Detailed Answer Key
IM8_B Community Assessment

1. A home health nurse is developing a plan of care for a child who has hemiplegic cerebral palsy. Which of the following goals is the priority for the nurse to include in the plan of care?

   A. Provide respite services for the parents.

      Rationale: Respite services are frequently used to provide support for parents who care for chronically ill or disabled children in the home. Although supporting the parents is important, this goal is not the priority.

   B. Improve the client's communication skills.

      Rationale: Communication is often impaired in children who have cerebral palsy. Although optimizing the child's ability to communicate is important, this goal is not the priority.

   C. Foster self-care activities.

      Rationale: Self-care is often impaired in children who have cerebral palsy. Although fostering self-care is important for independence, this goal is not the priority.

   D. Modify the environment.

      Rationale: Using the safety and risk reduction priority-setting framework, maintaining safety is the highest priority for this client. Modification of the environment includes making the child's home accessible and safe from hazards that could cause injury.

2. A nurse working for a home health agency is assessing an older adult male client. Which of the following findings is the priority for the nurse to address?

   A. Swollen gums

      Rationale: Swollen gums is nonurgent because it is an expected finding for an older adult client due to increased risk for periodontal disease; therefore, there is another finding that is the priority.

   B. Pruritus

      Rationale: Pruritus is nonurgent because it is an expected finding for an older adult client due to decreased function of glands that produce oil and moisture; therefore, there is another finding that is the priority.

   C. Urinary hesitancy

      Rationale: Urinary hesitancy is nonurgent because it is an expected finding for an older adult male client due to prostate enlargement; therefore, there is another finding that is the priority.

   D. Dysphagia

      Rationale: Dysphagia poses the greatest safety risk to the client because it can cause choking, or result in aspiration of food or liquids leading to pneumonia and respiratory compromise. This is the priority finding for the nurse to address.

3. A school nurse is teaching a group of nurses newly hired to work in the school system about pediculosis capitis (head lice). Which of the following information is appropriate to include in the teaching?

   A. Family pets can contribute to the transmission of lice.

      Rationale: The nurse should tell the group that a louse requires a human host to survive and is not transmitted through pets.

   B. Children from lower socioeconomic areas are more likely to have lice.

      Rationale: The nurse should inform the group that lice outbreaks occur regardless of age, socioeconomic status, or level of cleanliness.

   C. Nits that are shed into the environment are capable of hatching for up to 10 days.

      Rationale: Nits that shed into the environment are able to hatch for up to 7 to 10 days; therefore, this information is appropriate to include in the teaching.

   D. Infestation often appears as grayish brown, threadlike burrows along the skin behind the ears.

      Rationale: The nurse should identify a scabies infestation as grayish brown, threadlike burrows on the skin.

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4. An older adult client who lives alone tells a clinic nurse that he is unable to drive himself to the store and is afraid to cook on the stove. Which of the following community resources should the nurse recommend for this client?

   A. Hospice care

      Rationale: The nurse should recommend hospice care, or palliative care, for clients who are very ill or terminally ill.

   B. Meals on Wheels

      Rationale: Meals on Wheels is a service that delivers meals daily to older adults who need them, either at senior centers or directly to their homes. It is appropriate for the nurse to recommend this service for this client.

   C. A rehabilitation facility

      Rationale: The nurse should recommend a rehabilitation facility for clients following major surgeries, such as hip replacement.

   D. Temporary Assistance for Needy Families (TANF)

      Rationale: The nurse should recommend TANF for families who need financial resources.

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5. A nurse is working with an interdisciplinary disaster committee to develop a community-wide emergency response plan in the event of a nonbiological or chemical incident. The nurse should include which of the following agencies to be notified immediately after calling 911?

   A. Office of Emergency Management (OEM)

      Rationale:

The nurse should include OEM in the community communication plan to be contacted following the call to the emergency communication center (911). This agency is responsible for determining if additional resources to the initial first responders are needed.

