NCLEX-RN - Quiz Questions with Answers

Basic Care and Comfort

1.

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 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.

2.

A patient has been diagnosed with right-brain damage from an embolic (ischemic) stroke. Which of the following manifestations would the nurse expect to observe in this patient?

Select all that apply.

- **Impaired judgement**
- **Impaired time concepts**
- **Impulsivity**
- Right-sided hemiplegia
- Impaired speech and language aphasias

Brain injury from stroke results in manifestations on the contralateral side, which is the side of the body opposite the stroke. Therefore, assessment findings indicative of stroke on the right side of the brain involve impairments associated with right-brain damage and deficits on the left side of the body:

- *Impaired judgement*
- *Impaired time concepts*
- *Impulsivity and safety problems*
- *Left-sided neglect*
- *Left-sided hemiplegia (paralyzed)*
- *Rapid performance, short attention span*
- *Spatial-perceptual deficits*
- *Tendency to deny or minimize problems*

Impaired speech and language aphasias are seen in left-brain damage.

3.

A patient who is prescribed a high-potassium diet consisting of foods such as avocados, fish, bananas, cantaloupe, carrots, mushrooms, and strawberries is likely to have which of the following conditions?

Select all that apply.

- **Renal tubular acidosis**
- **Congestive heart failure on diuretic therapy**
- **Cushing's syndrome**
- Addison's disease
- Osteoporosis

A high-potassium diet is indicated for the patient with low serum potassium levels (hypokalemia), which may be caused by renal tubular acidosis, gastrointestinal losses (diarrhea, vomiting), intracellular shifts, antibiotic therapy, certain diuretics (which causes excess fluid to be excreted in the urine), primary or secondary aldosteronism, Cushing's syndrome, or exogenous corticosteroid use.

Addison's disease is caused by hyperkalemia and requires a low-potassium diet. The patient with osteoporosis needs a high-calcium diet.

4.

The nurse received an order to administer intravenous (IV) phenytoin (Dilantin) for seizure control. In administering this medication via IV route, the nurse knows to give slowly to prevent which of the following from occurring?

Select all that apply.

- **Hypotension**
- **Cardiac dysrhythmias**
- Severe nausea and vomiting
- Hypoglycemia
- Severe headache

Phenytoin is a common antiseizure medication used to prevent and control seizures. This drug must be given slowly to prevent hypotension and cardiac dysrhythmias. It should always be diluted in normal saline (dextrose causes the medication to precipitate), infused with an inline filter, and given no faster than 25 to 50 mg/minute. In addition, it may decrease the effectiveness of some birth control pills and may cause teratogenic effects if taken during pregnancy.

It is not likely to cause severe nausea and vomiting, hypoglycemia, or headache if administered too quickly.

5.

A patient suspected of having primary hypothyroidism would exhibit which of the following laboratory results?

Select all that apply.

Decreased FT4 (free thyroxine) levels

Elevated TSH (thyroid-stimulating hormone) levels

Decreased T3 (triiodothyronine) levels

Elevated total T4 (thyroxine) levels

Elevated T3 resin uptake

To diagnose thyroid disorders, the following blood tests are used:

- *T3 and T4 resin uptake test (T3 and T4 regulate thyroid-stimulating hormone)*

1. total triiodothyronine T3
2. total thyroxine T4
3. free thyroxine (FT4)

- *Thyroid-stimulating hormone (TSH)*

In primary hypothyroidism, the laboratory values are as follows:

- *T4 levels are decreased (both total and free)*
- *T3 levels are decreased*
- *TSH levels are increased*

6.

A nurse is working with a patient who has heart disease. The patient's height is 5'10" and his weight is 220 pounds. The nurse informs the patient that he should try to keep his body mass index (BMI) between 19 and 25. What is the patient's current BMI?

31.6

23.1

16.6

41.8

Correct answer: 31.6

The patient's current BMI is 31.6. In order to calculate the BMI, you will need to convert the patient's weight from pounds to kilograms, and his height to squared centimeters.

- *220 pounds x 0.453592 (the metric conversion factor) = 99.79024 kg*
- *70 inches x 0.0254 (the metric conversion factor) = 1.778 m*
- *Square the height: 1.778 x 1.778 = 3.161284*
- *Divide the converted weight by the squared height: 99.79024/3.161284 = 31.6*

The BMI for a patient who is 5'10" and 220 pounds is 31.6.

7.

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 ceruminolytic 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

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Correct answer: Clean the outside of the ear using a soft cloth to remove any visible wax and obtain an order for ceruminolytic 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. Ceruminolytic 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.

8.

During an examination, a patient informs his nurse that he suffers from flatulence. The nurse discusses the types of foods that the patient eats on a regular basis and she determines which food could be causing the patient's issues. Which food would the nurse **most likely** determine is causing the patient to suffer from flatulence?

Apples

Bananas

Rice

Potatoes

Correct answer: Apples

Apples could cause a patient to suffer from flatulence. Apples are harder to digest than other foods and cause flatulence. Other foods that cause flatulence include beans, raisins, cabbage, carbonated beverages, and onions.

Potatoes, rice, and bananas are easier to digest and most likely would not cause the patient to suffer from flatulence.

9.

A physician orders a 20 lb (9 kg) child to be infused with intravenous fluids to run at 20 mL/kg/day. At what rate of infusion should the nurse infuse the intravenous fluid?

7.5 mL/hr

1.3 mL/hr

3.8 mL/hr

16.6 mL/hr

Correct answer: 7.5 mL/hr

The nurse should infuse the intravenous fluid at 7.5 mL/hr. To find the rate that the intravenous fluid should be infused, follow these steps:

1. *Multiply 9-kg by 20 mL/kg, which gives you 180 mL*
2. *Divide 180 mL by 24 hours (number of hours in a day), which gives you 7.5 mL/hr*

In order to get the ordered amount of intravenous fluids, the nurse should infuse 7.5 mL over a 24 hour period.

10.

As part of the patient's wellness exam, the nurse conducts a rapid urine test. The rapid urine test indicates that the patient's urine contains ketone and sugar. What is this an indication of?

Uncontrolled diabetes mellitus

An inflammation of the kidneys

A bacterial infection

A urinary tract infection

Correct answer: Uncontrolled diabetes mellitus

Urine containing ketone and sugar is an indication of uncontrolled diabetes mellitus.

High protein levels in urine is an indication that the kidneys are inflamed. Urine containing leukocytes and nitrite indicates a bacterial infection. A urinary tract infection is indicated when the urine's pH level is over 7.

11.

A nurse is discharging a patient with a broken leg. The patient will need to use axillary crutches while his leg is in a cast. Which of the following is **not** a proper procedure for fitting crutches to a patient?

