Detailed Answer Key
IM8_B RN Comp-1

1. A nurse is caring for a client who has returned from the surgical suite following surgery for a fractured mandible. The client had intermaxillary fixation to repair and stabilize the fracture. Which of the following actions is the priority for the nurse to take?

A. Prevent aspiration.

Rationale: When using the airway, breathing, circulation approach to client care, the nurse should determine that the priority goal is to prevent the client from aspirating. Because the client's jaws are wired together, aspiration of emesis is a possibility. Therefore, the client should be given medication for nausea, and wire cutters should be kept at the bedside in case of vomiting.

B. Ensure adequate nutrition.

Rationale: The client should be NPO initially after surgery until the gag reflex has returned. Once the client is able to eat, the client may advance to a calorie-appropriate, high-protein liquid diet. However, this is not the priority at this time.

C. Promote oral hygiene

Rationale: The client will have an incision inside the mouth. While it is important that the client receive frequent mouth cleaning, this is not the priority at this time.

D. Relieve the client's pain.

Rationale: While the client may be in pain and will need to be medicated, this is not the priority at this time.

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2. A nurse is caring for a client who is 4 days postoperative following a right radical mastectomy. Which of the following activities should the nurse anticipate being the most difficult for this client to perform with her right hand?

A. Buttoning her blouse

Rationale: Although this arm motion mainly involves the hand, wrist, and elbow of the affected arm, it is not the most difficult for the client to perform.

B. Eating her breakfast

Rationale: Although this arm motion mainly involves the hand, wrist, and elbow of the affected arm, it is not the most difficult for the client to perform.

C. Combing her hair

Rationale: Abduction of the arm is the most difficult, and usually the last, type of movement to be regained by a client following a mastectomy.

D. Brushing her teeth

Rationale: Although this arm motion mainly involves the hand, wrist, and elbow of the affected arm, it is not the most difficult for the client to perform.

3. A nurse is assessing a client who is receiving one unit of packed RBCs to treat intraoperative blood loss. The client reports chills and back pain, and the client's blood pressure is 80/64 mm Hg. Which of the following actions should the nurse take first?

A. Stop the infusion of blood.

Rationale: This client is experiencing an acute intravascular hemolytic transfusion reaction. The greatest risk to this client is injury from receiving additional blood; therefore, the first action the nurse should take is to stop the infusion of blood.

B. Inform the provider.

Rationale: The nurse should inform the provider so that the provider can give prescriptions for monitoring and medication if needed. However, there is another action the nurse should take first.

C. Obtain a urine specimen.

Rationale: The nurse should obtain a urine specimen to check for hemolysis; however, there is another action the nurse should take first.

D. Notify the laboratory.

Rationale: The nurse should notify the blood bank so personnel can assist with checking for errors with the blood component product; however, there is another action the nurse should take first.

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4. A nurse is assessing a client who has a long history of smoking and is suspected of having laryngeal cancer. The nurse should anticipate that the client will report that her earliest manifestation was

A. dysphagia.

Rationale: Dysphagia, difficulty swallowing, is a later manifestation of cancer of the larynx. It occurs as the tumor grows in size and impedes the esophagus.

B. hoarseness.

Rationale: Laryngeal cancer, a malignant tumor of the larynx, is most often caused by long exposure to tobacco and alcohol. Hoarseness that does not resolve for several weeks is the earliest manifestation of cancer of the larynx because the tumor impedes the action of the vocal cords during speech. The voice may sound harsh and lower in pitch than normal.

C. dyspnea.

Rationale: Dyspnea, shortness of breath, is a later manifestation of laryngeal cancer. It occurs as the tumor grows in size and impedes the airway opening.

D. weight loss.

Rationale: Weight loss is a later manifestation of laryngeal cancer, usually indicative of metastasis.

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5. A nurse is caring for a client who is being admitted for an acute exacerbation of ulcerative colitis. Which of the following actions should the nurse take first?

A. Review the client's electrolyte values.

Rationale: The greatest risk to this client is injury from impaired function of cardiac or respiratory muscles; therefore, the first action the nurse should take is to review the client's electrolyte values. The client might have low sodium, potassium, and chloride from frequent diarrhea.

B. Check the client's perianal skin integrity.

Rationale: The nurse should check the client's perianal skin integrity to identify areas of breakdown or excoriation; however, the nurse should take a different action first.

C. Investigate the client's emotional concerns.

Rationale: The nurse should investigate the client's emotional concerns to assist the client with the psychosocial coping of her condition; however, the nurse should take a different action first.

D. Obtain a dietary history from the client.

Rationale: The nurse should obtain a dietary history from the client to identify triggers for inflammation of the colon; however, the nurse should take a different action first.

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6. A nurse is caring for a client who is 5 hr postoperative following a transurethral resection of the prostate (TURP). The nurse notes that the client's indwelling urinary catheter has not drained in the past hour. Which of the following actions should the nurse take first?

A. Notify the provider.

Rationale: The nurse may need to notify the provider if unable to induce fluid flow from the catheter, or if the output is bright rad and thick; however, the nurse should attempt a different intervention first.

B. Check the tubing for kinks.

Rationale: When providing client care, the nurse should first use the least restrictive intervention; therefore, the nurse should check the catheter tubing for kinks. The nurse must ensure constant flow of the bladder irrigant into the catheter and outward drainage from the catheter to prevent clotting, which could occlude the catheter lumen.

C. Adjust the rate of the bladder irrigant.

Rationale: The nurse may need to increase the rate of bladder irrigant to stimulate removal of urine and clots; however, the nurse should use a less restrictive intervention first.