B. Federal Emergency Management Agency (FEMA)

Rationale: The nurse should not plan to include notifying FEMA immediately following a 911 call in the community communication plan. FEMA is notified when a community determines regional abilities are unable to properly respond to the incident.

C. American Red Cross (ARC)

Rationale: The nurse should not plan to notify ARC immediately following a 911 call during a community-wide disaster. ARC provides response efforts that support emergency rescue and recovery services. ARC is contacted when additional resources are deemed necessary by the local community.

D. U.S. Department of Homeland Security (DHS)

Rationale: The nurse should not plan to notify DHS unless it is determined the disaster event is the result of an act of terrorism.

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6. An occupational health nurse in the clinic of an industrial plant is developing a guidebook for clinic workers. Which of the following actions should the nurse include as a secondary prevention strategy?

A. Teach plant workers about proper lifting techniques.

Rationale: The nurse should include proper lifting strategies as a primary prevention measure.

B. Set up an influenza immunization campaign.

Rationale: The nurse should include immunizations as a primary prevention measure.

C. Help plant workers identify signs of carpal tunnel syndrome.

Rationale: The nurse uses secondary prevention to screen for problems. This strategy is appropriate to include.

D. Collaborate with physical therapists to develop programs for injured employees to return to work.

Rationale: The nurse should promote recovery from existing conditions as part of tertiary prevention.

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7. A school nurse receives a call that some children and teachers report being exposed to an undetermined noxious gas odor presenting in the classrooms and are experiencing dizziness. Which of the following actions should the nurse take?

A. Have students evacuated from the school and establish a triage area in the school parking lot.

Rationale: Following the principle of mitigation, the nurse should facilitate evacuation out of the building to prevent exposure to the harmful gas and set up the triage site at a nearby location.

B. Move individuals who are reporting symptoms to one of the affected classrooms and create a triage area inside the room.

Rationale: The nurse should set up triage in an area that will protect the individuals from further exposure to an unknown chemical and protect the nurse and other rescue personnel from harm.

C. Arrange for client transportation to the nearest emergency department and tell the group triage will occur there.

Rationale: The nurse should plan to triage individuals exposed to chemical agents closest to the site of exposure. Triaging before emergency transport will provide the emergency personnel with information to know which individuals to move first.

D. Transport all children and school personnel to the nearest medical facility using school buses.

Rationale: The nurse should implement triage prior to transport to know which individuals are in the most serious condition and should be seen first. Transporting the entire school population to a medical facility would overwhelm the staff and resources and delay proper care for those who need it.

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8. A nurse is working with an emergency response team in caring for a group of people who may have been exposed to anthrax while doing farm work, but are not exhibiting manifestation of illness. Which of the following is the appropriate action for the nurse to take?

A. Place the clients in isolation.

Rationale: Anthrax is not spread from person to person; therefore, there is no need for the nurse to isolate the clients.

B. Initiate client decontamination.

Rationale: Clients exposed to anthrax do not require decontamination.

C. Administer antibiotic therapy.

Rationale: The nurse should administer an antibiotic and the anthrax vaccine within 24 hr as prophylaxis to all clients exposed to anthrax and are not exhibiting manifestations of illness.

D. Treat clients with an antitoxin.

Rationale: The nurse should expect to administer antitoxin to clients exposed to botulism.

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9. A nurse is participating in a biological disaster simulation where citizens are exposed to pneumonic plague. Which of the following isolation precautions should the nurse plan to use while caring for these clients?

A. Airborne

Rationale: The nurse who is caring for clients exposed to pneumonic plague does not need to use airborne precautions since the bacteria is not transmitted by droplet nuclei.

B. Contact

Rationale:

The nurse who is caring for clients exposed to pneumonic plague does not need to use contact precautions since the bacteria is not transmitted by touching items in the client's environment.