When measuring for the proper handpiece location, the patient's elbow should be flexed at a 45 degree angle

When measuring for the proper handpiece location, the patient's wrist should be in maximal extension

When measuring for the proper handpiece location, the patient's fingers should be in a fist

When measuring for the proper handpiece location, the crutch should be placed three inches lateral to the patient's foot

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Correct answer: When measuring for the proper handpiece location, the patient's elbow should be flexed at a 45 degree angle

The following is not a proper procedure for fitting crutches to a patient: When measuring for the proper handpiece location, the patient's elbow should be flexed at a 45 degree angle. The patient's elbow should be flexed at a 30 degree angle when measuring for the handpiece location, not a 45 degree angle.

When measuring for the proper handpiece location, the crutch should be placed three inches lateral to the patient's foot, the patient's wrist should be in maximal extension, and the patient's fingers should be in a fist.

12.

The nurse is caring for a patient who was admitted for a stroke. Which of the following are priority nursing assessments for this patient in the first 24 hours?

Select all that apply.

- **Pupillary check for size and response**
- **Assessment for posturing**
- **Assessment of airway patency**
- Serum cholesterol level assessment
- Assessment of bowel sounds

The nurse should monitor for increasing intracranial pressure (ICP) in the patient with a recent stroke because the patient is at most risk during the first 72 hours following the stroke. Checking pupillary size and response is critical to assess cranial nerve changes. Unilateral pupil dilation indicates compression of cranial nerve III. Midposition fixed pupils indicate midbrain injury. Pinpoint fixed pupils indicate pontine damage. Likewise, posturing (decorticate, decerebrate, or flaccid) indicates a deterioration of the patient's condition. Airway patency is always a priority.

Assessing cholesterol levels should be addressed for long-term healthy lifestyle rehabilitation but is not a priority assessment. Bowel sounds should be assessed because constipation or ileus can develop, but is not a priority in the first 24 hours after admission.

13.

A patient who has just undergone cervical spinal fusion is on a mechanical soft diet. Which of the following foods should the nurse instruct the patient to avoid?

Select all that apply.

Raw fruits and vegetables

Salted meats

Whole grains

Flaked fish

Cream soups

The mechanical soft diet includes foods that have been altered in texture (pureed, mashed, ground, or chopped) to require minimal chewing. Patients who have difficulty chewing, such as those with dental problems, surgery of the head and neck, or dysphagia would benefit from a mechanical soft diet. Foods in this type of diet include, but are not limited to, cream soups, ground or diced meats, flaked fish, cottage cheese, rice, potatoes, pancakes, light breads, cooked vegetables (not raw), canned or cooked fruits (not raw), bananas, peanut butter, and nonfried eggs.

Foods to be avoided in the mechanically soft diet include nuts or seeds (which can easily become trapped in the mouth and cause discomfort); raw fruits and vegetables; fried foods; whole grains; tough, smoked or salted meats, and foods with course textures.

14.

A nurse supervisor is conducting an educational inservice for newly licensed nurses who will be providing newborn care. One of the new nurses asks the supervisor why newborns are injected with vitamin K. Which of the following is the appropriate response to the nurse's question?

"Vitamin K is injected into newborns to activate blood clotting factors II, VII, IX, and X."

"Vitamin K is injected into newborns to prevent ophthalmia neonatorum."

"Vitamin K is injected into a newborn to boost the newborn's immunity system."

"Vitamin K is injected into a newborn to provide the newborn with nourishment."

Correct answer: "Vitamin K is injected into newborns to activate blood clotting factors II, VII, IX, and X."

The appropriate response is: "Vitamin K is injected into newborns to activate blood clotting factors II, VII, IX, and X." Newborns are vitamin K deficient due to the sterility of their colons. Therefore, until the newborn feeds and bacteria becomes available, he/she needs vitamin K to prevent hemorrhagic disease.

Erythromycin (Romycin) is administered to prevent ophthalmia neonatorum, not vitamin K. Vitamin K does not boost a newborn's immunity system or provide nourishment.

15.

The nurse is caring for a client who is one day post-op for a total hip replacement. What is the best position in which the nurse should place the client?

On the nonoperative side with the legs abducted

On the operative side

Side-lying with the affected leg internally rotated

Side-lying with the affected leg externally rotated

Correct answer: On the nonoperative side with the legs abducted

Positioning following a total hip replacement depends on the surgical techniques used, the method of implantation, the prosthesis, and the physician's preference. Abduction is maintained when the patient is in the supine position or positioned on the nonoperative side. The other options are incorrect positions for this client.

16.

The patient you have been assigned for the day is bedridden and requires continuous feeding through a peg tube. Which of the following must be completed before repositioning the patient?

Select all that apply.

Tube feeding must be paused while the patient is being moved.

Tube placement must be confirmed with an air flush before restarting the tube feed.

No interventions are required for hourly repositioning.

The patient must have a large water flush while lying flat on their back.

This patient's feeds must be paused prior to being moved or manipulated in bed due to the risk of aspiration. The patient will need to be laid on an angle in the bed to ensure that stomach continence does not aspirate and lead to pneumonia.

17.

A patient is admitted to the emergency department for observation for acute alcohol withdrawal. Which of the following findings would indicate the patient is experiencing delirium tremens (withdrawal delirium)?

Select all that apply.

- **Hypertension**
- **Changes in level of consciousness (LOC)**
- **Hallucinations**
- Lethargy
- Ataxia

Delirium tremens is a state of delirium usually peaking around 48 to 72 hours after stopping or drastically reducing alcohol intake, and lasts 2 to 3 days. It is considered a medical emergency. Death can occur from myocardial infarction, fat emboli, peripheral vascular collapse, electrolyte imbalance, aspiration pneumonia, or suicide. Symptoms include agitation, anorexia, anxiety, hallucinations and delusions, disorientation, fever, insomnia, tachycardia, and hypertension.

18.

Which of the following is accurate in regard to urinary tract infections (UTIs) in the preschooler?

Select all that apply.

Uncircumcised boys are more likely to develop a UTI than a circumcised boy

Educating hygiene (wipe perineum from front to back in girls) will decrease the likelihood of a UTI

Encourage the parents to ensure adequate fluid intake to flush out any toxins

Encourage tub bathing to clean the perineal area thoroughly

A child will always exhibit symptoms if a UTI is present

A UTI occurs when there is bacterial invasion of the urinary tract from flora from the skin or gastrointestinal tract. Uncircumcised boys are more likely to develop a UTI than circumcised boys. Hygiene is important. Bacteria can be easily spread from the rectum to the urinary meatus and cause infection if girls wipe from back to front or do not wipe adequately after going to the bathroom. Adequate fluid intake is important to flush out toxins that may be brewing. Tub bathing may be counterproductive at this age as soaking could increase the likelihood of a UTI in a female. Children may experience asymptomatic bacteriuria, so if there is a suspicion of infection in the urinary tract, they should be screened and treated accordingly.

19.

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, as aspiration may occur.

20.

A nurse was caring for an 82-year-old patient whose death was just confirmed by the physician. The nurse is responsible for performing the patient's post-mortem care. Which of the following actions is an appropriate action for the nurse to take while performing post-mortem care?

