

Lewis Chapter 16 Questions

Questions

1. The nurse is caring for a patient with a massive burn injury and possible hypovolemia. Which assessment data will be of **most** concern to the nurse?
 - A. Blood pressure is 90/40 mm Hg. CORRECT
 - B. Urine output is 30 mL over the last hour.
 - C. Oral fluid intake is 100 mL for the last 8 hours.
 - D. There is prolonged skin tenting over the sternum.
2. A patient who has a small cell carcinoma of the lung develops syndrome of inappropriate antidiuretic hormone (SIADH). The nurse should notify the health care provider about which assessment finding?
 - A. Reported weight gain
 - B. Serum hematocrit of 42%
 - C. Serum sodium level of 120 mg/dL CORRECT
 - D. Total urinary output of 280 mL during past 8 hours
3. A patient is admitted for hypovolemia associated with multiple draining wounds. Which assessment would be the **most** accurate way for the nurse to evaluate fluid balance?
 - A. Skin turgor
 - B. Daily weight CORRECT
 - C. Presence of edema
 - D. Hourly urine output
4. The home health nurse cares for an alert and oriented older adult patient with a history of dehydration. Which instructions should the nurse give to this patient related to fluid intake?
 - A. "Increase fluids if your mouth feels dry. CORRECT
 - B. "More fluids are needed if you feel thirsty."
 - C. "Drink more fluids in the late evening hours."
 - D. "If you feel lethargic or confused, you need more to drink."
5. A patient who is taking a potassium-wasting diuretic for treatment of hypertension complains of generalized weakness. It is **most** appropriate for the nurse to take which action?
 - A. Assess for facial muscle spasms.
 - B. Ask the patient about loose stools.
 - C. Suggest that the patient avoid orange juice with meals.

- D. Ask the health care provider to order a basic metabolic panel. CORRECT
6. Spironolactone (Aldactone), an aldosterone antagonist, is prescribed for a patient. Which statement by the patient indicates that the teaching about this medication has been effective?
- A. "I will try to drink at least 8 glasses of water every day."
- B. "I will use a salt substitute to decrease my sodium intake."
- C. "I will increase my intake of potassium-containing foods."
- D. "I will drink apple juice instead of orange juice for breakfast." CORRECT
7. A newly admitted patient is diagnosed with hyponatremia. When making room assignments, the charge nurse should take which action?
- A. Assign the patient to a room near the nurse's station. CORRECT
- B. Place the patient in a room nearest to the water fountain.
- C. Place the patient on telemetry to monitor for peaked T waves.
- D. Assign the patient to a semi-private room and place an order for a low-salt diet.
8. IV potassium chloride (KCl) 60 mEq is prescribed for treatment of a patient with severe hypokalemia. Which action should the nurse take?
- A. Administer the KCl as a rapid IV bolus.
- B. Infuse the KCl at a rate of 10 mEq/hour. CORRECT
- C. Only give the KCl through a central venous line.
- D. Discontinue cardiac monitoring during the infusion.
9. A postoperative patient who had surgery for a perforated gastric ulcer has been receiving nasogastric suction for 3 days. The patient now has a serum sodium level of 127 mEq/L (127 mmol/L). Which prescribed therapy should the nurse question?
- A. Infuse 5% dextrose in water at 125 mL/hr. CORRECT
- B. Administer IV morphine sulfate 4 mg every 2 hours PRN.
- C. Give IV metoclopramide (Reglan) 10 mg every 6 hours PRN for nausea.
- D. Administer 3% saline if serum sodium decreases to less than 128 mEq/L.
10. A patient who was involved in a motor vehicle crash has had a tracheostomy placed to allow for continued mechanical ventilation. How should the nurse interpret the following arterial blood gas results: pH 7.48, PaO₂ 85 mm Hg, PaCO₂ 32 mm Hg, and HCO₃⁻ 25 mEq/L?
- A. Metabolic acidosis
- B. Metabolic alkalosis
- C. Respiratory acidosis

D. Respiratory alkalosis CORRECT

11. The nurse notes that a patient who was admitted with diabetic ketoacidosis has rapid, deep respirations. Which action should the nurse take?

- A. Give the prescribed PRN lorazepam (Ativan).
- B. Start the prescribed PRN oxygen at 2 to 4 L/min.
- C. Administer the prescribed normal saline bolus and insulin. CORRECT
- D. Encourage the patient to take deep, slow breaths with guided imagery.

12. An older adult patient who is malnourished presents to the emergency department with a serum protein level of 5.2 g/dL. The nurse would expect which clinical manifestation?

- A. Pallor
- B. Edema CORRECT
- C. Confusion
- D. Restlessness

13. A patient receives 3% NaCl solution for correction of hyponatremia. Which assessment is **most** important for the nurse to monitor for while the patient is receiving this infusion?

- A. Lung sounds CORRECT
- B. Urinary output
- C. Peripheral pulses
- D. Peripheral edema

14. The long-term care nurse is evaluating the effectiveness of protein supplements for an older resident who has a low serum total protein level. Which assessment finding indicates that the patient's condition has improved?