D. Irrigate the catheter.

Rationale: The nurse may need to irrigate the catheter to check for an internal obstruction; however, the nurse should use a less restrictive intervention first.

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7. A nurse in the emergency department is caring for a client who has extensive partial and full-thickness burns of the head, neck, and chest. While planning the client's care, the nurse should identify which of the following risks as the priority for assessment and intervention?

A. Airway obstruction

Rationale: When using the airway, breathing, circulation approach to client care, the nurse determines that the priority risk is airway obstruction. Burns of the head, neck, and chest often involve damage to the pulmonary tree due to heat as well as smoke and soot inhalation. This can result in severe respiratory difficulty. Nursing measures to maintain a patent airway should take priority in this client's care.

B. Infection

Rationale: Prevention of infection is essential throughout hospitalization and treatment; however, another risk is the priority.

C. Fluid imbalance

Rationale: Adequate fluid replacement is essential throughout the acute phase of burn treatment; however, another risk is the priority.

D. Paralytic ileus

Rationale: Paralytic ileus can develop during the acute phase of burn care and might require nasogastric decompression; however, another risk is the priority.

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8. A nurse is caring for a client who is in the immediate postoperative period following a partial laryngectomy. Which of the following parameters should the nurse assess first?

A. Pain severity

Rationale: The nurse should assess the client's pain level to help provide adequate pain management; however, another assessment is the priority.

B. Wound drainage

Rationale: The nurse should assess the quantity and character of drainage from the surgical wound to monitor for hemorrhage; however, another assessment is the priority.

C. Tissue integrity

Rationale: Head and neck surgeries often require tissue flaps to close the surgical wound. The nurse should monitor color and capillary refill in the area of the flap(s) to help determine viability; however, another assessment is the priority.

D. Airway patency

Rationale: When using the airway, breathing, circulation approach to client care, the nurse determines that the priority assessment is airway patency. After head and neck surgery, a major, life-threatening complication is airway obstruction. The priority actions involve airway maintenance and gas exchange.

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9. A nurse is caring for a client who is 1 day postoperative following a transsphenoidal hypophysectomy. While assessing the client, the nurse notes a large area of clear drainage seeping from the nasal packing. Which of the

following should be the nurse's initial action?

A. Document the amount of drainage.

Rationale: The nurse should document the amount of drainage along with the clarity to determine the extent of the cerebral spinal fluid (CSF) leakage and the presence of blood or pus; however there is another action that is priority.

B. Obtain a culture of the drainage.

Rationale: Although infection is a potential complication of the procedure, there is another action that is priority.

C. Check the drainage for glucose.

Rationale: A potential complication of hypophysectomy is cerebral spinal fluid (CSF) leakage. Fluid leakage from the nose is a sign that this complication has occurred. The first action the nurse should take using the nursing process is to assess the drainage for the presence of glucose, which would indicate that the drainage is CSF.

D. Notify the client's provider.

Rationale: Although the provider should be notified of the findings, there is another action that is priority.

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10. A nurse is caring for a client who reports a throbbing headache after a lumbar puncture. Which of the following actions is most likely to facilitate resolution of the headache?

A. Administer pain medication.

Rationale: A spinal headache following a lumbar puncture develops due to a leaking of the cerebrospinal fluid (CSF) which depletes the amount of circulating CSF and results in insufficient fluid to maintain the mechanical stability of the brain. While a medication for pain may help control the symptoms, it doesn't facilitate resolution of the headache.

B. Darken the client's room and close the door.

Rationale: The client who has a spinal headache experiences a throbbing headache that worsens with sitting or standing and is the result of a decreased amount of circulating CSF. Darkening the room and closing the door may assist in controlling the pain for the client who has a migraine, but it is not useful in the client who has a spinal headache.

C. Increase fluid intake.

Rationale: The client who has had a lumbar puncture is at risk for continued leaking of CSF from the puncture site. This results in a decreased amount of circulating CSF. Increasing fluids is helpful in quickly replacing the cerebrospinal fluid that was removed during the procedure and increasing fluids will facilitate resolution of the headache. The client should also be instructed to remain in a prone position for 6 hours to prevent leaking of CSF fluid.

D. Elevate the head of the bed to 30º.

Rationale: The client who has a spinal headache experiences a throbbing headache that worsens with sitting or standing and is the result of a decreased amount of circulating CSF. Resolution of the discomfort will occur by placing the client in a prone position. A client who has increased

intracranial pressure would be placed in a position with the head of the bed at 30º.

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11. A nurse in the post-anesthesia care unit is caring for a client who is postoperative following a thoracotomy and lobectomy. Which of the following postoperative assessments should the nurse give highest priority to?

A. Arterial blood gases

Rationale: According to the ABC priority-setting framework, the postoperative surgical client may need supplemental oxygen in order to maintain normal blood oxygen levels. The effectiveness of oxygenation is monitored using pulse oximetry and arterial blood gases.

B. Urinary output

Rationale: The nurse should monitor the client's urinary output in order to monitor fluid status and cardiac output of the client who is postoperative; however, there is another assessment that would take priority.

C. Chest tube drainage

Rationale: The nurse should monitor the amount and characteristics of chest tube drainage because drainage in excess of 70 mL/hr may indicate acute bleeding or require that administration of blood products. While this is an appropriate intervention, there is another intervention that would take priority.

D. Pain level

Rationale: The nurse should monitor for and treat pain in the client who is postoperative following a thoracotomy to provide comfort and to enhance the client's ability to deep breathe. However, there is another assessment that would take priority.