Straighten the patient's limbs

Remove the patient's dentures

Tape the patient's eyelids shut

Remove the patient's hospital ID bracelet

Correct answer: Straighten the patient's limbs

An appropriate action for a nurse to take when performing post-mortem care is to straighten the patient's limbs. The goal of post-mortem care is for the nurse to make the patient look as natural as possible in order to avoid upsetting the patient's family and friends.

The nurse should not remove the patient's dentures. If the patient's dentures have been removed, the nurse should put them in the individual's mouth, as this helps maintain the patient's normal appearance. The nurse should not tape the patient's eyes shut, as this action could leave unsightly marks on the face. Instead, the nurse should hold the eyelids closed with her fingers or use a moistened gauze pad. The nurse should not remove the patient's hospital ID bracelet. In fact, if the ID bracelet is missing, the nurse should place a new one on the individual.

21.

Your male patient has had a TURP (transurethral resection of the prostate). He has a 3-way catheter and CBI (continuous bladder irrigation) is ongoing. He suddenly complains of lower abdominal discomfort. He is diaphoretic and tachycardic. You notice that his catheter is bypassing. What should you do **first**?

Stop the irrigation immediately

Increase the flow of the irrigant

Call the physician

Attempt to manually irrigate the catheter

Correct answer: Stop the irrigation immediately

You should turn off the bladder irrigation immediately to prevent further distention of the bladder. It is likely that the catheter has become blocked, resulting in the patient's symptoms. You may manually irrigate the catheter if it is within your scope of practice. The physician should be notified, but the most important first step is to stop the irrigation.

22.

You are caring for a female patient with a history of repeated urinary tract infections.

Which of the following statements would indicate that the patient needs additional education?

Select all that apply.

"I love using bath bombs and taking bubble baths."

"I'll go the whole day at work without using the restroom."

"I drink 9 cups of water a day."

"I change my absorbent briefs often and clean myself each time."

Chronic UTIs worsen with bath bombs and bubble baths, as the scents are irritating and can cause cystitis. Not emptying one's bladder or urinating when one has the urge increases the risk of infection.

Drinking plenty of water assists in flushing bacteria from the urinary system. Wearing a brief for long periods can lead to the build-up of bacteria, but changing it often and cleaning afterward can reduce that risk.

23.

A nurse is monitoring the status of a postoperative client. The nurse would become most concerned with which of the following signs that could indicate an evolving complication?

Increased restlessness

A negative Homans' sign

Hypoactive bowel sounds in all four quadrants

Blood pressure of 110/70mm Hg and a pulse of 86 beats per minute

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Correct answer: Increased restlessness

Increased restlessness is a sign that requires continuous and close monitoring because it could indicate a potential problem such as hemorrhage, shock, or pulmonary embolus. The other options are normal.

24.

A nurse checks in on a patient who is sleeping. The nurse monitors the patient and decides that the patient must be in Stage 4 of the sleep cycle. Which action would cause the nurse to make this decision?

The patient's respiration rate is increased

The patient wet the bed

The patient's body temperature is decreasing

The patient awakened easily

Correct answer: The patient's respiration rate is increased

The nurse would choose Stage 4 of the sleep cycle if the patient's respiration rate is increased. Stage 4 of the sleep cycle is when most dreaming occurs and is when an individual's respiration rate increases, their eyes move, and their brain activity increases.

The patient is most likely to awaken easily during Stage 1. The patient's body temperature starts to decrease during Stage 2. When bed-wetting occurs, it's generally at the end of Stage 3.

25.

A nurse assists a physician in performing a liver biopsy. After the biopsy, the nurse places the client in which position?

A right side-lying position with a small pillow or towel under the puncture site

Prone

Supine

A left side-lying position with a small pillow or towel under the puncture site

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Correct answer: A right side-lying position with a small pillow or towel under the puncture site

After a liver biopsy, the client is assisted to assume a right side-lying position for 3 hours. This position compresses the liver against the chest wall at the biopsy site.

26.

The nurse should encourage a patient with osteoporosis to increase consumption of:

Turnip greens

Red meat

Soft drinks

Enriched grains

Correct answer: Turnip greens

Turnip greens are high in calcium, but not in phosphorus. The high levels of nitrogen from breakdown of the protein found in red meat may increase calcium reabsorption from the bones to serve as a buffer of the nitrogen. Soft drinks that are high in phosphorus may interfere with calcium absorption from the GI tract. Enriched grains that are high in phosphorus may interfere with calcium absorption from the GI tract.

27.

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 teenage patient.

28.

Which of the following interventions would **best** help an elderly woman who has just had 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 two 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 themselves more comfortably in the bed more 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.

29.

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.

30.

A patient informs her nurse that she has not been able to pass stool for three days and she is feeling extremely uncomfortable. What advice would the nurse **most likely** give the patient?

Drink hot liquids

Eat bland foods

Eat a low-fiber diet

Drink less carbonated beverages

Correct answer: Drink hot liquids

When a patient is constipated, a nurse is likely to tell the patient to drink hot liquids. The nurse may also tell the patient to increase her fluid intake, drink fruit juices, and eat a high-fiber diet.

If a patient has diarrhea, a nurse is likely to tell the patient to eat bland foods or eat a low-fiber diet. If a patient has flatulence, a nurse is likely to tell the patient to drink less carbonated beverages.

31.

A patient who is eight months pregnant is diagnosed with high blood pressure and her physician orders her to be on complete bed rest. What instructions would the nurse **most likely** give this patient?

You should lay on your side, preferably your left side

You should only get up to use the restroom and to shower

You should lay on your back with a pillow under your knees

You should exercise for at least 20 minutes a day to keep your blood flowing

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Correct answer: You should lay on your side, preferably your left side

The nurse would most likely tell the patient to lay on her side, preferably her left side. The best position for bed rest is the side. The left side is preferred, as studies have shown that laying on the left side tends to lower women's blood pressure.

The nurse would not advise the patient to lay on her back, as the side is preferred. Being on complete bed rest generally means that the patient cannot shower or exercise. The patient can squeeze stress balls, turn her hands and feet in circles, or tighten her arm and leg muscles to keep her blood flowing.

32.

Which of the following are significant risk factors for peripheral arterial disease (PAD)?

Select all that apply.

- **Hyperlipidemia**
- **Hypertension**
- **Cigarette smoking**
- Alcohol intake
- Obesity

The most significant risk factors for the development of PAD are hypertension, hyperlipidemia, smoking, diabetes mellitus, and chronic kidney disease.

Obesity and alcohol intake could contribute to this condition but are not significant risk factors.

33.

A nurse is caring for a patient who has hemorrhoids. The nurse has provided the patient with a prescribed local anesthetic and a warm sitz bath to reduce the patient's pain and swelling. What educational advice would the nurse **most likely** give this patient?