- A. Hematocrit 28%
- B. Absence of skin tenting
- C. Decreased peripheral edema CORRECT
- D. Blood pressure 110/72 mm Hg

15. A patient who is lethargic and exhibits deep, rapid respirations has the following arterial blood gas (ABG) results: pH 7.32, PaO₂ 88 mm Hg, PaCO₂ 37 mm Hg, and HCO₃⁻ 16 mEq/L. How should the nurse interpret these results?

- A. Metabolic acidosis CORRECT
- B. Metabolic alkalosis
- C. Respiratory acidosis

D. Respiratory alkalosis

16. A patient who has been receiving diuretic therapy is admitted to the emergency department with a serum potassium level of 3.0 mEq/L. The nurse should alert the health care provider **immediately** that the patient is on which medication?

A. Oral digoxin (Lanoxin) 0.25 mg daily CORRECT

B. Ibuprofen (Motrin) 400 mg every 6 hours

C. Metoprolol (Lopressor) 12.5 mg orally daily

D. Lantus insulin 24 U subcutaneously every evening

17. The nurse is caring for a patient who has a calcium level of 12.1 mg/dL. Which nursing action should the nurse include on the care plan?

A. Maintain the patient on bed rest.

B. Auscultate lung sounds every 4 hours.

C. Monitor for Trousseau's and Chvostek's signs.

D. Encourage fluid intake up to 4000 mL every day. CORRECT

~~18. When caring for a patient with renal failure on a low phosphate diet, the nurse will inform unlicensed assistive personnel (UAP) to remove which food from the patient's food tray?~~

A. Grape juice

B. Milk carton CORRECT

C. Mixed green salad

D. Fried chicken breast

~~19. A nurse in the outpatient clinic is caring for a patient who has a magnesium level of 1.3 mg/dL. Which assessment would be **most** important for the nurse to make?~~

A. Daily alcohol intake CORRECT

B. Intake of dietary protein

C. Multivitamin/mineral use

D. Use of over-the-counter (OTC) laxatives

~~20. A patient has a parenteral nutrition infusion of 25% dextrose. A student nurse asks the nurse why a peripherally inserted central catheter was inserted. Which response by the nurse is **most** appropriate?~~

A. "There is a decreased risk for infection when 25% dextrose is infused through a central line."

B. "The prescribed infusion can be given much more rapidly when the patient has a central line."

- C. "The 25% dextrose is hypertonic and will be more rapidly diluted when given through a central line." CORRECT
- D. "The required blood glucose monitoring is more accurate when samples are obtained from a central line."

21. ~~The nurse is caring for a patient who has a central venous access device (CVAD). Which action by the nurse is appropriate?~~

- A. Avoid using friction when cleaning around the CVAD insertion site.
- B. Use the push-pause method to flush the CVAD after giving medications. CORRECT
- C. Obtain an order from the health care provider to change CVAD dressing.
- D. Position the patient's face toward the CVAD during injection cap changes.

22. An older patient receiving iso-osmolar continuous tube feedings develops restlessness, agitation, and weakness. Which laboratory result should the nurse report to the health care provider **immediately**?

- A. K^+ 3.4 mEq/L (3.4 mmol/L)
- B. Ca^{+2} 7.8 mg/dL (1.95 mmol/L)
- C. Na^+ 154 mEq/L (154 mmol/L) CORRECT
- D. PO_4^{-3} 4.8 mg/dL (1.55 mmol/L)

23. The nurse assesses a patient who has been hospitalized for 2 days. The patient has been receiving normal saline IV at 100 mL/hr, has a nasogastric tube to low suction, and is NPO. Which assessment finding would be a **priority** for the nurse to report to the health care provider?

- A. Oral temperature of 100.1° F
- B. Serum sodium level of 138 mEq/L (138 mmol/L)
- C. Gradually decreasing level of consciousness (LOC) CORRECT
- D. Weight gain of 2 pounds (1 kg) above the admission weight

24. A nurse is assessing a newly admitted patient with chronic heart failure who forgot to take prescribed medications and seems confused. The patient complains of "just blowing up" and has peripheral edema and shortness of breath. Which assessment should the nurse complete **first**?

- A. Skin turgor
- B. Heart sounds
- C. Mental status CORRECT
- D. Capillary refill

25. ~~A patient with renal failure has been taking aluminum hydroxide/magnesium hydroxide suspension (Maalox) at home for indigestion. The patient arrives for outpatient hemodialysis and is unresponsive~~

to questions and has decreased deep tendon reflexes. Which action should the dialysis nurse take **first**?

- A. Notify the patient's health care provider. CORRECT
- B. Obtain an order to draw a potassium level.
- C. Review the magnesium level on the patient's chart.
- D. Teach the patient about the risk of magnesium-containing antacids

26. A patient who had a transverse colectomy for diverticulosis 18 hours ago has nasogastric suction and is complaining of anxiety and incisional pain. The patient's respiratory rate is 32 breaths/minute and the arterial blood gases (ABGs) indicate respiratory alkalosis. Which action should the nurse take **first**?