C. Droplet

Rationale: The nurse who is caring for clients exposed to pneumonic plague should use droplet precautions because pneumonic plague *(Yersinia pestis)* is transmitted by large respiratory droplets.

D. Protective

Rationale: The nurse should use protective precautions for clients who are immunosuppressed.

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10. A nurse is among the first responders to a mass-casualty incident and does not know what type of personal protective equipment (PPE) is needed. Which of the following actions should the nurse take?

A. Wait until the type of equipment needed is known.

Rationale: The nurse should not delay care to the injured in a mass-casualty incident by waiting to learn which type of PPE is needed.

B. Decontaminate victims before intervening.

Rationale: The nurse should don PPE prior to implementing decontamination to prevent self-contamination.

C. Choose the highest level of protection equipment available.

Rationale: When the level or type of PPE is unknown, the nurse should wear the highest level of protection.

D. Use a dosimeter to measure the level of radiation in the area before intervening.

Rationale: The nurse should wear a dosimeter to monitor personal radiation exposure over time; it does not determine the quantity of radiation at a given location. This action also does not prevent personal contact with hazardous materials.

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11. A nurse is performing triage for a group of clients following a mass casualty incident (MCI). Which of the following clients should the nurse plan to care for first?

A. A client experiencing a tension pneumothorax

Rationale: When performing triage for an MCI, the nurse should classify a client experiencing a tension pneumothorax as immediate. This client should receive priority care.

B. A client who has a closed upper extremity fracture

Rationale: When performing triage for an MCI, the nurse should recognize that a client who has a closed upper extremity fracture could wait several hours for treatment with little risk of adverse effects. This minimal category is the third priority for care.

C. A client who has full-thickness burns over 80% of his body

Rationale:

When performing triage for an MCI, the nurse should classify a client who has partial-thickness to full-thickness burns in excess of 60% of his body as expectant. Health care personnel should give clients in this category comfort measures when possible, after all other clients have received initial treatment.

D. A client who has agonal respirations

Rationale: When performing triage for an MCI, a client who has agonal respirations should be classified as expectant. Health care personnel should give clients in this category comfort measures when possible, after all other clients have received initial treatment.

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12. A nurse is helping to triage a group of clients at a mass casualty incident who were involved in an explosion at a local factory. Which of the following clients should the nurse tag to be the priority for care?

A. A client who has severe head injuries, respiratory rate 6/min, and is unresponsive

Rationale: A client who has severe head injuries, respiratory rate 6/min and is unresponsive has a minimal chance of survival even with intervention; therefore, the nurse should not recommend this client as the priority for care.

B. A client who has a simple fracture of the femur, multiple scratches on both legs, and is crying hysterically

Rationale: A client who has a simple fracture of the femur does not have an immediate threat to life and can wait for treatment; therefore, the nurse should not recommend this client as the priority for care.

C. A client who has a piece of wood punctured into the chest wall and has an audible hissing sound coming from the wound site

Rationale: A client who has air leaking from a chest wound requires immediate intervention for survival; therefore, when using the survival approach to client care, the nurse should recommend this client as the priority for care.

D. A female who is pregnant at 20 weeks of gestation, has multiple cuts and abrasions, and is walking around

Rationale: A client who is pregnant at 20 weeks of gestation and has topical lacerations does not have an immediate threat to life and can wait for treatment; therefore, the nurse should not recommend this client as the priority for care.

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13. A is nurse assisting with field triage following a motor-vehicle crash involving a bus with multiple victims. The nurse assesses a child who has an open fracture of the femur. Which of the following actions should the nurse take?

A. Locate the child's parents to obtain consent for treatment.

Rationale: In emergent conditions, parental consent is assumed.

B. Place a yellow triage tag on the child.

Rationale: The child's Condition indicates the need for treatment within 30 min to 2 hr. Therefore, the nurse should triage the child with a yellow tag.