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12. A nurse is caring for a client who is postoperative following an open reduction and internal fixation of a fractured femur. Which of the following actions is the most important for the nurse to complete in the postoperative period?

A. Medicate the client for pain.

Rationale: The nurse should assess and treat the client for pain because uncontrolled pain has deleterious effects systemically, e.g., increased pulse and blood pressure, increased oxygen demand, and delayed healing. Medicating the client for pain is an appropriate nursing action, but another action is the priority.

B. Instruct the client on use of crutches.

Rationale: It will be important for the nurse to instruct the client on the proper use of crutches to avoid further injury; however, another action is the priority.

C. Perform neurovascular checks of the extremities.

Rationale: The priority action the nurse should take when using the airway, breathing, circulation approach to client care is the performance of neurovascular checks. These are a vital aspect of care for the client who has a sustained a fracture and should be monitored every hour for the first 24 hr. Circulation can easily become impaired due to constriction, which develops as the extremity

swells from edema. This may cause nerve damage and tissue anoxia.

D. Direct the client to perform exercises of the ankle and toes.

Rationale: The nurse should instruct the client to perform frequent exercises of the hip, ankle, and toes in order to preserve muscle strength. Active muscle movement also serves to enhance healing as blood supply to the injured extremity is increased; however, another action is the priority.

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13. A nurse in the emergency room is assessing a client who was brought in following a seizure. The nurse suspects the client may have meningococcal meningitis when assessment findings include nuchal rigidity and a petechial rash. After implementing droplet precautions, which of the following actions should the nurse initiate next?

A. Complete a vascular assessment.

Rationale: The nurse should assess the client's vascular status as the client with meningitis is at risk for thrombotic or embolic complications, most often affecting the hands. Assessment of temperature, color, pulses, and capillary refill should be performed every 4 hr; however, another action is the priority.

B. Administer an antipyretic.

Rationale: It will be important to treat and manage the elevated temperature in the client by administering antipyretics and using cooling blankets; however, another action is the priority.

C. Decrease environmental stimuli.

Rationale: A client who has meningitis will have photophobia and severe headaches. Decreasing the environmental stimuli by providing a quiet and darkened environment will assist in increasing the client's comfort; however, another action is the priority.

D. Assess the cranial nerves.

Rationale: The greatest risk to the client is from increased intracranial pressure (ICP) which may lead to herniation of the brain and death. The nurse should perform neurological assessments including evaluation of the cranial nerves at least every 4 hr. Early neurological changes to be monitoring for include a decrease in the level of consciousness, the development of Cushing's triad (severe hypertension, widened pulse pressure, and bradycardia), and changes in pupillary reaction.

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14. A nurse is caring for a client who has acute pancreatitis. After treating the client's pain, which of the following should the nurse address as the priority intervention?

A. Auscultate the client's lungs.

Rationale: Monitoring respiratory status is appropriate; however, another action is the priority.

B. Assist the client to a side-lying position.

Rationale: Encouraging a side-lying position with knees flexed is appropriate; however, another action is the priority.

C. Provide oral hygiene.

Rationale: Providing oral hygiene is appropriate and should be done frequently; however, another action is the priority.

D. Withhold oral fluids and food.

Rationale: To rest the pancreas and reduce secretion of pancreatic enzymes, NPO status must be initiated and maintained during the acute phase of pancreatitis. This is the priority intervention to address after the client's pain has been treated.

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15. A nurse in an emergency department is caring for a client who is bleeding profusely from a deep laceration on his left lower forearm. After observing standard precautions, which of the following actions should the nurse perform first?

A. Apply a tourniquet just below the elbow.

Rationale: The nurse should apply a tourniquet as a last resort to stop external extremity bleeding that is severe enough that the risk of limb viability is justified to save a life.

B. Apply direct pressure over the wound.

Rationale: The greatest risk to the client is injury from hemorrhage. Therefore, the first action the nurse should take is to apply firm pressure with a thick, dry dressing material directly over the wound to stop bleeding.

C. Clean the wound.

Rationale: The nurse should clean the wound after the bleeding is controlled.

D. Elevate the limb and apply ice.

Rationale: The nurse should elevate the limb after the bleeding is controlled.

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16. A nurse is caring for a client who has type 1 diabetes mellitus. The nurse misread the client's morning blood glucose level as 210 mg/dL instead of 120 mg/dL and administered the insulin dose appropriate for a reading over 200 mg/dL before the client's breakfast. Which of the following actions is the nurse's priority?

A. Give the client 15 to 20 g of carbohydrate.

Rationale: It might become necessary to administer a ready source of carbohydrate to counteract the effects of the excessive dose of insulin, but this is not the nurse's immediate priority.

B. Monitor the client for hypoglycemia.

Rationale: The first action the nurse should take using the nursing process is to assess or collect data from the client. The nurse should immediately check the client's blood glucose level, expecting it to be low because of the excessive dose of insulin. If it is within the expected reference range, the nurse should continue to monitor the client for signs of hypoglycemia.

C. Complete an incident report.

Rationale:

The nurse will have to complete an incident report detailing the medication error, but this is not the nurse's immediate priority.

D. Notify the nurse manager.

Rationale: The nurse will have to notify the nurse manager about the medication error, but this is not the nurse's immediate priority.

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17. A nurse is caring for a client who is unconscious following a cerebral hemorrhage. Which of the following nursing interventions is of highest priority?

A. Perform passive range of motion on each extremity.

Rationale: The nurse should perform passive range of motion for the client who is unconscious, to help prevent complications of impaired physical mobility; however, this is not the highest priority intervention according to the safety and risk reduction priority setting framework.