- A. Discontinue the nasogastric suction.
- B. Give the patient the PRN IV morphine sulfate 4 mg. CORRECT
- C. Notify the health care provider about the ABG results.
- D. Teach the patient how to take slow, deep breaths when anxious.

27. Which action can the registered nurse (RN) who is caring for a critically ill patient with multiple IV lines delegate to an experienced licensed practical/vocational nurse (LPN/LVN)?

- A. Administer IV antibiotics through the implantable port.
- B. Monitor the IV sites for redness, swelling, or tenderness. CORRECT
- C. Remove the patient's nontunneled subclavian central venous catheter.
- D. Adjust the flow rate of the 0.9% normal saline in the peripheral IV line.

28. A patient has a serum calcium level of 7.0 mEq/L. Which assessment finding is **most** important for the nurse to report to the health care provider?

- A. The patient is experiencing laryngeal stridor. CORRECT
- B. The patient complains of generalized fatigue.
- C. The patient's bowels have not moved for 4 days.
- D. The patient has numbness and tingling of the lips.

29. Following a thyroidectomy, a patient complains of "a tingling feeling around my mouth." Which assessment should the nurse complete **immediately**?

- A. Presence of the Chvostek's sign CORRECT
- B. Abnormal serum potassium level
- C. Decreased thyroid hormone level
- D. Bleeding on the patient's dressing

30. A patient is admitted to the emergency department with severe fatigue and confusion. Laboratory studies are done. Which laboratory value will require the **most** immediate action by the nurse?

- A. Arterial blood pH is 7.32.
- B. Serum calcium is 18 mg/dL. CORRECT
- C. Serum potassium is 5.1 mEq/L.
- D. Arterial oxygen saturation is 91%.

~~31. When assessing a pregnant patient with eclampsia who is receiving IV magnesium sulfate, which finding should the nurse report to the health care provider **immediately**?~~

- A. The bibasilar breath sounds are decreased.
- B. The patellar and triceps reflexes are absent. CORRECT
- C. The patient has been sleeping most of the day.
- D. The patient reports feeling "sick to my stomach."

32. A patient is receiving a 3% saline continuous IV infusion for hyponatremia. Which assessment data will require the **most** rapid response by the nurse?

- A. The patient's radial pulse is 105 beats/minute.
- B. There is sediment and blood in the patient's urine.
- C. The blood pressure increases from 120/80 to 142/94.
- D. There are crackles audible throughout both lung fields. CORRECT

~~33. The nurse notes a serum calcium level of 7.9 mg/dL for a patient who has chronic malnutrition. Which action should the nurse take **next**?~~

- A. Monitor ionized calcium level. CORRECT
- B. Give oral calcium citrate tablets.
- C. Check parathyroid hormone level.
- D. Administer vitamin D supplements.

34. A patient comes to the clinic complaining of frequent, watery stools for the last 2 days. Which action should the nurse take **first**?

- A. Obtain the baseline weight.
- B. Check the patient's blood pressure. CORRECT
- C. Draw blood for serum electrolyte levels.
- D. Ask about any extremity numbness or tingling.

~~35. Which action should the nurse take **first** when a patient complains of acute chest pain and dyspnea soon after insertion of a centrally inserted IV catheter?~~

- A. Notify the health care provider.
- B. Offer reassurance to the patient.
- C. Auscultate the patient's breath sounds. CORRECT
- D. Give the prescribed PRN morphine sulfate IV.

36. After receiving change-of-shift report, which patient should the nurse assess first?

- A. Patient with serum potassium level of 5.0 mEq/L who is complaining of abdominal cramping
- B. Patient with serum sodium level of 145 mEq/L who has a dry mouth and is asking for a glass of water
- C. Patient with serum magnesium level of 1.1 mEq/L who has tremors and hyperactive deep tendon reflexes CORRECT
- D. Patient with serum phosphorus level of 4.5 mg/dL who has multiple soft tissue calcium-phosphate precipitates

37. During the admission process, the nurse obtains information about a patient through the physical assessment and diagnostic testing. Based on the data shown in the accompanying figure, which nursing diagnosis is appropriate?

Physical Assessment	Electrolytes	Arterial Blood Gases
<ul style="list-style-type: none"> • Lungs clear to auscultation • Good skin turgor • Complaining of muscle cramps • Respirations 18 breaths/minute 	<ul style="list-style-type: none"> • Sodium 145 mEq/L • Potassium 3.6 mEq/L • Calcium 6.9 mg/dL • Magnesium 2 mEq/L 	<ul style="list-style-type: none"> • pH 7.41 • PaCO₂ 37 mmHg • PaO₂ 92 mmHg • SaO₂ 95% • HCO₃ 24 mEq/L

- A. Deficient fluid volume
- B. Impaired gas exchange
- C. Risk for injury: Seizures
- D. Risk for impaired skin integrity CORRECT