C. Notify the emergency department of the child's imminent arrival.

Rationale: The triage nurse is responsible for quickly assessing victims and tagging them according to their medical needs. The triage nurse does not communicate directly with the emergency department.

D. Perform a complete head-to-toe assessment.

Rationale: During a disaster situation with multiple victims, there is not time to perform a complete assessment.

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14. A nurse is triaging victims of a multiple motor-vehicle crash. The nurse assesses a client trapped under a car who is apneic and has a weak pulse at 120/min. After repositioning his upper airway, the client remains apneic. Which of the following actions should the nurse take?

A. Start CPR.

Rationale: Clients in need of CPR are not immediately treated when multiple victims are present. Furthermore, CPR will not be effective if the client is trapped under a vehicle.

B. Place a red tag on the client's upper body and obtain immediate help from other personnel.

Rationale: A red triage tag is not appropriate for a client who has apnea. This client's condition is imminently terminal. Therefore, the client should place a black tag on the client.

C. Place a black tag on the client's upper body and attempt to help the next client in need.

Rationale: When assessing an apneic adult casualty in a disaster situation, a nurse should attempt to reposition the upper airway on time. If the client still does not breathe, a black tag should be placed on the upper body and the nurse should move on to the next client in need.

D. Reposition the client's upper airway a second time before assessing his respirations.

Rationale: After attempting to reposition the airway one time, the nurse should triage the client and move on to the next client in need.

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15. A nurse is educating community members about how to prepare for a disaster. Which of the following supplies should the nurse instruct the clients to include in a disaster preparedness kit? (Select all that apply.)

A. Three quarts of water per person

B. Clean clothing

C. Personal identification

D. Matches

E. Prescription medications

Rationale: **Three quarts of water per person is incorrect.** Basic supplies for personal preparedness include 3.7 liters (1 gallon) of water per person per day. A three day supply is recommended.

Clean clothing is correct. Clean clothing is recommended to include in basic supplies for personal preparedness.

Personal identification is correct. Personal identification is recommended to include in basic supplies for personal preparedness.

Matches is correct. Matches are recommended to include in basic supplies for personal preparedness.

Prescription medications is correct. Prescription medications are recommended to include in basic supplies for personal preparedness.

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16. A nurse is reviewing the guidelines for reporting nationally notifiable infectious diseases. Which of the following diseases should the nurse plan to report to the Centers for Disease Control and Prevention (CDC)?

A. Lyme disease

Rationale: Lyme disease is a nationally notifiable infectious disease.

B. Cytomegalovirus

Rationale: Cytomegalovirus is not a nationally notifiable infectious disease.

C. Streptococcus pharyngitis

Rationale: Streptococcus pharyngitis is not a nationally notifiable infectious disease.

D. Toxoplasmosis

Rationale: Toxoplasmosis is not a nationally notifiable infectious disease.

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17. A community health nurse is reviewing the levels of disease prevention. Which of the following activities is an example of tertiary prevention?

A. Providing treatment for clients who have chronic obstructive pulmonary disease

Rationale: Tertiary prevention reduces complications and disabilities experienced by clients who already have a medical illness.

B. Performing screening for sexually transmitted infections

Rationale: Screening for STIs is an example of both primary and secondary prevention.

C. Administering influenza immunizations at a local health fair

Rationale: Immunizations are an example of primary prevention.

D. Testing new nurses for exposure to tuberculosis.

Rationale:

Testing for exposure to tuberculosis is an example of secondary prevention.

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18. A nurse is reinforcing teaching with a group of adolescent females who are pregnant about expected changes related to pregnancy. Which of the following client statements indicates understanding of the teaching?

A. "It is normal to have a white vaginal discharge."

Rationale: Hormone stimulation causes leukorrhea, in which the cervix produces excess mucous. The nurse should instruct the client to use good perineal hygiene and report any discharge that is foul-smelling or a different color.