Eat a high fiber diet

Avoid spicy foods

Avoid caffeine

Vigorously wipe to promote good anal hygiene

Correct answer: Eat a high fiber diet

The nurse would most likely encourage the patient to eat a high fiber diet in order to promote a regular bowel movement and reduce the risk of hemorrhoids.

The nurse would ask the patient to avoid spicy foods and caffeine if diarrhea was a factor. The nurse should promote good anal hygiene, but she should not instruct the patient to vigorously wipe.

34.

A nurse is conducting a dietary assessment on a client who is on a vegan diet. The nurse plans to provide dietary teaching focusing on foods high in which vitamin that may be lacking in a vegan diet?

Vitamin B12

Vitamin A

Vitamin C

Vitamin E

Correct answer: Vitamin B12

Vegans do not consume any animal products. Vitamin B12 is found in animal products and, therefore, would be most lacking in a vegan diet. Vitamins A, C, and E are found in fresh fruits and vegetables, which are consumed in a vegan diet.

35.

Your patient with urethritis has been prescribed antibiotics and is being discharged home. He asks you about measures that may be used at home to relieve discomfort. Which of the following measures may be helpful?

Drinking plenty of fluids to dilute the urine

Washing the genitals frequently with antibacterial soap

Taking prescribed antibiotics only until symptoms begin to dissipate

Taking Tylenol 1000 mg every 2 hours for pain

Correct answer: Drinking plenty of fluids to dilute the urine

Drinking plenty of fluids will dilute the urine, relieving dysuria. Washing with antibacterial soaps may cause more irritation. Antibiotics should be taken until finished, even if symptoms disappear, to avoid rebound infection and decrease the risk of antibiotic-resistant organisms. Tylenol may be taken every four hours to a maximum of 4 grams per day.

36.

A patient is scheduled for an echocardiogram. This is a noninvasive procedure to detect which of the following?

Select all that apply.

- **Valvular abnormalities**
- **Congenital heart disease**
- **Ejection fraction**
- Size of the heart
- Electrical activity

Echocardiography is a noninvasive procedure using ultrasound principles, and evaluates structural and functional changes of the heart. It allows visualization of the valves as they open and close and, therefore, detects valvular abnormalities. It is also the procedure of choice for congenital heart defects, cardiac wall motion, ejection fraction, and overall cardiac function.

A chest x-ray determines the size of the heart. Electrocardiography reflects the electrical activity of cardiac cells and records electrical activity.

37.

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: "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 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.

38.

Which of the following patients is **most** at risk of developing a pressure ulcer?

A thin 82-year-old diabetic woman confined to bed

An obese 60-year-old client who is able to turn himself in bed

A 2-year-old with vomiting and diarrhea

An anorexic 17-year-old who walks in the hallways all day long

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Correct answer: A thin 82-year-old diabetic woman confined to bed

The thin, elderly patient confined to bed would be most at risk of developing a pressure ulcer. Thin patients have very little protection over bony prominences and may experience skin breakdown if confined to bed, particularly if they are unable to reposition themselves.

39.

You are teaching a new aid how to assist a patient onto and off 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.

40.

Your patient has been diagnosed with Crohn's disease. He asks you what he should be eating during an acute flare of the condition. Choose the **correct** response.

"There is no specific diet for Crohn's. You should try to eat a well-balanced diet and avoid hard-to-digest foods during an acute flare."

"You should avoid foods containing gluten during an acute flare."

"During an acute flare, you should eat only one meal per day and be sure to drink plenty of fluids."

"Eat an abundance of dairy products if you are experiencing an acute flare."

Correct answer: "There is no specific diet for Crohn's. You should try to eat a well-balanced diet and avoid hard-to-digest foods during an acute flare."

There is no specific diet for Crohn's disease. Patients should eat small, frequent meals and avoid drinking a lot of fluid during meals, Many patients with Crohn's disease are lactose intolerant. There is no need to avoid foods containing gluten unless the patient also has Celiac disease.

41.

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.

42.

A nurse is assessing a 28-year-old male patient's ability to eat. The patient's lab results show that his Albumin level is 6.2 g/dL and his Hemoglobin level is 18.1 g/dL. From the patient's lab results, the nurse knows that the patient is **most likely** suffering from which of the following?

Dehydration

Vitamin B-12 deficiency

Low protein diet

Iron deficiency

Correct answer: Dehydration

The patient is most likely suffering from dehydration. The patient's albumin level is higher than normal (normal is 3.4 to 5.4 g/dL) and his hemoglobin level is higher than normal (normal for an adult male is 13.5 to 17.5 g/dL). Dehydration is a symptom of both of these results.

A vitamin B-12 deficiency and an iron deficiency may be the case if the patient's hemoglobin levels were lower than normal. An increased albumin level is a sign of a high protein diet, not a low protein diet.

43.

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 two hours from side to side may promote comfort but will not prevent contractures. Massaging the extremities daily 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.

44.

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 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.

45.

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.

46.

A nurse hears an occlusion alarm sound on an enteral pump, which denotes that the patient's feeding tube is clogged. If the nurse uses warm water to de-clog the feeding tube, what would be her **first** action?

The nurse would use a 60 mL irrigation syringe to aspirate as much liquid as possible from the feeding tube

The nurse would clamp the feeding tube for 5 minutes

The nurse would fill a 60 mL syringe with warm water and apply manual back-and-forth pressure to help dislodge the clog

The nurse would aspirate and flush the feeding tube with warm water

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Correct answer: The nurse would use a 60 mL irrigation syringe to aspirate as much liquid as possible from the feeding tube

The first action a nurse should take to de-clog a feeding tube with warm water is use a 60 mL irrigation syringe to aspirate as much liquid as possible from the feeding tube.

The nurse would then fill a 60 mL syringe with warm water and apply manual back-and-forth pressure to help dislodge the clog. Next, the nurse would clamp the feeding tube for 5 minutes and then the nurse would aspirate and flush the feeding tube with warm water.

47.

A female patient with a visual deficit is receiving her annual wellness exam. When she is shown to the examining room, she is informed that once she is ready to see the nurse, she just needs to push the top green button and the nurse will be in to see her. Once the patient pushes the green button, what should she expect?

The nurse will announce that she is coming into the room and to state her name

The nurse will knock on the door and wait until the patient opens it

The nurse will enter the room and explain the wellness exam procedures

The nurse will enter the room and use a very loud voice when speaking to the patient

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Correct answer: The nurse will announce that she is coming into the room and to state her name

The patient should expect that the nurse will announce that she is coming into the room and to state her name. It is important when caring for a patient with visual deficits that the patient knows that the nurse is entering the room.

The nurse should not have the patient answer the door, as this is an inconvenience for the patient. The nurse should explain the wellness exam procedures, but she should announce that she is entering the room first. The nurse should use a warm, pleasant voice when speaking to the patient, not a loud voice.

48.