B. Monitor the client's electrolyte levels.

Rationale: The nurse should monitor the electrolyte levels for the client who is unconscious, to help identify complications of increased intracranial pressure and to limit the risk of cardiac dysrhythmia; however, this is not the highest priority intervention according to the safety and risk reduction priority setting framework.

C. Suction saliva from the client's mouth.

Rationale: The unconscious client is unable to independently maintain a clear airway and is at risk for ineffective airway clearance. According to the safety and risk reduction priority setting framework, maintaining the client's airway, breathing, and circulation is the highest priority.

D. Record the client's intake and output.

Rationale: The nurse should record the intake and output for the client who is unconscious, to help identify complications of altered neurological status and increased intracranial pressure; however, this is not the highest priority intervention according to the safety and risk reduction priority setting framework.

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18. A nurse is caring for a female client in the emergency department who reports shortness of breath and pain in the lung area. She states that she started taking birth control pills 3 weeks ago and that she smokes. Her heart rate is 110/min, respiratory rate 40/min, and blood pressure 140/80 mm Hg. Her arterial blood gases are pH 7.50, PaCO2 29 mm Hg, PaO2 60 mm Hg, HCO3 20 mEq/L, and SaO2 86%. Which of the following is the priority nursing intervention?

A. Prepare for mechanical ventilation.

Rationale: If the client cannot compensate for this acid-base imbalance and conservative treatment does not help, mechanical ventilation might become necessary; however, it is not the first step in managing this client's imbalance.

B. Administer oxygen via face mask.

Rationale:

The pH reflects alkalosis, and the low $PaCO_2$ indicates that the lungs are involved, so the client has respiratory alkalosis. The client's oxygen saturation is low, so one priority is to administer oxygen via mask attempting to achieve an oxygen saturation of at least 95%. The greatest risk to this client is hypoxia, thus the priority is to restore oxygenation.

C. Prepare to administer a sedative.

Rationale: In many cases, the cause of this acid-base disorder is extreme anxiety with hyperventilation and loss of CO_2, as evidenced by the client's respiratory rate of 40/min and her $PaCO_2$ of 29. A sedative will help relieve anxiety and slow her breathing enough to correct the acid-base imbalance. However, the greatest risk to the client is hypoxia, so administering a sedative is not the priority action.

D. Assess for indications of pulmonary embolism.

Rationale: Pulmonary embolism is a possible cause of this type of acid-base imbalance, particularly with the client's history of birth control pills and smoking, so the nurse should be alert for manifestations of this disorder. However, this is part of ongoing client monitoring and not the first step in managing the imbalance.

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19. A nurse is preparing an adolescent client who has pneumonia for percussion, vibration, and postural drainage. Prior to the procedure, which of the following nursing actions should the nurse complete first?

A. Auscultate lung fields.

Rationale: The first action the nurse should take when using the airway, breathing, circulation (ABC) approach to client care is to auscultate lung fields to provide knowledge of which lung areas are most affected and would be the focus of the procedure.

B. Assess pulse and respirations.

Rationale: The nurse should assess vital signs every shift and during the procedure to determine the client's tolerance to positioning, but this is not the first actions the nurse should take.

C. Assess characteristics of her sputum.

Rationale: The nurse should assess the characteristics of the sputum following the procedure, but this is not the first action the nurse should take.

D. Instruct to slowly exhale with pursed lips.

Rationale: The nurse should instruct the client to slowly exhale with pursed lips and use diaphragmatic breathing techniques to expel mucus during and following the procedure, but this is not the first action the nurse should take.

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20. A nurse is caring for a child on the oncology unit. The child's parents are asking the nurse about the cancer diagnosis. Which of the following information should the nurse provide the parents about the most common malignant renal and intra-abdominal tumor of childhood?

A. Ewing sarcoma

Rationale:

Ewing sarcoma is the second most common malignant bone tumor in children and adolescents. It arises in the marrow spaces of the bones, such as the femur, tibia, fibula, ulna, humerus, pelvis, ribs, and skull.

B. Osteosarcoma

Rationale: Osteosarcoma is the most frequent malignant bone cancer in children with a peak incidence between 10 to 25 years of age.

C. Neuroblastoma

Rationale: Neuroblastoma is the most common malignant extracranial solid tumor in children.

D. Wilms' tumor

Rationale: Wilms' tumor, or nephroblastoma, is the most common malignant renal and intra-abdominal tumor of childhood.

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21. 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.

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22. A nurse is caring for a group of adolescents. Which of the following findings should be reported to the provider immediately?

A. A who is client 1 day postoperative and has a temperature of 37.5° C (99.5° F)

Rationale: It is not unusual for a client to develop a slightly elevated temperature after surgery related to inflammation and trauma. The nurse should observe for sources of infection, such as the surgical wound, lungs, or urine. The nurse should initiate care to prevent infection at these

sites, such as aseptic wound care, coughing or deep breathing, incentive spirometer use, and catheter care. If the client's temperature exceeds 38.9° C (102° F), the nurse should contact the provider.

B. A client who has a burn injury to an estimated 5% his leg and is crying

Rationale: Crying is not a reason to call the provider immediately. The nurse should talk with the client to discover more about the crying and provide appropriate care. The nurse should not assume why the client is crying. The cause could be pain, concerns about body image, or reasons unrelated to the burn.

