

In which of the following patients would the licensed practical nurse (LPN) obtain an apical pulse measurement?

Select all that apply.

- **In the patient with an irregular radial pulse**
- **In the patient with a heart condition**
- **Before the administration of digoxin**
- In the child younger than five years
- In the older adult

The apical pulse (best detected at the left midclavicular, fifth intercostal space) is counted for 1 full minute and is assessed in patients with an irregular radial pulse or a heart condition, before the administration of cardiac medications (such as digoxin and beta-blockers), and in children younger than two years. When administering cardiac medications, if the apical pulse is less than 60 bpm, the dose should be held and the primary health care provider (PHCP) notified.

44.

Your client is lethargic, and you will be providing passive range of motion exercises. What statement about these exercises is accurate?

Passive range of motion prevents further disability

Passive range of motion prevents bone calcification

The nurse should perform active, rather than passive, range of motion for this client

This passive range of motion decreases pain and promotes sleep and rest

---

Correct answer: Passive range of motion prevents further disability

Passive range of motion for all joints is done when the client is not able to perform range of motion independently or with minimal assistance. The purpose of passive range of motion is to prevent further disability among clients who are deeply lethargic or in a comatose state.

45.

When providing care to a postoperative patient following a simple right mastectomy, which of the following procedures should be avoided in the right arm?

Select all that apply.

- **IV therapy**
- **Injections**
- **Blood pressure measurements**
- **Blood draws**
- Pulse oximetry reading
- Radial pulse assessment

A mastectomy is a procedure which involves removal of malignant breast tissue and lymph nodes. No IVs, no injections, no blood pressure measurements, and no venipunctures should be done on the arm on the side of the mastectomy. Rather, the arm on the side of the mastectomy should be protected, and any intervention that could traumatize the affected arm is avoided because of the risk for lymphedema. The patient should avoid overuse of the arm during the first few months and keep it elevated as much as possible to reduce this risk.

A pulse oximetry reading and assessing a radial pulse can be performed on the affected arm, as these are not invasive procedures.

46.

The nurse is caring for a patient who is receiving mechanical ventilation. The nurse hears the "high-pressure" alarm going off, and understands that which of the following are potential reasons for this?

Select all that apply.

Increased secretions are in the airway

The endotracheal (ET) tube has been displaced

The endotracheal (ET) tube has been obstructed as a result of water or a kink in the tubing

The patient has stopped spontaneously breathing

A disconnection in the patient's airway cuff has occurred

A leak in the ventilator has occurred

Causes of ventilator alarms are as follows:

High-pressure alarm:

- *Increased secretions in the airway*
- *Wheezing or bronchospasm is causing decreased airway size*
- *The ET tube is displaced or obstructed as a result of water or a kink in the tubing*
- *The patient coughs, gags, or bites on the oral ET tube*
- *The patient is anxious or "fights" the ventilator*

Low-pressure alarm:

- *Disconnection or leak in the ventilator or in the patient's airway cuff occurs*
- *The patient stops spontaneous breathing*

47.

The nurse is caring for a patient who has an intravenous (IV) urography ordered, an x-ray procedure used to visualize and identify abnormalities in the renal system. Which of the following interventions are appropriate to implement before and after this procedure?

Select all that apply.

- **Ensure an informed consent has been obtained prior to the procedure**
- **Monitor urinary output closely after the procedure**
- **Assess BUN and creatinine levels prior to procedure**
- Encourage increased fluids both before and after the procedure
- Administer an antidiarrheal prior to the procedure, as prescribed

---

An IV urography is an x-ray procedure in which an IV injection of a radiopaque dye is used to visualize and identify abnormalities in the renal system. Prior to the procedure, ensure the patient has signed an informed consent and check the patient for allergies to iodine, seafood, and radiopaque dyes; ensure the patient is not pregnant. Because the dye (contrast media) used in IV urography may be nephrotoxic, it is imperative to encourage increased fluids after the procedure (withhold food and fluids prior to the procedure); the patient should be encouraged to drink at least 1 L of fluid unless contraindicated. Urinary output should be closely monitored postprocedure, and BUN and creatinine levels should be assessed prior to the procedure (on any patient undergoing a procedure where dye is injected). Administer laxatives (not antidiarrheals) prior to the procedure, as prescribed.

The primary health care provider (PHCP) may institute precautionary measures to prevent acute kidney injury (AKI) or use smaller amounts of the dye, if indicated.

48.

How far down from the urinary meatus should you wash an indwelling urinary catheter during perineal care for the female client?

4 inches in a downward manner

4 inches in an upward manner

8 inches in a downward manner

8 inches in an upward manner

Correct answer: 4 inches in a downward manner

Perineal care for females and males with indwelling urinary catheters is done with a clean washcloth and soap. Cleansing of the urinary catheter begins at the urinary meatus and for 4 inches below it and should be done using short strokes in a downward manner and then rinsing in the same direction. The aseptic technique requires that all cleaning be done from the "cleanest" area to the "dirtiest" area in order to prevent infection.

49.

Which of the following assessment findings are considered normal variations of the newborn?

Select all that apply.