B. "I should recognize fetal movement by 12 weeks."

Rationale: A multiparous client can experience fetal movements as early as 14 to 16 weeks of gestation. The nulliparous woman may not notice these sensations until the 18th week or later. Quickening is commonly described as a flutter and is difficult to distinguish from peristalsis.

C. "I will take fluid pills if my ankles begin to swell."

Rationale: Diuretics are contraindicated during pregnancy. The nurse should instruct the clients to drink adequate fluid to promote natural diuretic effects and to call their provider if generalized edema is noted.

D. "My nipples and areolae will become pale as my breasts enlarge."

Rationale: The nurse should inform the clients that breast changes include hyperpigmentation, which causes the areolae to darken.

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19. A nurse is preparing to administer ciprofloxacin to a client. The nurse should identify that the medication is treatment for exposure to which of the following agents?

A. Smallpox

Rationale: Smallpox is a virus and is not responsive to treatment with an antibiotic, such as ciprofloxacin; however, severe adverse effects can be treated with vaccinia immune globulin and cidofovir (an antiviral medication), but neither is actually approved for this use.

B. Sarin gas

Rationale: Sarin gas is a nerve agent and may respond to pralidoxime, which should be administered immediately at the time of exposure to be effective.

C. Ebola virus

Rationale: The Ebola virus is not responsive to treatment with an antibiotic, such as ciprofloxacin.

D. Anthrax

Rationale: Anthrax is a form of bacteria and is responsive to treatment with ciprofloxacin, which is the preferred antibiotic of treatment along with doxycycline for both inhalational and cutaneous anthrax.

20. A nurse is establishing health promotion goals for a female client who smokes cigarettes, has hypertension, and has a BMI of 26. Which of the following goals should the nurse include?

A. The client will list foods that are high in calcium, which should be avoided.

Rationale: Female clients are at increased risk for osteoporosis; therefore, the nurse should instruct the client to increase intake of calcium and vitamin D.

B. The client will walk for 30 min 5 days a week.

Rationale: CDC recommendations include engaging in a moderate exercise, such as walking, for a total of 150 min each week.

C. The client will increase calorie intake by 200 cal per day.

Rationale: The client's BMI indicates the client is overweight; therefore, the nurse should counsel the client on weight reduction strategies.

D. The client will replace cigarettes with smokeless tobacco products.

Rationale: Smokeless tobacco delivers a higher concentration of nicotine and places the client at risk for cancer. The nurse should discuss nicotine replacement and acupuncture as measures to stop smoking tobacco products.

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21. A community health nurse in a pediatric clinic is reviewing the history of a 12-year-old client. Which of the following immunizations should the nurse expect to administer?

A. Meningococcal conjugate

Rationale: The CDC recommends administering the meningococcal vaccine to children who are 11 through 12 years old and then giving a booster dose at age 16. The nurse should prepare to administer this immunization.

B. Herpes zoster

Rationale: The nurse should plan to administer a single dose of herpes zoster vaccine to an adult client 60 years old or older.

C. Rotavirus

Rationale: The CDC recommends administering rotavirus vaccine during a child's first year of life.

F. Pneumococcal polysaccharide

Rationale: The nurse should plan to administer the pneumococcal polysaccharide vaccine only when a child over 2 years old has a specific medical indication that puts him at high risk for this infection.

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22. A public health nurse is assessing an older adult client who lives with a family member. The nurse identifies

several bruises in various stages of healing. The client and family member explain that the bruises are a result of clumsiness. However, based on the distribution of the bruises, the nurse suspects abuse. Which of the following actions should the nurse take first?

A. Document the bruises in the client's chart.

Rationale: The nurse should document the bruises in the client's chart after providing care to comply with legal guidelines; however, there is another action the nurse should take first.

B. Report the findings to a supervisor.

Rationale: The greatest risk to this client is further injury from continued abuse; therefore, the first action the nurse should take is to report the findings to a supervisor. Nurses are required to report suspected cases of child and older adult abuse.