C. A client's blood pressure changes from 112/60 mm Hg to 90/54 mm Hg when standing

Rationale: Vital sign ranges for adolescents are similar to those for adults. A drop in the systolic blood pressure of more than 20 mm Hg or a drop in the diastolic of more than 10 mm Hg after standing is considered to be orthostatic hypotension. One of the most common causes of orthostatic hypotension is hypovolemia. The client likely will feel lightheaded and dizzy. This finding should be reported to the provider.

D. A client who has an ankle fracture reports a pain level increase from 3 to 5 after initial ambulation

Rationale: An increase in the level of pain with ambulation is expected. The nurse should check to see what interventions have been implemented and provide additional pain relief as needed.

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23. A nurse is reviewing data for four children. Which of the following children should the nurse assess first?

A. A 10-year-old child who has sickle cell anemia who reports severe chest pain

Rationale: When using the urgent vs. nonurgent approach to client care, the nurse should determine that the 10-year-old child who has sickle cell anemia and reports severe chest pain should be assessed first. This finding is a medical emergency because it is a manifestation of acute chest syndrome.

B. A 7-year-old child who has diabetes insipidus and a urine specific gravity of 1.016

Rationale: A specific gravity of 1.016 is nonurgent because it is within the expected reference range for a 7 year-old child. There is another child the nurse should assess first.

C. A 1-year-old toddler who has roseola and a temperature of 39° C (102.2° F)

Rationale: A temperature of 39° C (102.2° F) is nonurgent because it is an expected finding of roseola. There is another child the nurse should assess first.

D. A 4-year-old child who has asthma and a PCO2 of 37 mm Hg

Rationale: A PCO2 of 37 mm Hg is a nonurgent finding because it is within the expected reference range for a 4 year-old child. There is another child the nurse should assess first.

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24. A nurse reports an incident of suspected child abuse. One of the parents of the child becomes upset and demands to know the reason for the nurse's action. Which of the following responses by the nurse is appropriate?

- A. "As a nurse, I am required by law to report suspected child abuse."

  Rationale: A nurse is required by law to report suspected child abuse. Therefore, this is a truthful, non-accusatory response.

- B. "I am unable to discuss this, but I can contact my supervisor to speak with you."

  Rationale: This response defers to another authority figure, rather than providing the parent with an answer.

- C. "The provider will be coming to explain the situation."

  Rationale: This response does not answer the parent's concern. Although the provider will speak with the family, the nurse should address the parent's question.

- D. "I reported the incident to my supervisor who decided to contact the authorities."

  Rationale: Although a nurse supervisor can assist with the process, the nurse is mandated to report suspected child abuse.

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25. A nurse is planning to apply a transdermal analgesic cream prior to inserting an IV for a preschool-age child. Which of the following actions should the nurse plan to take? (Select all that apply.)

- A. Spread the cream over the lateral surface of both forearms.
- B. Apply to intact skin.
- C. Apply the medication an hour before the procedure begins.
- D. Cleanse the skin prior to procedure.
- E. Use a visual pain rating scale to evaluate effectiveness of the treatment.

Rationale: Spread the cream over the lateral surface of both forearms is incorrect. The nurse should apply the smallest amount of cream to the smallest area required to reduce the risk for systemic toxicity. Systemic effects of the anesthetic include bradycardia, heart block, and seizures.Apply to intact skin is correct. The nurse should apply cream over intact skin to reduce the risk for systemic toxicity. The nurse should wear gloves while applying the cream to reduce the risk of absorbing the anesthetic.Apply the medication an hour before the procedure begins is correct. The nurse should allow 30 min to 1 hr for the topical analgesic to take effect.Cleanse the skin prior to procedure is correct. Apply the topical analgesic to clean skin to increase absorption.Use a visual pain rating scale to evaluate effectiveness of the treatment is correct. A childs response and understanding of pain depends on the childs age and stage of development. A preschooler might be unable to describe pain due to a limited vocabulary. Use a visual scale (FACES or OUCHER Scale) with faces or colors to assess evaluate the effectiveness of the treatment.

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26. A nurse is caring for a client who has Cushing's syndrome. The nurse should recognize that which of the following are manifestations of Cushing's syndrome? (Select all that apply.)

- A. Alopecia

B. Tremors

C. Moon face

D. Purple striations

E. Buffalo hump

Rationale: **Alopecia is incorrect.** Clients who have Cushing's syndrome have hirsutism, which is excessive body hair, rather than alopecia, which is hair loss.

Tremors is incorrect. Tremors are not a common manifestation of Cushing's syndrome.

Moon face is correct. Moon face, which is manifested by a round, red, full face, is a common manifestation of Cushing's syndrome.

Purple striations is correct. Purple striations on the skin of the abdomen, thighs, and breasts are common manifestations of Cushing's syndrome.

Buffalo hump is correct. Buffalo hump, which is a collection of fat between the shoulder blades, is a common manifestation of Cushing's syndrome.

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27. A nurse is preparing a client for surgery. Prior to administering the prescribed hydroxyzine, the nurse should explain to the client that the medication is for which of the following indications? (Select all that apply.)

A. Controlling emesis

B. Diminishing anxiety

C. Reducing the amount of narcotics needed for pain relief

D. Preventing thrombus formation

F. Drying secretions

Rationale: Controlling emesis is correct. Hydroxyzine is an effective antiemetic that may be used to control nausea and vomiting in preoperative and postoperative clients.Diminishing anxiety is correct. Hydroxyzine is an effective antianxiety agent that may be used to diminish anxiety in surgical clients, as well as in clients who have moderate anxiety.Reducing the amount of narcotics needed for pain relief is correct. Hydroxyzine potentiates the actions of narcotic pain medications; therefore, narcotic requirements may be significantly reduced.Preventing thrombus formation is incorrect. Hydroxyzine, an antihistamine, has no role in the prevention of thrombi.Drying secretions is correct. Hydroxyzine, an antihistamine, commonly causes drying of the oral mucous membranes.