- **Mongolian spot**
- **Caput succedaneum**
- **Milia**
- **Blood-tinged mucus in a newborn female's diaper**
- Torticollis
- A two-vessel cord

A Mongolian spot is a common type of birthmark; it is a bluish-black pigmentation often seen on the lumbar-dorsal area and buttocks of Asian and dark-skinned individuals. Caput succedaneum is edema on the head of the newborn (of the soft tissue over bone), and is common after a vaginal birth from the trauma of delivery; it subsides within a few days. Milia is normal in the newborn, and is best characterized as small white sebaceous glands that appear on the forehead, nose, and chin at or shortly after birth. Blood-tinged vaginal mucus in the female newborn is a result of withdrawal of maternal estrogen and is referred to as "pseudo menstruation."

Torticollis is when the head is inclined to one side as a result of tight, contracted muscles on that side of the neck. This finding is not normal and often requires physical therapy treatments. The umbilical cord should have three vessels: two arteries and one vein. Although a two-vessel cord may present no problems, there is a higher association with intrauterine growth restriction (IUGR) and genetic or chromosomal problems. If fewer than three vessels are noted, the primary health care provider (PHCP) should be notified.

50.

Of the following diets, which is **most** appropriate for the patient with a diagnosis of congestive heart failure?

Low sodium diet

Low carbohydrate diet

Low calorie diet

Low cholesterol diet

Correct answer: Low sodium diet

Congestive heart failure develops as a result of the heart's inability to pump blood effectively. When the heart is unable to pump blood effectively, the result is fluid retention and symptoms associated with fluid retention. Making dietary changes can actually help to reduce some of the symptoms associated with congestive heart failure. A low sodium diet helps to minimize fluid retention, which will in turn reduce peripheral edema and shortness of breath.

51.

Which of the following types of tracheostomy tubes allows the patient to speak when it is capped?

Fenestrated tube

Single lumen tube

Cuffed tube

Double lumen tube

Correct answer: Fenestrated tube

A tracheostomy is a direct opening into the trachea to maintain patency of the airway. A tube is then inserted into the opening; there are different types of tubes. The fenestrated tube is a type that has an opening along the posterior aspect of the outer cannula. When it is capped, the patient is able to breathe through their upper airway and speak as well. It is important to note that the cuff must always be deflated prior to capping a fenestrated tube.

52.

Your patient has chronic explosive diarrhea, steatorrhea, abdominal bloating, and flatulence. The patient has progressively lost weight and hair. His skin is dry, and he has a moderate amount of dependent edema. The patient's wife is concerned about the condition of her husband and asks you what is happening with the client. How should you respond to this patient's spouse?

The doctor has diagnosed your husband with a failure to thrive. This condition interferes with the digestion of food and with the absorption of necessary food and nutrients.

The doctor has ordered parenteral nutrition for your husband. We will begin these feedings today.

Your husband is ill. Many ill patients in the hospital just do not respond well to hospital food. I am sure that he will do better when he gets home.

I would not worry about this. Your husband has a great doctor who is keeping a close eye on him and his condition.

Correct answer: The doctor has diagnosed your husband with a failure to thrive. This condition interferes with the digestion of food and with the absorption of necessary food and nutrients.

This client has a failure to thrive, which is also referred to as malabsorption syndrome. Malabsorption syndrome can result from a number of causes including lactase deficiency, increased digestive acid production, decreased digestive enzyme production, decreased bile, some medications like tetracycline, infections, Celiac disease, and Crohn's disease. The treatment includes the correction of any underlying cause(s) and enteral or parenteral nutrition, as indicated. False reassurances are not appropriate.

53.

You are a licensed practical nurse providing transfer assistance for an 86-year-old female, when the patient begins to fall. Your **most** appropriate action is to:

Allow the patient to slide down your leg and onto the floor

Gently grasp the patient's arms

Leave the patient to call for help

Stand with your feet together and bend at the waist to break the patient's fall

---

Correct answer: Allow the patient to slide down your leg and onto the floor

When a patient appears to be falling, it is critical to protect their head and attempt to provide a smooth transition onto the ground. This can be done by using your leg in a slightly bent position to brace the fall and slide the patient down onto the floor. You should then call for help. The nurse or other health care worker's legs should never be placed together or straight, as this can result in injury. It is best for the knees to be apart to provide a wide base of support.

54.

Your client is recovering from a hip repair. He complains of pain and is reluctant to engage in physiotherapy. Which of the following interventions might be utilized to increase comfort during physiotherapy?

Provide pain medication 30 minutes prior to physiotherapy

Application of a cold pack to the painful area after physiotherapy is completed

Application of heat to the incision prior to physiotherapy

Ask the physiotherapist to reduce physiotherapy to 10 minutes instead of 30 minutes

---

Correct answer: Provide pain medication 30 minutes prior to physiotherapy

Providing pain medication prior to physiotherapy will make physiotherapy more comfortable for the patient and may increase compliance. Applying an ice pack to the painful area after physiotherapy is done won't help during physiotherapy. Heat should not be applied to a fresh incision. Reducing physiotherapy may delay recovery, and it is the physiotherapist's determination to make regarding length of sessions.

55.