The physician has ordered a bladder scan for your patient with urinary retention. You are providing patient teaching to the patient regarding the procedure. Which of the following statements is **false**?

"The scan will be painful, but only for a minute."

"I will apply some gel to the end of the scanning head to make it easier to see the bladder."

"You will be positioned lying on your back for the procedure."

"Results can be obtained immediately."

Correct answer: "The scan will be painful, but only for a minute."

Bladder scanning may be mildly uncomfortable if the bladder is overly full, but the procedure is not painful.

Ultrasound transmission gel is applied to the scanning head to facilitate the transmission of the sound waves. The patient is usually positioned lying supine. Results are immediate.

49.

A client with hypertension has been told to maintain a diet low in sodium. A nurse who is teaching this client about foods that are low in sodium and the foods allowed would include which of the following?

Summer squash

Boiled shrimp

Instant oatmeal

Tomato soup

Correct answer: Summer squash

Foods that are lower in sodium include fruits and vegetables because they do not contain physiological saline. Highly processed foods are higher in sodium unless their food labels specifically state "low sodium."

50.

A nurse is monitoring a newborn in its first 24 hours. The newborn's respirations are 70 per minute. The nurse knows that this is an indication of which of the following?

Tachypnea

Bradypnea

Abnormal breath sounds

Respiratory distress

Correct answer: Tachypnea

Respirations that are greater than 60 per minute is a sign of tachypnea (rapid breathing).

Respirations that are less than 25 per minute is a sign of bradypnea (slow breathing). Expiratory wheezes, crackles, or grunts are signs of abnormal breath sounds. Labored breathing, nasal flaring, and grunting are signs of respiratory distress.

51.

Your elderly patient is functionally incontinent due to arthritis. What measures can you implement to decrease episodes of incontinence?

Suggest the patient wear clothing that can be easily removed, such as pants with elastic in the waistband

Reduce the dosage of the patient's diuretic medication

Increase the dosage of the patient's diuretic medication

Prescribe an antispasmodic to decrease the incontinence

Correct answer: Suggest the patient wear clothing that can be easily removed, such as pants with elastic in the waistband

Patients who are functionally incontinent have normal functioning of the bladder and urethral sphincter. They are incontinent due to the time it takes them to get to the washroom and remove the necessary clothing.

Reducing or increasing the dosage of medications or prescribing new medications are not within the scope of nursing practice.

52.

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

The top of the cane should reach the crease of the patient's wrist. The cane should be held in the hand on the opposite 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).

53.

Your patient has been sitting on the toilet 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. 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. 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.

54.

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.

55.

Essential fatty acids (EFAs) are an integral part of the diet because the human body cannot make them and, therefore, they must come from the foods we eat. Which of the following conditions is/are associated with inadequate intake of EFAs in the diet?

Select all that apply.

- **Skin lesions**
- **Increased risk of infection**
- **Amenorrhea**
- Increased risk of cardiovascular disease
- Irritable bowel syndrome (IBS)

The two major EFAs are omega-3s and omega-6s. These healthy fats are required in the diet because the body cannot manufacture them on its own. They help our bodies to build and maintain cell membranes and absorb and transport vitamins. Inadequate intake results in functions in these vital processes being impaired and leads to clinical manifestations of cold sensitivity, dry and scaly skin, skin lesions, dry eyes and dry hair, hormonal problems (including amenorrhea), constant fatigue, increased risk of infection, and difficulties concentrating.

IBS is not a manifestation of deficient EFAs. Diets high in fat can increase the risk of cardiovascular disease, obesity, and some cancers.

56.

While a nurse is assessing an elderly patient, she notices that the patient's stability is severely impaired. Which assistive device would be **most** appropriate for this patient?

Walker

Single-point cane

Quad cane

Bilateral crutches

Correct answer: Walker

The assistive device that would be most appropriate for a patient whose stability is severely impaired is a walker.

A single-point cane is appropriate when stability is mildly impaired. A quad cane is appropriate when stability is moderately impaired. Bilateral crutches are appropriate when the bilateral lower extremity shows weakness.

57.

A nurse witnesses a neighbor's husband sustain a fall from the roof of his house. The nurse rushes to the victim and determines the need to open the airway. The nurse opens the airway in the victim by using which method?

Jaw thrust maneuver

Head tilt-chin lift

Modified head tilt-chin lift

Flexed position

Correct answer: Jaw thrust maneuver

If a neck injury is suspected, the jaw thrust maneuver is used to open the airway.

58.

Your patient has a badly sprained ankle. You are providing discharge teaching. Your patient asks how to reduce pain at home. Which of the following interventions are appropriate to reduce pain due to sprain or strain?

Apply ice to the affected area for 10 to 15 minutes, 3 to 4 times per day

Keep the injured ankle below the level of the heart

Take a brisk walk four times daily

Take ibuprofen 800 mg four times daily as needed for pain

Correct answer: Apply ice to the affected area for 10 to 15 minutes, 3 to 4 times per day

Remember R-I-C-E: rest, ice, compression and elevation. All of these measures will help to reduce swelling and pain due to sprains/strains. Ice promotes vasoconstriction, helping to relieve swelling and also provides pain relief.

Elevation above heart level, not keeping the ankle below heart level, promotes venous return and will minimize edema. The injured ankle should be rested to control pain and swelling; brisk exercise is not recommended. Anti-inflammatories may be used to control pain and reduce inflammation, however the correct dosage of ibuprofen is 200-400mg every 6-8 hours, not 800 mg four times daily.

59.

Which of the following diagnostic studies are used to determine the presence of coronary artery disease (CAD) in a patient?

Select all that apply.

- **Electrocardiography**
- **Blood lipid levels**
- **Cardiac catheterization**
- Troponin and cardiac enzyme levels
- Stress testing

CAD is a narrowing or an obstruction of one or more coronary arteries as a results of atherosclerosis (accumulation of lipid-containing plaque in the arteries). Diagnostic studies include: electrocardiography (ST-segment depression, T-wave inversion, or both is noted); cardiac catheterization (shows the presence of atherosclerotic lesions), and blood lipid levels (elevated).

Troponin and cardiac enzyme levels and stress testing are diagnostic studies for angina (chest pain resulting from myocardial ischemia), not coronary artery disease.

60.

Which of the following precautions should be initiated when caring for the pediatric patient at risk for seizures?

Select all that apply.

Ensure side rails and other hard objects are padded

Raise side rails when child is sleeping or resting

Ensure suction and artificial airway is available at the bedside

Keep the patient in a supine position with bed raised

Ensure there is not a pillow under patient's head

Seizure precautions include:

- *Side rails up and padded*
- *Patient in side-lying position*
- *Pillow under head (prevents trauma in case of a seizure)*
- *Suction, oxygen, and artificial airway available and ready at bedside*
- *Bed in lowest position*
- *Curtain for privacy*

61.

Which of the following nonpharmacological orders would you expect to see for a patient with chronic heart failure (CHF)?