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28. A nurse is caring for a client who was admitted with acute psychosis and is being treated with haloperidol. The nurse should suspect that the client may be experiencing tardive dyskinesia when the client exhibits which of the following? (Select all that apply.)

A. Urinary retention and constipation

- B. Tongue thrusting and lip smacking
- C. Fine hand tremors and pill rolling
- D. Facial grimacing and eye blinking
- F. Involuntary pelvic rocking and hip thrusting movements

Rationale: Urinary retention and constipation is incorrect. Haloperidol can cause anticholinergic effects, such as dry mucous membranes, urinary retention, and constipation. However, these are not manifestations of tardive dyskinesia.Tongue thrusting and lip smacking is correct. Individuals who have tardive dyskinesia make repetitive and uncontrollable movements such as tongue thrusting and lip smacking.Fine hand tremors and pill rolling is incorrect. The side effects of haloperidol can include extrapyramidal (parkinsonian) symptoms, such as fine hand tremors and pill rolling. However, these are not manifestations of tardive dyskinesia.Facial grimacing and eye blinking is correct. Individuals who have tardive dyskinesia make repetitive and uncontrollable movements such as facial grimacing and eye blinking.Involuntary pelvic rocking and hip thrusting movements is correct. Repetitive, irregular, and involuntary movements of the head, neck, trunk, and extremities can occur in tardive dyskinesia.

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29. A nurse is caring for an older adult client who has had surgery for an intestinal obstruction and has an NG tube to wall suction. Which of the following interventions should the nurse include in the client's postoperative plan of care? (Select all that apply.)

- A. Discontinue suction when assessing for peristalsis
- B. Irrigate the NG tube with 0.9% sodium chloride irrigation solution.
- C. Place sequential compression devices on the bilateral lower extremities.
- D. Reposition the client from side to side every 2 hr.
- E. Encourage the use of an incentive spirometer every 2 hr while the client is awake.

Rationale: Discontinue suction when assessing for peristalsis is correct. The nurse should turn off suction while auscultating the abdomen to determine the return of peristalsis because the suction masks any present bowel sounds.Irrigate the NG tube with 0.9% sodium chloride irrigation solution is correct. The client requires the NG tube for gastric decompression, so the nurse must make sure it remains patent. Irrigating the NG tube with normal saline irrigation solution every 4 hr will ensure patency.Place sequential compression devices on the bilateral lower extremities is correct. Sequential compression devices improve blood flow for clients who have mobility limitations and help prevent venous thromboembolism in the lower extremities.Reposition the client from side to side every 2 hr is correct. The nurse should reposition the client from side to side at least every 2 hr but should also assist with early ambulation to improve ventilation and help mobilize secretions.Encourage the use of an incentive spirometer every 2 hr while the client is awake is incorrect. Use of the incentive spirometer helps prevent atelectasis. The client should use the device each hour while awake.

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30. A nurse and an experienced licensed practical nurse (LPN) are caring for a group of clients. Which of the following tasks should the nurse delegate to the LPN? (Select all that apply.)

A. Provide discharge instructions to a confused client's spouse.

B. Obtain vital signs from a client who is 6 hr postoperative.

C. Administer a tap-water enema to a client who is preoperative.

D. Initiate a plan of care for a client who is postoperative from an appendectomy.

E. Catheterize a client who has not voided in 8 hr.

Rationale: Providing discharge instructions to a confused client's spouse is incorrect. The nurse is responsible for delegating a task to the person who has proper training and skill. Client education is the responsibility of the registered nurse.Obtaining vital signs from a client who is 6 hr postoperative is correct. Obtaining is a task that is appropriate to the education and skills of an LPN.Administering a tap-water enema to a client who is preoperative is correct. Administering a tap-water enema is a task that is appropriate to the education and skills of an LPN.Initiating a plan of care for a client who is postoperative from an appendectomy is incorrect. Planning care is the responsibility of the registered nurse.Catheterizing a client who has not voided in 8 hr is correct. Urinary catheterization is a task that is appropriate to the education and skills of an LPN.

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31. A nurse is teaching a class of older adults about the expected physiologic changes of aging. Which of the following changes should the nurse include in the discussion? (Select all that apply.)

A. More difficulty seeing due to a greater sensitivity to glare

B. Decreased cough reflex

C. Decreased bladder capacity

D. Decreased systolic blood pressure

E. Dehydration of intervertebral discs

Rationale: More difficulty seeing due to a greater sensitivity to glare is correct. Older adults have an increased susceptibility to glare, greater difficulty in seeing at low levels of illumination, and alterations in color perception.Decreased cough reflex is correct. Older adults have a decreased cough reflex, increased airway resistance, fewer alveoli, and a greater risk for respiratory infections.Decreased bladder capacity is correct. Older adults have a decreased bladder capacity and a reduction in renal blood flow.Decreased systolic blood pressure is incorrect. Older adults have increased systolic blood pressure, thickening of blood-vessel walls, and decreased peripheral circulation.Dehydration of intervertebral discs is correct. Older adults have dehydration of intervertebral discs, decreased muscle strength and mass, and decalcification of bones.

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32. A nurse is caring for an adolescent who is experiencing indications of depression. Which of the following findings should the nurse expect? (Select all that apply.)