All of the following are potential purposes of a nasogastric tube **except**:

To evaluate bleeding in a patient on warfarin (Coumadin)

To allow surgical anastomoses to heal

To decompress the abdomen and relieve pain

To decrease the risk of aspiration

Correct answer: To evaluate bleeding in a patient on warfarin (Coumadin)

A nasogastric tube may be placed for multiple reasons. The tube may be placed to decompress the abdomen and relieve pain, to allow a surgical anastomosis to heal, to decrease the risk of aspiration, to administer medication, to provide temporary nutrition, or to irrigate the stomach and remove toxic substances. A nasogastric tube should not be placed in a patient with a coagulation abnormality, such as a patient on warfarin (Coumadin).

56.

The licensed practical nurse (LPN) is caring for a patient who has just undergone a mastectomy. In maintaining proper positioning for this patient, what actions should the LPN take?

Select all that apply.

Keep the head of the bed at a 30-degree angle or higher

Keep the patient's affected arm elevated on a pillow

Use a trochanter roll to elevate the affected arm

Have the patient lay on the affected side to limit bleeding from the surgical site

Allow the patient to choose a position that will decrease discomfort and alleviate pain

---

Position a post-mastectomy patient with the head of bed elevated at least 30 degrees, and the affected arm elevated on a pillow to promote lymphatic fluid return (and prevent lymphedema) after the removal of axillary lymph nodes. Keep the patient as comfortable as possible, while ensuring they are in a semi-Fowler's position with the affected arm elevated.

If the patient was undergoing a liver biopsy, it would be appropriate to lay on the affected side to apply pressure and limit bleeding from the surgical site, for a minimum of 3 hours. A trochanter roll is used to prevent the external rotation of the legs when the patient is in the supine position.

57.

Of the following, which patient(s) should the nurse monitor very closely for fluid imbalances during an inpatient hospitalization?

Select all that apply.

- **An infant**
- **An older adult**
- A diabetic patient
- An obese patient
- A patient with heart disease

Patients at greatest risk for fluid imbalance are infants and older adults. Total body fluid amounts to approximately 80% in the infant, and any illness that prevents oral fluid intake (think vomiting) or results in fluid loses (think diarrhea, burns, etc.) are especially significant because they deplete the fluid stores in infants much more rapidly than in adults.

The elderly often have altered homeostasis mechanisms due to factors such as age-related changes, medications, and diseases, making them much more susceptible to fluid and electrolyte imbalances.

Diabetes, obesity, and heart disease can put individuals at risk for fluid imbalances, but those at greatest risk are elderly and infants.

58.

All of the following are purposes of traction **except**:

To treat a sprain

To reduce a fracture

To maintain skeletal alignment

To rest a diseased joint

Correct answer: To treat a sprain

Traction is defined as the application of a pulling force to a part of the body, with countertraction applied in the opposite direction. The purpose of traction can be to reduce a fracture or dislocation, to rest a diseased joint, to maintain skeletal length and alignment, and to prevent the development of contractures. A contraindication to traction would be to treat a sprain or inflammation, pregnancy, or patients with spinal instability or osteoporosis.

59.

Which of the following foods should you counsel your patient with GERD to avoid?

All of these

Orange juice

Ground beef

Coffee

Correct answer: All of these

Patients who suffer from heartburn due to GERD should avoid all of these foods. Citric juices and foods high in citric acid may increase heartburn. Coffee is a known trigger for many people with GERD. Meats with high fat content, such as ground beef, may also cause heartburn.

60.

Your patient asks you how much water he should be drinking each day. You know that the average adult should consume _____ mL per day to maintain proper hydration.

1,500 to 2,000 mL

500 to 1,000 mL

1,000 mL

2,000 to 3,000 mL

Correct answer: 1,500 to 2,000 mL

The average adult should strive to consume 1,500 to 2,000 mL of water every day. More fluids may be required when losses are higher (i.e., exercise, fever). Certain patients may be restricted to lower amounts (i.e., patients with congestive heart failure).

61.

Which is the best nonpharmacological nursing measure that you can use to induce sleep for clients who have difficulty falling asleep?

The provision of a sleep-conducive environment

Encouraging light exercise just before bedtime

The administration of over-the-counter nonprescription strength diphenhydramine

Topical capzasin cream applied with a backrub

Correct answer: The provision of a sleep-conducive environment

Some of these nonpharmacological sleep interventions include soft, soothing music, progressive relaxation techniques, and a back rub. Capzasin cream is used for the topical relief of arthritis and is not used for backrubs. Additionally, capzasin and diphenhydramine are pharmacological, not nonpharmacological, interventions. Exercise during the day is conducive to night time sleep; however, exercise just prior to bedtime can interfere with sleep.

62.

A 16-year-old female patient who has just become sexually active has been diagnosed with simple cystitis. She asks you how she can avoid getting another infection in the future. Choose the **best** response.

"Voiding immediately after intercourse can help to prevent cystitis."

"Abstinence is the best defense against cystitis."

"Sensitivity to the latex in condoms may cause cystitis; therefore, you should not use condoms."

"Birth control pills can predispose one to cystitis."

Correct answer: "Voiding immediately after intercourse can help to prevent cystitis."

*Sexual intercourse can result in bacteria being pushed into the urethra. **Voiding immediately after intercourse** can help to wash bacteria away from the urethra. Counseling abstinence is not likely to lead to compliance. Some forms of birth control can predispose to cystitis in susceptible women, but counseling against the use of birth control may not be wise for a teenaged patient.*

63.