Select all that apply.

Elevate the patient's feet while lying or sitting down

Place TED Hose stockings on the patient's legs before ADL activities

Review orders for fluid restrictions

Apply heat packs to the patient's bilateral lower extremities

Have the patient walk frequently with minimal rest to ensure continued circulation

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With CHF and lower extremity edema, the patient will likely require some form of vascular assistance, such as compression stockings, which help move third-spaced fluid from the legs back into the vasculature.

It is best to place TED Hose stockings earlier in the morning before getting out of bed, as gravity from standing worsens lower extremity edema. Fluid restrictions may be implemented to reduce the access fluid in the vasculature, which may third-space and lead to edema.

62.

Janet has been diagnosed with esophageal cancer and is unable to eat or drink due to pain. Janet's husband, Ryan, will be her primary caregiver when she is released from the hospital and is informed he will need to give her feedings three times daily through a PEG tube. What are some educational points to tell Ryan before going home?

Select all that apply.

Replace the feed bag every 24 hours

Check residual volume before administering meds and feedings

Clean the area around the tube daily and apply a dry dressing to cover it

Allow the patient to lie flat when giving tube feedings

Push whole pills through a large-diameter PEG tube

When caring for a patient with a PEG tube, it is best to label and date each feed bag and change them every 24 hours. This will reduce the risk of bacterial growth. Checking the residual volume before administering crushed meds or feedings will let the caregiver know if the residual feed is still present. Cleaning the area around the tube daily and applying a clear dressing allows the area to stay free of infection.

Never lay a patient flat when giving tube feedings. This can lead to aspiration.

Crush all medications before administration via a PEG tube to ensure the patency of the tube and proper digestion.

63.

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.

64.

Which of the following vitamins are fat-soluble and can be stored in the body?

Select all that apply.

- **Vitamin A**
- **Vitamin K**
- **Vitamin D**
- Vitamin C
- B vitamins

Vitamins are classified as fat-soluble or water-soluble. The four types of fat-soluble vitamins are vitamins A, D, E, and K and can be stored in the body, so an excess of any of these vitamins can cause toxicity.

Water-soluble vitamins include folic acid, niacin, the B vitamins, and vitamin C, are not stored in the body and are excreted in the urine.

65.

A nurse is instructing a new mother on how to properly bottle feed her newborn. Which statement from the mother indicates that she understands the nurse's instruction?

"The nipple should be kept full of formula while the newborn is feeding."

"I should warm the bottle in the microwave before feeding the baby."

"I should burp my baby when he begins to squirm."

"I should place my baby in a supine position to feed him."

Correct answer: "The nipple should be kept full of formula while the newborn is feeding."

The statement that indicates that the mother understands is: "The nipple should be kept full of formula while the newborn is feeding."

The mother should burp the newborn after every 0.5 ounce that he consumes, not when he begins to squirm. The newborn should be held in a semi-upright position, not a supine position. The mother should not warm the bottle in the microwave, as microwaving causes uneven hot spots, which could burn the newborn.

66.

Your patient is receiving total parenteral nutrition (TPN). You should change the TPN solution:

Every 24 hours

Every 48 hours

Every 72 hours

Weekly

Correct answer: Every 24 hours

TPN solution should be changed daily (every 24 hours). This is done to prevent bacterial overgrowth. TPN is a hypertonic solution.

67.

You are caring for an elderly patient in a long-term care facility. While creating a plan of care for this patient, which intervention should you include that will contribute to the patient's autonomy and independence?

Encouraging the patient to choose social activities

Planning meals

Scheduling grooming appointments

Decorating the patient's room

Correct answer: Encouraging the patient to choose social activities

An autonomous individual is capable of rational thought and freedom to direct his or her own life, so long as it does not infringe on the rights of others. You should allow your patient to identify problems, search for alternatives, and select solutions that promote continued personal freedom. Loss of independence and autonomy is a major fear of older adults. Therefore, the correct answer is the only one that allows this patient to be the decision maker.

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.

The nurse is caring for a patient on hospice for advanced pancreatic cancer. When planning pain relief for this patient, the nurse should consider which of the following factors?

Select all that apply.

- **Scheduled dosing gives better pain relief than PRN dosing**
- **Pain medication can reduce fear and anxiety**
- Narcotics are highly addictive and should be given sparingly
- Narcotics can lead to tachypnea
- Not all pain described by the patient should be perceived as real by the nurse

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Though narcotic analgesics are highly addictive, this is not a concern when providing pain relief to a terminally ill patient. Narcotics often can cause bradycardia and a decreased respiratory rate and effort. Dosing the terminally ill patient around-the-clock provides much better pain relief than dosing on an as needed basis only, and can also alleviate fear and anxiety related to pain. Pain is what the patient describes it as, and the nurse caring for a terminally ill patient should perceive the patient's description of that pain as real and treat accordingly.

70.

When transporting a patient on a stretcher, the nurse makes sure the patient's arms do not dangle over the edge. Taking this precaution prevents injury to the:

Brachial plexus

Solar plexus

Celiac plexus

Basilar plexus

Correct answer: Brachial plexus

The brachial plexus is a bundle of nerves extending from the axilla to the neck in the shoulder area. Trauma to the arm may also injure this plexus.

The solar plexus is also known as the celiac plexus. It is located where the splanchnic nerves terminate. It is unrelated to the arms. The basilar plexus is a venous plexus over the basilar part of the occipital bone. It is unrelated to the arms.

71.

A nurse is working with a 34-year-old female to develop dietary guidelines. The patient has a pear-shaped body and her lab results show that her BMI is 24 and her BMR is 1495. The nurse knows that this patient is at a higher risk for which of the following?

Mechanical problems

Cardiovascular disease

Hypertension

Type 2 diabetes

Correct answer: Mechanical problems

This patient is at a higher risk for mechanical problems, which include issues with her hips, thighs, and bottom. This patient's BMI and BMR figures are normal; however, her pear-shaped body puts her at a higher risk for mechanical problems.

Patients with an apple-shaped body are at a higher risk for cardiovascular disease, hypertension, and type 2 diabetes.

72.

A nurse is preparing a discharge plan for a 42-year-old male patient who has heart disease. The patient needs to lower his LDL cholesterol, so the nurse is listing some foods that the patient should avoid or eat in moderation. Which of the following foods is **not** a food that the nurse would likely list?

Salmon

Crackers

Lamb chops

Whole milk

Correct answer: Salmon

On the list of foods to avoid or eat in moderation, the nurse would probably not list salmon. Salmon contains omega-3 fatty acids and is a good choice for individuals with heart disease.

Crackers generally contain trans fat, which raises LDL cholesterol; therefore, individuals with heart disease should avoid or limit their consumption of crackers. Lamb chops and whole milk are also food products that raise LDL cholesterol; therefore, the nurse should suggest that the individual limit their consumption of these two foods.

73.