A. Irritability

B. Euphoria

- C. Insomnia
- D. Low self-esteem
- F. Chronic pain

Rationale: Depressed teens are often irritable, taking out much of their anger on their friends and family. Signs include being critical, sarcastic, or abusive, and appearing restless, agitated, and angry. Euphoria, or a feeling of well-being or elation, is not associated with depression; it is associated with the manic phase of bipolar disorder. Insomnia (too little sleep) and hypersomnia (too much sleep) are two sleep pattern disturbances that may be associated with depression. A depressed teen may also complain of chronic or persistent fatigue, regardless of the amount of sleep they get. Low self-esteem is one of the most common causes of teen depression. Teens who have trouble in school are at a higher risk for depression than kids who do well in school. Somatic, or physical, symptoms of depression are common in teens. Chronic pain that is not caused by physical disease most often includes headaches and stomachaches.

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33. A nurse in a mental health clinic is caring for a client who has bipolar disorder and a prescription for an antipsychotic medication. The provider and nursing staff suspect the client is not adhering to his medication therapy. Which of the following interventions should the staff use to encourage the client's adherence? (Select all that apply.)

- A. Perform mouth checks following the administration of the medication.
- B. Provide for once-daily dosing.
- C. Use sustained-release forms.
- D. Engage the client in conversation following medication administration.
- E. Rotate staff that administer the medications.

Rationale: Perform mouth checks following the administration of medication is incorrect. Mouth checks may not find pills that the client has hidden in his mouth.Provide for once-daily dosing is correct. Once-daily dosing of medications simplifies the therapy, making it easier for the client to comply.Use sustained-release forms is correct. Sustained-release forms remain in the client's system longer, requiring less frequent dosing.Engage the client in conversation following medication administration is correct. If the client is speaking, he will be less likely able to hide the medication in his mouth.Rotate staff that administers the medications is incorrect. Rotating treatment providers is an obstacle that increases the risk of a client's nonadherence to therapy.

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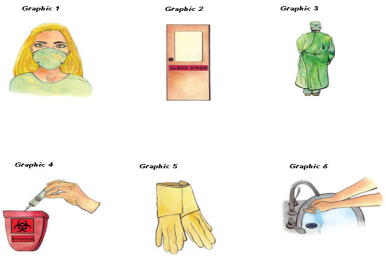
34. A nurse is caring for a client who requires isolation for active pulmonary tuberculosis. Which of the following precautions should the nurse include when creating a sign to post outside of the client's room? (Select all that apply.)



- A.
- B.
- C.
- D.
- F.

Rationale: A protective mask is correct. Clients who have active pulmonary tuberculosis require airborne precautions. Everyone entering the room requires respiratory protection, in the form of an appropriate filtration mask.A closed door is correct. Clients who have active pulmonary tuberculosis require airborne precautions. Everyone entering or leaving the room should close the door behind them.A gown is incorrect. Gowns are unnecessary for every individual entering the room; however, any staff who anticipate contact with body fluids should wear them.A puncture-proof sharps container is correct. Nurses must always dispose of needles and sharp instruments in puncture-proof sharps containers.Hand hygiene is correct. Hand hygiene is essential before and after all contact with clients.

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35. A nurse on a medical unit is planning care for an older adult client who takes several medications. Which of the following prescribed medications places the client at risk for orthostatic hypotension? (Select all that apply.)

- A. Furosemide
- B. Telmisartan
- C. Duloxetine
- D. Clopidogrel
- E. Atorvastatin

Rationale: Furosemide is correct. This medication is used to reduce edema and hypertension, and an adverse effect is orthostatic hypotension.Telmisartan is correct. This medication is used to control hypertension, and an adverse effect is orthostatic hypotension.Duloxetine is correct. This medication is used to treat depression and anxiety disorder, and an adverse effect is orthostatic hypotension.Clopidogrel is incorrect. This medication is used to reduce the risk of MI and stroke and does not cause orthostatic hypotension.Atorvastatin is incorrect. This medication is used to decrease cholesterol and does not cause orthostatic hypotension.

36. A nurse in a prenatal clinic is completing a skin assessment of a client who is in the second trimester. Which of the following findings should the nurse expect? (Select all that apply.)

    A. Eczema

    B. Psoriasis

    C. Linea nigra

    D. Chloasma

    E. Striae gravidarum

    Rationale: Eczema is incorrect. Eczema manifests as red, swollen, and itchy skin and is not an expected finding during pregnancy.Psoriasis is incorrect. Psoriasis manifests as thick red patches or plagues covered by silver scales on the skin and is not an expected finding during pregnancy.Linea nigra is correct. Linea nigra manifests as a line of pigmentation extending from the symphysis pubis to the top of the fundus and is an expected finding during pregnancy.Chloasma is correct. Chloasma, or the mask of pregnancy, manifests as blotchy, brownish hyperpigmentation of the skin over the forehead, nose, and cheeks and is an expected finding during pregnancy.Striae gravidarum is correct. Striae gravidarum, or stretch marks, occur because of the separation of underlying connective tissue on the breasts, thighs, and abdomen. They are an expected finding during pregnancy.

37. A nurse is working with a team of nursing personnel within a facility. Which of the following are necessary task performance roles that members of the group or the leader must perform? (Select all that apply.)

    A. Self-confessor

    B. Coordinator

    C. Evaluator

    D. Energizer

    E. Dominator

    Rationale: Self-confessor is incorrect. Self-confessor is a role that some group members use to meet a need for personal expression. It is not a role that must be performed.Coordinator is correct. Coordinator is a task performance role that focuses on clarification and coordination of ideas.Evaluator is correct. Evaluator is a task performance role that focuses on comparing group accomplishments with expected standards.Energizer is correct. Energizer is a task performance role that focuses on stimulating the group to higher levels of action.Dominator is incorrect. Dominator is a role that some group members use in attempting to gain control and manipulate a group. It is not a role that must be performed.