A child has been admitted to your nursing care unit with incessant, never-ending hiccoughs. The mother of the child finds it rather amusing and states that the child "is pretending." How should you respond to this mother?

Singultus is a true medical condition. It can usually be treated rather promptly, but it is highly distressing to the patient.

Dysphagia is a true medical condition. It cannot be treated, and it is highly distressing to the patient.

You are correct. Many young children do this on purpose to get attention.

It is a serious condition. Your child is most likely affected with cancer of the colon.

Correct answer: Singultus is a true medical condition. It can usually be treated rather promptly, but it is highly distressing to the patient.

Constant hiccoughing, often referred to as singultus, is a real medical problem that can be very distressing to the affected child. It can result from a number of causes such as gastroesophageal reflux disease, gastric distension, hepatic tumors, renal failure, hyponatremia, and brain stem lesions. It can be relatively easily treated when it does not spontaneously disappear.

64.

When obtaining vital signs, the licensed practical nurse (LPN) knows to avoid taking a rectal temperature in which of the following patients?

Select all that apply.

A cardiac patient

A patient who has undergone rectal surgery

A patient who is at risk for bleeding

A patient with an irregular respiratory pattern

A patient at risk for seizures

The temperature is taken rectally when an accurate temperature cannot be obtained orally or when the patient has undergone a procedure in which other measurement methods are not possible. However, taking a temperature rectally is contraindicated in cardiac patients, rectal surgery patients, any patient with diarrhea, fecal impaction, or rectal bleeding, or any patient who is at risk for bleeding. Other methods of taking the temperature include axillary, tympanic, oral, or via the temporal artery.

An irregular respiratory pattern is not a contraindication for obtaining a rectal temperature, but the nurse should always count the respiratory rate in these patients for a full 1 minute (not the usual 30 seconds, then multiply by 2). A rectal temperature measurement would be appropriate in the patient at risk for seizures (because an accurate measurement cannot be obtained orally in this patient).

65.

The licensed practical nurse is caring for a post-operative patient who underwent an arthroscopic knee procedure. The discharge orders include teaching the patient flexion and extension exercises on the operated knee. The LPN understands that flexion and extension refers to:

Bending and straightening

Contracting and relaxing

Moving from right to left

Moving up and down

Correct answer: Bending and straightening

There are two different types of range of motion exercises, and both may require the assistance of the nursing staff in some way. Active range of motion involves the patient moving the affected limb or area on their own, while passive range of motion requires another individual to move the affected limb or area for the patient. Flexion and extension refers to a particular range of motion that involves bending and straightening. Flexion and extension can be used for knee range of motion exercises.

66.

Your client has just emitted a foul-smelling, clay-colored stool. What would you suspect?

Pancreatic disease

Constipation

Diarrhea

Megacolon

Correct answer: Pancreatic disease

A foul-smelling, clay-colored stool is abnormal. This stool can result from a number of diseases and disorders such as pancreatitis, cystic fibrosis, Crohn's disease, infections, and malabsorption syndrome, but not diarrhea or constipation.

67.

Your patient complains of chronic constipation. He asks you how he can prevent constipation at home. Which of the following non-pharmacologic measures might you recommend?

All of these

Increase the amount of daily exercise

Increase fluid intake

Eat a high-fiber diet

Correct answer: All of these

All of these non-pharmacologic measures can be used to manage constipation. Before recommending an increase in fluids, ensure that it is safe for the patient to drink more fluids (i.e., that they are not on a fluid-restricted diet due to CHF or another condition). When advising patients to increase their fiber intake, they should also be instructed to increase their fluid intake to avoid becoming constipated.

68.

Your 66-year-old male patient complains of urinary hesitancy. Workup reveals an enlarged prostate. The patient asks you if there are any signs and symptoms he should be concerned with that should be reported to his physician. Which of the following symptoms should be reported **immediately** to the patient's physician?

Complete inability to void

Frequency

Difficulty initiating the urine stream

Dribbling

Correct answer: Complete inability to void

Complete inability to void is a medical emergency and may lead to kidney damage if left too long. Counsel the patient to seek care if unable to void for several hours. The other symptoms are common with prostate disease.

69.

Shear stress may be defined as:

the force per unit area exerted parallel to the plane of interest

the force per unit area exerted perpendicular to the plane of interest

force distribution acting on a surface

the ability of a support surface to distribute load over the contact areas of the human body

---

Correct answer: the force per unit area exerted parallel to the plane of interest

Shear stress is force exerted parallel to the plane of interest. Shear stress may result in skin breakdown.

70.

Sequential compression devices are used to prevent:

Deep vein thrombosis

Muscle atrophy

Pain

Compartment syndrome

Correct answer: Deep vein thrombosis

Sequential compression devices, or SCD's, (also known as lymphedema pumps) are designed to limit the development of deep vein thrombosis (DVT) and peripheral edema in immobile patients. They are frequently used after surgery.

71.

The clinic nurse is performing an eye exam on a patient utilizing the Snellen chart. Which of the following statements are **true** regarding this test?

Select all that apply.