C. Provide the client with a crisis hotline number.

Rationale: The nurse should provide the client and family with a crisis hotline number in case emergency help is needed; however, there is another action the nurse should take first.

D. Discuss respite care with the client's family.

Rationale: The nurse should discuss respite care with the client's family to prevent caregiver role strain; however, there is another action the nurse should take first.

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23. A community health nurse is conducting an educational program on various environmental pollutants. The nurse should emphasize that clients who have which of the following disorders are especially vulnerable to ozone effects?

A. Osteoarthritis

Rationale: Although the ozone can have adverse effects on the entire population, as well as on agriculture and other forms of vegetation, clients who have osteoarthritis are no more vulnerable than the general population. Certain occupations predispose clients to developing osteoarthritis.

B. Basal cell carcinoma

Rationale: Although the ozone can have adverse effects on the entire population, as well as on agriculture and other forms of vegetation, clients who have skin cancer are no more vulnerable than the general population. Occupational exposure to pollution from arsenic, coal, and nitrates is a risk factor for developing basal cell carcinoma.

C. Asthma

Rationale: The ozone exerts its primary adverse effects on the respiratory system, reducing lung function and increasing the risk of respiratory infection. Clients who have respiratory disorders, such as asthma and COPD, are especially vulnerable.

D. Hypothyroidism

Rationale: Although the ozone can have adverse effects on the entire population, as well as on agriculture and other forms of vegetation, clients who have thyroid disease are no more vulnerable than the general population. Exposure to iodine and radiation can cause hypothyroidism.

24. A nurse is triaging clients injured during a tornado. The nurse assesses a client who has an open fracture of his arm. Which of the following actions should the nurse take?

- A. Place a yellow tag on the client's upper body.

  Rationale: A yellow tag indicates the client has injuries that need treated within 30 min to 2 hr.

- B. Place a red tag on the client's upper body.

  Rationale: The client's current status is not emergent. Therefore, the nurse should not place a red tag on the client.

- C. Perform a rapid head-to-toe assessment.

  Rationale: The nurse's role is to perform triage and provide care for clients identified with an emergent triage status.

- D. Have the client's wife drive him to the hospital.

  Rationale: The client needs to receive a disaster triage tag and then receive appropriate medical care following the guidelines of the disaster plan.

25. A nurse is preparing a response protocol for botulism as a bioterrorism agent. The nurse should prepare the protocol based on which of the following information? (Select all that apply.)

- A. Botulism can produce paralysis within 12 to 72 hr following exposure.
- B. Notify the Centers for Disease Control and Prevention (CDC) when more than three cases are confirmed.
- C. Botulism is acquired through direct contact with an infected person.
- D. Vomiting and diarrhea are expected findings following exposure.
- E. Botulism is a toxin found in castor beans.

  Rationale: Botulism can produce paralysis within 12 to 72 hr following exposure is correct. Botulism is a neurotoxin that can cause flaccid paralysis within hours of exposure. Notify the Centers for Disease Control and Prevention (CDC) when more than three cases are confirmed is incorrect. Due to the threat of a botulism outbreak, the CDC should be notified if even a single case is suspected. Botulism is acquired through direct contact with an infected person is incorrect. Botulism is primarily acquired through ingestion of a contaminated food source. Vomiting and diarrhea are expected findings following exposure is correct. Vomiting and diarrhea are expected findings following ingestion of botulism. Botulism is a toxin found in castor beans is incorrect. Ricin, rather than botulism, is a toxin found in castor beans.

26. A nurse is providing staff education about smallpox as a bioterrorism threat. Which of the following statements indicates an understanding of this agent? (Select all that apply.)

- A. "Smallpox is transmitted person to person."