A patient who has chronic pain, due to cancer, expresses her concern about taking medications for pain. The patient asks the nurse about alternative therapies that could help ease her pain. What form of alternative therapy could the nurse help the patient try?

Music therapy

Yoga

Hypnosis

Acupuncture

Correct answer: Music therapy

The nurse could help the patient try music therapy as an alternative therapy for her chronic pain. Music therapy is an alternative therapy that has been proven to ease pain, as it redirects the patient's mind to something besides the pain.

Yoga is an alternative therapy; however, it should be instructed by a certified yoga instructor, not a nurse. Hypnosis is an alternative therapy; however, it should be conducted by a professional, not a nurse. Acupuncture is also an alternative therapy; however, it should be performed by a trained practitioner, not a nurse.

74.

Your 6-year-old patient has had a tonsillectomy and is complaining of throat pain three 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

Ice chips can be given as soon as the patient is awake and often help to numb the operative area.

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.

75.

The nurse is caring for a patient who states she follows an ovo-vegetarian diet by choice. Based on this information, what type of food(s) can the patient eat?

Select all that apply.

- **Organic fruits and vegetables**
- **Whole grains**
- **Eggs**
- Cheese
- Fish

Patients who follow an ovo-vegetarian diet exclude all animal-based foods except eggs, which are an excellent source of complete proteins. These individuals eat only foods of plant origin and eliminate all meat, poultry, fish, and dairy products (including milk, yogurt, and cheese). However, whole eggs, egg whites, and egg-containing foods such as egg noodles, mayonnaise, as well as certain egg-baked goods, are acceptable.

76.

After conducting a rapid urine test on a patient, the nurse informs the physician that she feels the patient should have a urine culture. Why would a nurse want a patient to have a urine culture?

To check the patient's urine for bacteria or fungi

To check the patient's urine for protein, ketone, and nitrite

To check the patient's urine for the human chorionic gonadotropin hormone

To check the patient's urine to see how their body secretes proteins and hormones

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Correct answer: To check the patient's urine for bacteria or fungi

The nurse would want a patient to have a urine culture in order to check the patient's urine for bacteria or fungi.

The nurse would want a patient to have a urinalysis to check the patient's urine for protein, ketone, and nitrite. The nurse would want the patient to take a pregnancy test in order to check the patient's urine for the human chorionic gonadotropin hormone. The nurse would want the patient to do a 24-hour urine sample test in order to see how the patient's body secretes proteins and hormones.

77.

A nurse is caring for a client immediately after removal of the endotracheal tube. The nurse reports which of the following signs immediately if experienced by the client?

Stridor

Occasional pink-tinged sputum

A few basilar lung crackles on the right

Respiratory rate of 24 breaths per minute

Correct answer: Stridor

The nurse reports stridor to the physician immediately. This high-pitched, coarse sound is heard with the stethoscope over the trachea. Stridor indicates airway edema and places the client at risk for airway obstruction.

78.

A client is recovering from abdominal surgery and has a large abdominal wound. A nurse encourages the client to eat which food item that is naturally high in vitamin C to promote wound healing?

Oranges

Milk

Bananas

Chicken

Correct Answer: Oranges

Citrus fruit and juices are especially high in vitamin C. Bananas are high in potassium. Meats and dairy products are high in B vitamins.

79.

A nurse is performing cardiopulmonary resuscitation (CPR) on an infant. When performing chest compressions, the nurse understands that the compression rate is at least how many times per minute?

100 times per minute

60 times per minute

80 times per minute

160 times per minute

Correct answer: 100 times per minute

For the infant, the rate of chest compressions is at least 100 times per minute. The other options are incorrect.

80.

A nurse is working on the pediatric trauma unit and needs to temporarily immobilize a child's fractured leg. Which of the following forms of traction should the nurse use?

Buck's traction

Bryant's traction

Russell's traction

Cervical traction

Correct answer: Buck's traction

The nurse should use Buck's traction (also known as Buck's extension). Buck's traction is used to immobilize fractured legs.

Bryant's traction is used to stabilize hips or reduce femur fractures in children younger than 2 years. Russell's traction is used to reduce fractures of the femur or hip. Cervical traction is used to stabilize a muscle spasm or a spinal fracture.

81.

The crutch gait the nurse should teach the client wearing a prosthesis after a single leg amputation is the:

Four-point gait

Three-point gait

Tripod crutch gait

Swing-through crutch gait

Correct answer: Four-point gait

A four-point gait provides for weight bearing on all four extremities and maximum support during ambulation.

A three-point gait and a tripod crutch gait are used when one extremity cannot bear weight. A swing-through crutch gait does not simulate ambulation. It is used when an individual can bear weight but lacks the muscular control needed for ambulation without an assistive device.

82.

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 actually be slightly bent when using the handgrips.

All other statements are correct.

83.

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 and/or tunneling may be present. Depth will vary by anatomic location.

84.

A 28-year-old male informs the nurse that he is experiencing pain that will come and go around his groin, lower abdomen, and back. The patient also informs his nurse that he has the frequent urge to urinate and that it burns when he does. The nurse assesses the patient and notices that the patient also has a fever. Which of the following urinary issues does this patient **most likely** have?

Prostatitis

Cystitis

Urethritis

Pyelonephritis

Correct answer: Prostatitis

The patient most likely has prostatitis. The symptoms that accompany prostatitis include the frequent urge to urinate, difficulty urinating, pain or burning while urinating, chills and fever, and pain that comes and goes in the lower abdomen, around the anus, in the groin, or in the back.

Cystitis, pyelonephritis, and urethritis also have similar urinary tract infection (UTI) symptoms as prostatitis (i.e. frequent urge to urinate, difficulty urinating, and pain or burning while urinating). In addition to the UTI symptoms, urethritis also causes an individual to have pain during sex and difficulty with starting to urinate. Other symptoms of cystitis include low-grade fever, pressure in the lower abdomen, discomfort in the pelvic area, and cloudy or strong-smelling urine. Other symptoms of pyelonephritis include feeling sick, nausea and vomiting, confusion, blood in urine, cloudy or foul-smelling urine, and back or flank pain.

85.

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.

86.

A nurse is caring for a patient who has a broken leg and a broken arm. The nurse informs the patient that he should keep his blood flowing by wiggling his fingers and toes every hour. The nurse also advises the patient to eat a balanced diet. What food should the nurse warn the patient against while he is on bed rest?

Large portions of milk products

Bananas and apples

Breads

Fish

Correct answer: Large portions of milk products

The nurse should warn the patient against eating large portions of milk products. Milk products increase the kidney's excretion of calcium, which can lead to kidney stones.

Bananas, apples, breads, and fish are all appropriate foods to eat when on bed rest. When on bed rest, it is important to maintain a balanced diet. It is okay to consume milk products, just not in large portions.

87.

While working in the emergency room, you witness a 77-year-old male having difficulty catching his breath. Which position would be most beneficial for the patient?

Select all that apply.