- **One eye is tested at a time, then both eyes are tested**
- **Normal visual acuity is 20/20**
- **The patient is asked to read the smallest line on the chart s/he can discern**
- This is a simple tool to measure near vision
- The patient is instructed to remove glasses or contact lenses prior to the exam

---

The Snellen eye chart measures distance vision (not near vision). The patient should be positioned in a well-lit spot, 20 feet from the chart, with the chart at eye-level, and asked to read the smallest line s/he can discern. The patient is instructed to leave glasses on or contacts in (unless the glasses are for reading only, in which case they should be removed prior to testing because reading glasses will blur distant vision). One eye is tested at a time, and then both eyes are tested at the end.

Normal visual acuity is 20/20 (distance in feet at which the patient is standing from the chart/distance in feet at which a normal eye could have read that particular line). Results are recorded using the fraction at the end of the last line successfully read on the chart.

72.

The nurse is caring for an infant with pneumonia. Which of the following assessment findings would indicate to the nurse that this child is suffering from dehydration?

Select all that apply.

- **Decreased urinary output**
- **Dry mucous membranes**
- **Decreased tear production**
- Dilute urine
- Bulging fontanel

Children hospitalized with a respiratory disorder should be monitored for weight loss and for signs of dehydration, including a sunken (not bulging) fontanel, non-elastic skin turgor, decreased and concentrated (not dilute) urinary output, decreased tear production, and dry mucous membranes. All of these findings should be reported to the RN or primary health care provider (PHCP).

73.

All of the following measures may be implemented to promote sleep **except**:

Eliminate "white noise" such as a fan, tape-recorded sounds, or soft music

Administer diuretics early in the morning

Encourage patients to participate in relaxation activities in the evening

Encourage patients to avoid smoking in the evening

Correct answer: Eliminate "white noise" such as a fan, tape-recorded sounds, or soft music

For patients admitted to a hospital or unfamiliar environment, sleep can be problematic. Sleep is a basic human need, and is required for physiologic repair of cells. Measures should be implemented by the nurse to ensure that sleep is interrupted as little as possible. "White noise" often facilitates sleep and may be provided through the use of a fan, tape-recorded sounds, or soft music. Additionally, medications such as diuretics or steroids should be given early in the morning hours. Patients should avoid smoking in the evening, as nicotine is a stimulant. Finally, patients may be encouraged to participate in relaxation exercises to prepare themselves for a restful night of sleep.

74.

You are to perform passive range of motion (ROM) exercises with your bedbound patient. Passive ROM exercises help to prevent:

Joint stiffening and contracture

Skin breakdown

Incontinence

Heart disease

Correct answer: Joint stiffening and contracture

Passive ROM exercises are performed to prevent joints from stiffening due to disuse. Active ROM exercises are performed by the patient, while passive ROM exercises are performed by a caregiver.

75.

Your patient is complaining of a sensation of fullness in his ear, itchiness, tinnitus and difficulty hearing. You look into the affected ear and note a large build-up of wax. What is your **best** option to manage the problem?

Clean the outside of the ear using a soft cloth to remove any visible wax and obtain an order for cerumenolytic solution to soften the remaining wax in the ear

Use sterile Q-tips to dig out any impacted ear wax

Irrigate the ear using hot water to "melt" the wax

Provide the patient with cotton swabs and tell him to remove the ear wax himself

---

Correct answer: Clean the outside of the ear using a soft cloth to remove any visible wax and obtain an order for cerumenolytic solution to soften the remaining wax in the ear

The outer portion of the ear can be cleaned with a soft cloth to remove any wax, but this likely won't help if the ear canal is impacted. Cerumenolytic agents, such as mineral oil, baby oil or hydrogen peroxide, can help to soften wax that is hard. Irrigating/syringing the ear may be performed once the wax has been softened sufficiently.

76.

You are teaching a patient's wife how to perform range of motion exercises on her husband. You tell the patient's wife that it is important to remember to:

All of these

Support the limb throughout movement

Never force the joint past resistance

Stop the exercise if pain is experienced

Correct answer: All of these

It is important to support the joint with one hand while moving the limb with the other. The joint should never be "forced" as this may result in injury to the joint. Although range of motion exercises may be uncomfortable if the joints are stiff, exercises should not cause pain; stop the exercise if the patient complains of pain.

77.

Your patient is scheduled for an ileostomy. You are providing patient teaching regarding ileostomy care. Choose the **incorrect** statement:

"Your ileostomy will be most active first thing in the morning and before meals."

"Redness of the skin around the stoma is an indication of irritation and should be addressed promptly."

"You can shower with the appliance, or take it off prior to showering."

"Symptoms of blockage may include absence or decrease in the amount of stool, or an increase in watery, foul-smelling stool."

Correct answer: "Your ileostomy will be most active first thing in the morning and before meals."

Ileostomies are typically least active upon awakening and before meals. The other statements are true.

78.

Your elderly patient chokes whenever she is given oral fluids. You should:

Provide thickened fluids and request a swallowing study

Push oral fluids and request an occupational therapy consult

Request a physical therapy consult

Notify the physician

Correct answer: Provide thickened fluids and request a swallowing study

Although you will certainly want to let the physician know, a swallowing study will provide information regarding the cause of dysphagia. Older patients are at higher risk of swallowing difficulties due to aging and the presence of other conditions that may predispose to dysphagia, such as stroke and Parkinson's disease. Thickened fluids are easier to swallow for patients with dysphagia and can help to prevent aspiration of thin liquids.