B. "Infection is characterized by severe respiratory distress."

C. "Smallpox vaccination ensures lifelong immunity."

D. "Naturally occurring smallpox has been eradicated from the world."

E. "Smallpox is often confused with varicella."

Rationale: Smallpox is transmitted person to person is correct. Smallpox is highly communicable through droplet or airborne inhalation or contact with lesions.Infection is characterized by severe respiratory distress is incorrect. Severe respiratory distress is a manifestation of inhalation anthrax rather than smallpox.Smallpox vaccination ensures lifelong immunity is incorrect. The smallpox vaccine does not provide effective lifelong immunity.Naturally occurring smallpox has been eradicated from the world is correct. Naturally occurring cases of smallpox have been considered to be eradicated since 1979."Smallpox is often confused with varicella is correct. Smallpox and varicella both present with rashes that are similar in appearance and can lead to possible misdiagnosis.

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27. A nurse is planning a staff education session regarding biological weapons of mass destruction. Which of the following should he plan to include in the session? (Select all that apply.)

A. Sarin

B. Smallpox

C. Anthrax

D. Hydrogen cyanide

E. Botulism

Rationale: Sarin is incorrect. Sarin is a chemical rather than a biological agent of mass destruction.Smallpox is correct. Smallpox is a biological weapon of mass destruction.Anthrax is correct. Anthrax is a biological weapon of mass destruction.Hydrogen cyanide is incorrect. Hydrogen cyanide is a chemical rather than a biological agent of mass destruction.Botulism is correct. Botulism is a biological weapon of mass destruction.

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28. A community health nurse is developing a pamphlet about breast self-examination (BSE) for a local health fair. Which of the following instructions should the nurse include?

A. Expect some breast dimpling or discharge with age.

Rationale: The nurse should instruct clients to report breast dimpling or discharge. Changes in the texture of breast tissue are associated with menses, menopause, hormone replacement therapy, and pregnancy.

B. For those who have a menstrual cycle, perform a BSE every month, 2 or 3 days before menstruation.

Rationale: The nurse should instruct clients who have a menstrual cycle to perform a BSE every month, about 7 days after menstruation ends.

C. Using the palm of the hand, feel for lumps using a circular motion.

Rationale: The nurse should instruct clients to use the sensitive finger pads of the middle three fingers to perform a BSE.

D. Breasts can be examined in the shower with soapy hands.

Rationale: The nurse should encourage clients to perform a BSE or do an extra examination while showering. This allows clients to concentrate more easily on feeling for tissue changes.

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29. A charge nurse is making a room assignment for a client who has scabies. In which of the following rooms should the nurse place the client?

A. A negative-pressure isolation room

Rationale: A client who has scabies does not require a negative-pressure isolation room because scabies is not spread through airborne means.

B. A semi-private room with a client who has pediculosis capitis

Rationale: The nurse should only place clients who have a communicable condition in a semi-private room with another client who has the same condition to prevent cross-contamination.

C. A positive-pressure isolation room

Rationale: The nurse should choose a positive-pressure isolation room for a client who requires a protective environment.

D. A private room

Rationale: The nurse should place a client who has a communicable condition, such as scabies, in a private room to reduce the risk of exposure and possible transmission to other clients. If necessary, the nurse can use a semi-private room with a client who has the same condition.

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30. A nurse is leading a therapeutic group for clients at an outpatient mental health clinic. Which of the following client statements indicates a problem with role transition?

A. "If my husband had gone to the doctor like I told him to, he'd be alive today."

Rationale: This statement indicates that the client is experiencing grief, rather than a problem with role transition.

B. "I am so angry with my husband's attitude. He thinks he knows everything!"

Rationale: This statement indicates that the client is experiencing a role dispute, rather than a problem with role transition.

C. "I want to have an intimate relationship, but I end up breaking off relationships as soon as they begin."

Rationale: This statement indicates that the client is experiencing an interpersonal deficit, rather than a problem with role transition.

D. "I just can't seem to find any energy to take care of my children since my husband divorced me."

Rationale: This statement indicates that the client is experiencing a problem with role transition, which can result from a change in personal, occupational, or social status.