- **Orthopneic**
- High fowler's
- Prone
- Trendelenburg

Orthopneic or tripod positioning is when the patient places their hands either on their knees or folded across a stack of pillows. This position allows for the greatest amount of oxygen exchange by decreasing the work necessary to move oxygen and increasing the use of accessory muscles.

88.

A nurse is conducting preoperative teaching with a client about the use of an incentive spirometer. The nurse should include which piece of information in discussions with the client?

The best results are achieved when sitting up or with the head of the bed elevated at 45 degrees to 90 degrees

Inhale as rapidly as possible

After maximum inspiration, hold the breath for 15 seconds and exhale

Keep a loose seal between the lips and the mouthpiece

Correct answer: The best results are achieved when sitting up or with the head of the bed elevated at 45 degrees to 90 degrees

For optimal lung expansion with the incentive spirometer, the client should assume the semi-fowlers position. The mouth piece should be covered completely and tightly while the client inhales slowly with a constant flow through the unit. The breath should be held for 5 seconds before exhaling slowly.

89.

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.

90.

Chronic kidney disease (CKD) affects all major body systems. A patient with this diagnosis will likely exhibit which of the following manifestations?

Select all that apply.

Ataxia (gait alteration)

Oliguria in late stages of disease

Kussmaul's respirations

Hypotension

Increased glomerular filtration rate (GFR)

CKD is a slow, progressive, irreversible loss in kidney function, with a decreasing GFR rate (less than or equal to 60 mL per minute for three months or longer. It occurs in stages and eventually results in uremia or end-stage kidney disease. Often, CKD requires dialysis or kidney transplantation to maintain life. Clinical manifestations are vast, including ataxia, polyuria in early stages that advances to oliguria and anuria in later stages, Kussmaul's respirations (associated with severe metabolic acidosis), hypertension (the kidneys fail to maintain BP homeostasis), anemia (decreased secretion of erythropoietin by damaged nephrons), and electrolyte disturbances.

91.

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.

92.

During a routine physical examination of a newborn infant, the nurse assesses for developmental dysplasia of the hip (DDH). Which of the following assessment findings would the nurse expect in this condition?

Select all that apply.

- **Asymmetry of the gluteal and thigh folds**
- **Limited hip abduction**
- **Ortolani click**
- Negative Barlow's test
- Laxity of the ligaments around the hip

Problems related to abnormal development of the hip may develop during fetal life, infancy, or childhood. With DDH, the head of the femur sits improperly in the acetabulum (hip socket) of the pelvis. At birth, the ligaments around the infant's hips should be quite loose, allowing easy and wide abduction of the hips. Limited hip abduction would be a sign of possible DDH. Asymmetry of the gluteal and thigh folds is also indicative of DDH. Ortolani's maneuver is a test that assesses hip stability, with a "click" indicating a dislocated femoral head moving into the acetabulum. A positive Barlow's test (not negative) would also be an indication of DDH (the examiner adducts the hips and applies gentle pressure down and back with the thumbs; if the examiner can feel the femoral head move out the hip socket, the test is said to be positive).

93.

A patient was recently diagnosed with pancreatitis. Which of the following would be an approved meal following this diagnosis?

Select all that apply.

- **Baked chicken and rice**
- **Egg white omelet with a side of fruit**
- Bacon, lettuce, and tomato sandwich with avocado
- Fried eggs with whole milk

Those with pancreatitis must avoid fried or fatty foods. This includes whole milk, high-fat produce like avocados, and processed meats. If these dietary recommendations are not followed, it can lead to increased inflammation and pain.

94.

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.

95.

A newborn requires immediate care after it is born. What is the nurse's **highest** priority in providing care to a newborn immediately after it is born?

Swaddling the newborn in a blanket

Administering a vitamin K injection

Promoting the maternal-newborn bonding by initiating breastfeeding

Providing prophylactic eye care

Correct answer: Swaddling the newborn in a blanket

The nurse's highest priority when providing care to a newborn immediately after it is born is to swaddle the newborn in a blanket. Cold stress is a newborn's greatest risk; therefore, the highest priority is to prevent heat loss.

Promoting the maternal-newborn bond by initiating breastfeeding should be done as soon as possible, but it is not the highest priority. Administering the vitamin K injection should be done within the first hour and providing prophylactic eye care should be done within the first two hours.

96.

A nurse caring for a client with a pneumothorax who has had a chest tube inserted notes continuous gentle bubbling in the suction control chamber. What action is appropriate?

Do nothing because this is an expected finding

Immediately clamp the chest tube and notify the physician

Check for an air leak because the bubbling should be intermittent

Increase the suction pressure so that the bubbling becomes vigorous

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Correct answer: Do nothing because this is an expected finding

Continuous gentle bubbling should be noted in the suction chamber. Chest tubes should only be clamped to check for an air leak or when changing drainage devices.

97.

A nurse is instructing a patient on how to use a single-point cane. Which of the following assessments would have initiated this education?

The patient's balance was mildly impaired

The patient's balance was moderately impaired

The patient has moderate unilateral weakness

The patient is showing signs of bilateral lower extremity weakness

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Correct answer: The patient's balance was mildly impaired

A nurse would demonstrate the use of a single-point cane to a patient whose balance is mildly impaired.

A quad cane would be demonstrated to a patient whose balance is moderately impaired. A walk cane would be demonstrated to a patient who has moderate unilateral weakness. Bilateral crutches would be demonstrated to a patient who has bilateral lower extremity weakness.

98.

A patient returns from the post-operative unit following receiving a partial colectomy. The incision site has a moderate amount of bleeding noted around the sutures. How would you document the following findings when assessing her incision?

Select all that apply.

- **Sanguineous**
- Purulent
- Serosanguineous
- Serous

Sanguineous fluid is blood without signs of infection or discharge.

Purulent fluid shows signs of infection through thick, white, and pus-like discharge.

Serous discharge is clear and thin.

Serosanguineous discharge is a mixture of serous and sanguineous discharge, without signs of infection.

99.

The nurse is caring for a patient with hypertension who has a DASH diet ordered. Upon discharge, which of the following instructions should the nurse give to this patient?

Select all that apply.

"Incorporate nuts and nut butters into your diet."

"Have a glass of low-fat milk with each meal."

"Read nutritional facts on product packaging regarding sodium content per serving."

"Restrict intake of dietary protein."

"Limit your caffeine intake to one cup per day."

The Dietary Approaches to Stop Hypertension (DASH diet) is recommended to prevent and control obesity, high cholesterol, and hypertension. It consists of primarily fruits and vegetables, whole grains, low-fat dairy foods, meat, fish, poultry, nuts, and beans and limits the intake of high sugar foods and beverages, red meats, and added fats. The patient should be taught to learn how to read nutritional facts on packaging and avoid high sodium content foods.

Limiting caffeine and restricting dietary proteins (other than limiting red meats) are not included in the DASH diet recommendations.