79.

Which pain and comfort measure is correctly and accurately paired with its description?

Reiki: The placing of hands above or on the person to facilitate the client's own healing processes

Transcutaneous nerve stimulator: Magnets and electromagnetic fields to alleviate pain

T'ai chi ch'uan: The use of fine needles under the skin at certain locations to decrease pain

Feng shui: The application of pressure to certain bodily points to decrease pain

---

Correct answer: Reiki: The placing of hands above or on the person to facilitate the client's own healing processes

This Eastern therapy is based on the belief that energy from another's hands supports healing and relieves pain. It is similar to the therapeutic touch technique put forth by Delores Krieger. Transcutaneous nerve stimulation uses low-voltage electrical stimulation to decrease pain. T'ai chi ch'uan is a martial art that promotes inner balance, and feng shui is an environmental decorating technique that promotes bodily balance and peace.

80.

A patient with stage 1 hypertension is being taught about dietary changes to reduce blood pressure. The nurse introduces the DASH diet to the patient, explaining that which of the following foods are encouraged to be incorporated as a part of this diet?

Select all that apply.

- **Fruits and vegetables**
- **Whole grain breads and cereals**
- **Nuts and beans**
- Red meat
- Full-fat dairy products

DASH stands for "Dietary Approaches to Stop Hypertension." This diet reduces the risk of heart disease and prevents and controls hypertension, hypercholesterolemia, and obesity. It includes fruits, vegetables, whole grains, and low-fat dairy foods; meats, fish, poultry, nuts, and beans. It is limited in sugar-sweetened foods and beverages, red meat, and added fats.

81.

The postoperative nurse is caring for a patient who just underwent surgery and is on a clear liquid diet. Which of the following items would the nurse offer the patient?

Select all that apply.

- **Tea**
- **Gelatin**
- **Popsicle**
- Strained vegetable juice
- Sherbet
- Pudding

Clear liquid diets provide liquids and electrolytes to the patient to prevent dehydration and are often used after surgery as the patient slowly advances to solid foods. Clear liquid food items include items that are relatively transparent to light and are liquid at body temperature (water, bouillon, clear broth, carbonated beverages, gelatin, hard candy, lemonade, ice pops, and regular or decaffeinated coffee or tea).

Full liquids are both clear and opaque liquid foods and those that are liquid at body temperature and include plain ice cream, sherbet, breakfast drinks, milk, pudding and custard, soups that are strained, refined cooked cereals, fruit juices, and strained vegetable juices.

82.

You are teaching an elderly patient how to use a cane. Which of the following statements is **correct**?

"The top of your cane should reach to your wrist crease when standing upright."

"You should hold your cane in the hand on the same side that requires support."

"When you are walking, the cane and your uninjured leg swing and strike the ground at the same time."

"When negotiating stairs, never use a handrail."

Correct answer: The top of the cane should reach the crease of the patient's wrist.

The cane should be held in the hand opposite the side that requires support. When walking, the cane and the injured leg swing and strike the ground at the same time. Handrails should be used if possible when going up stairs, and the patient should step up on their good leg first, with the cane held in the hand opposite the injured leg (unaffected side).

83.

You are caring for a client who has continuous bladder irrigation. There are 2200 mLs of irrigation normal saline in the bag when you begin your shift at 7 a.m. Later, you hang another bag of irrigating solution that contains 5000 mL. When your shift ends, there is 1500 mL of irrigating solution remaining, and the total amount of fluid in the urinary drainage bag is 6410 mL. What is the patient's urinary output during your shift?

710 mLs

3500 mLs

1790 mLs

5700 mLs

Correct answer: 710 mLs

The total urinary output for this client is 710 mLs. A total of 5700 mLs (2200 mLs plus the difference of 5000 and 1500 mLs) of irrigating solution was instilled, and the total amount of fluid in the urinary drainage bag was 6410 mLs. Therefore, there was 710 mL of urinary drainage, and the remainder was irrigating solution.

84.

Which of the following positions would be appropriate for the postoperative craniotomy patient?

Select all that apply.

- **Reverse Trendelenburg's position**
- **Semi-Fowler's position**
- **Fowler's position**
- Flat and supine
- Trendelenburg's position
- Lithotomy position

The patient who underwent a craniotomy should not be positioned on the site that was operated on, especially if the bone flap has been removed, because the brain has no bony covering over the affected site. Do not place the patient in a flat Trendelenburg position (supine with the foot of the bed inclined 15 to 30 degrees, feet elevated above the head), because of the risk of increased intracranial pressure (ICP) in these positions. Rather, elevate the head of the bed 30 to 45 degrees (semi-Fowler's to Fowler's position), and maintain the head in a midline, neutral position to facilitate venous drainage from the head. Reverse Trendelenburg's is the opposite of Trendelenburg's positioning (head of bed elevated 15 to 30 degrees), and is appropriate for the craniotomy patient.

Lithotomy position involves laying flat on the back with legs apart and supported by stirrups; it is a common position for procedures involving the lower abdomen and pelvis, as well as childbirth.

85.

Which joint is correctly paired with its normal total range of motion?

The arm at the shoulder: 360 degrees circumduction

The knee: 360 degrees circumduction

The head: Hyperextension

The leg at the hip: Hyperextension

Correct answer: The arm at the shoulder: 360 degrees circumduction

The arm, under normal circumstances, can move in a complete 360 degree circle. This 360 degree joint movement is referred to as circumduction. The knee is not capable of this 360 degree joint movement, and both the head and the leg at the hip do not normally hyperextend. Instead, these joints can flex and extend.

86.

Your 6-year-old patient has had a tonsillectomy and is complaining of throat pain 3 hours post-op. He is not scheduled for pain medication for another hour. Which of the following interventions may safely soothe the patient's sore throat?

Ice chips

Warm chicken broth

Tea with milk and sugar

Suctioning of blood from the oropharynx

Correct answer: Ice chips

Warm fluids should be avoided in the first few hours after a tonsillectomy, as they may increase bleeding. Suctioning the mouth to remove blood and secretions may be done, but suctioning the oropharynx should be kept to a minimum to prevent trauma to the area and increased bleeding. Ice chips can be given as soon as the patient is awake and often help to numb the operative area.

87.

Your home care pediatric client, who is five years old, is complaining about intense rectal itching. What disorder would you suspect?

Pin worm infestation

Constipation

Irritable bowel syndrome

Scabies

Correct answer: Pin worm infestation

Pin worm infestations are characterized by anal and/or vaginal itching, insomnia, and restlessness. It is most common among school-age children as the result of poor hand washing. It is treated with an antiparasite medication such as mebendazole or albendazole.

88.

Your patient has an area of erythema on her right hip, over the bony prominence. The area does not blanch when you press it. The skin is intact. What stage of pressure ulcer formation would you describe this as?

Stage I

Stage II

Stage III

Stage IV

Correct answer: Stage I:

Stage I pressure ulcers are areas of skin that are reddened and non-blanchable. They occur over bony prominences. The area may be painful and warmer or cooler to touch than the surrounding skin.

89.

Your male patient is complaining of dysuria, frequency, hematuria and mild swelling of the penis. His symptoms are **most** compatible with:

Urethritis

Cystitis

Pyelonephritis

Prostatitis

Correct answer: Urethritis

Pain and burning with urination are common symptoms of urethritis. Hematuria or blood in the semen, swelling of the penis and itching and tenderness of the penis may also occur. Cystitis, pyelonephritis and prostatitis do not typically result in swelling of the penis.

90.

The nurse is caring for a patient who underwent a total hip replacement. Which of the following positioning techniques should the nurse **avoid** when providing care for this patient?

Select all that apply.

- **Extreme internal and external rotation**
- **Adduction**
- Side-lying position
- Abduction when in a supine position
- Elevation of the head of the bed and hip flexion

Positioning the patient with a total hip replacement depends on the surgical approach used (anterior vs. posterior), the method of implantation, and the prosthesis. Always avoid extreme internal and external rotation, as this could harm the newly placed prosthetic or cause dislocation. Avoid adduction (moving the leg towards the midline of the body). Rather, the patient is often placed in a side-lying position with an abduction (wedge) pillow (a triangular-shaped pillow made of heavy foam) in place between the thighs. Maintain abduction when in a supine position, or when the patient is positioned on the non-operative side.

In most cases, elevating the head of the bed and hip flexion is allowed (not avoided), but the nurse should check the surgeon's orders first to make sure.

91.

Your patient complains of nocturia and asks you what he can do to decrease the number of times he must get up in the night to go to the restroom. Which of the following measures may be helpful?

Limiting the amount of fluids consumed before bedtime

Limiting the amount of fluids consumed throughout the day

Drinking only carbonated beverages, such as sparkling water

Drinking coffee or tea only in the mornings for their diuretic effects

---

Correct answer: Limiting the amount of fluids consumed before bedtime

Decreasing the amount of fluids consumed just before bed and voiding prior to getting into bed at night will reduce excessive nighttime voiding. However, patients should be counseled to make up for this deficit during the daytime to avoid dehydration. Caffeinated and carbonated beverages may irritate the bladder, leading to increased voiding.

92.

The licensed practical nurse (LPN) is caring for a patient who is hearing-impaired. Which of the following approaches **best** facilitate(s) communication?

Select all that apply.

- **Facing the patient and speaking directly and clearly**
- **If the patient does not understand what is being said, expressing it differently**
- **Reducing background noise and eliminating distractions**
- Speaking in a louder than normal tone
- Moving close to the patient and talking directly into the impaired ear

---

The hearing-impaired patient often relies heavily on visual cues to help them to comprehend what is being said (including lip-reading). When communicating with this patient, the nurse should ensure s/he is facing the patient, speaking clearing and directly, minimizing background noise, and eliminating distractions. Express the information differently if the patient does not understand what is being said, and move in closer and toward the better ear (not the impaired ear) if needed to facilitate communication. Speak in a normal tone (avoid shouting), and do not show frustration or annoyance with the patient's impairment to help preserve self-esteem and rapport.

93.

Your patient has diarrhea from an infectious cause and has been prescribed antibiotics. He asks you what he should be eating until the diarrhea has resolved. Choose the **best** response.

"Eat bland foods such as toast, apples, rice, and bananas."

"Eating spicy foods will kill the bacteria causing the diarrhea."

"Caffeine will decrease bouts of diarrhea due to its dehydrating effects."

"Eating a high-fiber diet will decrease diarrhea."

Correct answer: "Eat bland foods such as toast, apples, rice, and bananas."

Eating bland foods when experiencing diarrhea may be helpful and less irritating to the gastrointestinal tract. Spicy foods and caffeine may cause increased diarrhea. Increasing fiber in the diet may increase diarrhea.

94.

When caring for a hospitalized patient, the nurse should be aware of Maslow's Hierarchy of Needs to establish priorities. Which of the following would be examples of the nurse meeting the patient's basic physiological needs?

Select all that apply.

Monitoring the patient's intake and output

Ensuring the patient has ordered meals

Monitoring the patient's vital signs

Ensuring the patient has personal belongings in a separate bag per hospital policy

Informing the patient when visiting hours are each day

When referencing Maslow's Hierarchy of Needs, the nurse should remember that physiological needs are the priority (airway, respiratory effort, heart rate and rhythm, nutrition, and elimination), followed by safety needs. Thus, monitoring intake and output, vital signs, and ensuring meals have been ordered by the patient, are all examples of the nurse meeting the hospitalized patient's physiological needs.

Safety and security are addressed next (protection from injury, promoting feelings of security and trust). Ensuring personal belongings are all safe and in a hospital belongings bag per hospital protocol, meets this need. Love and belonging follows, and maintaining support systems are important in this category. The patient needs to know when visiting hours are in order for loved ones to come and visit when allowed, thus, helping to meet this need.

95.

Of the following patients, which should the licensed practical nurse **not** provide foot care for?

Patients with diabetes

Patients with hypertension

Patients with peripheral vascular disease

Patients with a wound infection

Correct answer: Patients with diabetes

Patients with diabetes are at risk for both foot ulcers and delayed wound healing. Therefore, care for their feet and, in particular, trimming their toenails, should be delegated to a professional that has expertise in caring for the feet of patients with diabetes. Most often, this task should be performed by a podiatrist.

96.

Which position should be utilized for the patient receiving bolus tube feedings?

High Fowler's

Semi-Fowler's

Supine

Prone

Correct answer: High Fowler's

To reduce the risk of aspiration in a patient receiving bolus tube feedings, the patient should be maintained in a high Fowler's position both during and for thirty minutes following administration of the tube feeds. A semi-Fowler's position would be most appropriate for the patient receiving continuous tube feedings, as these deliver a very small amount of feed at a time.

97.

You are assisting a patient from bed to commode. How should the commode be positioned relative to the bed?

Parallel to the bed

Facing toward the bed

Facing away from the bed

Over the toilet in the bathroom

Correct answer: Parallel to the bed

The commode should be placed parallel to the bed so that the patient can stand, pivot, then sit on the commode. Place the bucket/bedpan under the seat prior to the patient sitting on the commode, as it may be difficult to insert once the patient is seated. Alternately you may wheel the commode without a receptacle over the toilet in the bathroom once the patient is seated on it. Be sure brakes are on before leaving the room and ensure the patient has access to a call bell.

98.

A 70-year-old obese male is admitted to the cardiac unit with new onset of atrial fibrillation. While in the hospital, the night shift nurse notes that the patient is snoring loudly, then waking abruptly. In the early morning, he reports being excessively tired during the day. The nurse is suspicious for which of the following?

Obstructive sleep apnea

Circadian rhythm disturbance

Narcolepsy

Delayed phase sleep disorder

Correct answer: Obstructive sleep apnea

Obstructive sleep apnea is a disorder found most often in older obese males. It is the lack of airflow due to an obstruction of the pharynx during sleep. Patients with obstructive sleep apnea often snore loudly and awaken frequently throughout the night following episodes of apnea. They often report daytime tiredness, sore throat, and headaches. For severe cases of sleep apnea, a device called a continuous positive airway pressure (CPAP) machine may be utilized.

99.

A patient with an intestinal tumor has just undergone lymph node resection of the tumor and temporary placement of a colostomy. The licensed practical nurse (LPN) caring for this patient postoperatively should notify the RN immediately if the stoma is which of the following colors upon assessment?

Select all that apply.

- **Dark blue**
- **Pale pink**
- **Purple**
- **Black**
- Dark pink
- Red

A dark blue, purple, or black stoma indicates compromised circulation, and a pale pink stoma indicates low hemoglobin and hematocrit levels. All of these findings require immediate RN and primary health care provider (PHCP) notification.

A healthy stoma is red or dark pink in color, indicating high vascularity and proper functioning. Expect liquid stool postoperatively (will become more solid, depending on the area of the colostomy).

100.

Which area of the body is adversely affected when the client is in the lateral position?

The ear

The sacrum

The coccyx

The heels

Correct answer: The ear

The pressure points that occur when a person is in the left or right lateral, or side-lying, position include the ears, toes, knees, male genitals, breasts, shoulder and cheek. All positions have pressure points that are prone to skin breakdown; therefore, frequent repositioning and skin care are necessary in order to prevent pressure ulcers.