38. A nurse is receiving a provider's prescription for a client via telephone. Which of the following actions should the nurse take to ensure the accuracy of the telephone prescription? (Select all that apply.)

- A. Repeat the order back to the provider.
- B. Question any part of the order that is unclear or inappropriate.
- C. Transcribe the order into the client's health record.
- D. Obtain the provider's signature within 8 hr.
- E. Implement a recorded order message if the nurse can hear and understand it clearly.

Rationale: Repeat the order back to the provider is correct. The nurse should read the order back and have the provider verbally confirm that it is correct.Question any part of the order that is unclear or inappropriate is correct. The nurse should question any part of the prescription or an order that is unclear or inappropriate. This is essential for any verbal or written prescription or order.Transcribe the order into the clients health record is correct. The prescription should be entered in the health record as it is obtained and verified.Obtain the providers signature within 8 hr is incorrect. Although the policy may vary with each facility, the usual rule is to obtain the providers signature within 24 hr.Implement a recorded order message if the nurse can hear and understand it clearly is incorrect. If a provider leaves a recorded order message, the nurse should call the provider and obtain the prescription verbally over the telephone.

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39. A nurse is teaching staff which factors to include in an abuse assessment of a client. Which of the following factors should the nurse include in the teaching? (Select all that apply.)

- A. Suicide risk
- B. Socioeconomic status
- C. Coping patterns
- D. Support systems
- E. Alcohol use

Rationale: Suicide risk is correct. The person may feel desperate and trapped and view suicide as the only option. Any risk of harm to the client or to other people should be included in the assessment. Socioeconomic status is incorrect. Abuse can occur in all levels of socioeconomic status; therefore, it is not necessary to include this in an abuse assessment. Coping patterns is correct. Coping patterns should be included in an abuse assessment to assess family strengths and stressors. Support systems is correct. Support systems should be included in an abuse assessment, as the person may be in a dependent and isolated situation and unaware of available support. Alcohol use is correct. Alcohol and drug use should be included in an abuse assessment, as the person may self-medicate to escape the situation.

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40. A nurse is discussing indications for urinary catheterization with a newly licensed nurse. Which of following indications should the nurse include? (Select all that apply).

- A. Relief of urinary retention
- B. Convenience for the nursing staff or the client's family

- C. Measurement of residual urine after urination
- D. Routine acquisition of a urine specimen
- E. An open perineal wound

Rationale: **Relief of urinary retention is correct.** Valid indications for urinary catheterization include urinary retention, bladder distention, management of urinary elimination for clients who have spinal cord injuries, and prevention of urethral obstruction from blood clots following genitourinary surgery.

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41. A nurse is teaching a newly licensed nurse about the risk factors for dehiscence for clients who have surgical incisions. Which of the following factors should the nurse include in the teaching? (Select all that apply.)

- A. Poor nutritional state
- B. Altered mental status
- C. Obesity
- D. Pain medication administration
- E. Wound infection

Rationale: Poor nutritional state is correct. A client who is in a poor nutritional state is at risk for dehiscence due to impaired healing.Altered mental status is incorrect. Altered mental status is not a risk factor for dehiscence. Obesity is correct. A client who is obese is at risk for dehiscence due to poor healing abilities of adipose tissue and the constant strain placed on the incision. Pain medication administration is incorrect. A client who is taking pain medication is not at risk for dehiscence.Wound infection is correct. A client who has a wound infection is at risk for dehiscence due to delayed healing.

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42. A nurse is caring for a client who is 2 days postpartum, is breastfeeding, and reports nipple soreness. Which of the following measures should the nurse suggest to reduce discomfort during breastfeeding? (Select all that apply.)

- A. Apply breast milk to the nipples before each feeding.
- B. Place breast pads inside the nursing bra.
- C. Massage the breasts and nipples prior to feeding.
- D. Start breastfeeding with the nipple that is less sore.
- E. Change the infant's position on the nipples.

Rationale: Apply breast milk to the nipples before each feeding is correct.The application of colostrum and breast milk to the nipples moistens them and prepares them for breastfeeding. This can prevent and reduce nipple tenderness.Place breast pads inside the nursing bra is incorrect. Sore nipples should be exposed to the air as much as possible. The use of breast shells or cups inside the nursing bra is another option to reduce discomfort.Massage the breasts and nipples prior to feeding is incorrect. Massage can irritate nipple tissue. Massage is effective in

promoting emptying of the engorged breast.Start breastfeeding with the nipple that is less sore is correct. The client who is breastfeeding should start with the nipple that is less sore, as the newborns initial sucking motions are the strongest.Change the infants position on the nipples is correct. Changing the newborns position on the nipples reduces discomfort and prevents nipple soreness. Repositioning of the mother can also prevent nipple discomfort.

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43. A nurse is providing dietary teaching to a client who has chronic kidney disease (CKD).The nurse should instruct the client to limit which of the following nutrients? (Select all that apply.)

- A. Protein
- B. Calcium
- C. Calories
- D. Phosphorous
- E. Sodium

Rationale: Protein is correct. A client who has CKD should restrict protein intake to prevent uremia that can develop as a result of the kidneys' inability to remove the waste products of protein.Calcium is incorrect. A client who has CKD is at risk for hypocalcemia due to an alteration in the conversion of vitamin D by the kidneys.Calories is incorrect. A client who has CKD requires adequate calories to meet metabolic needs.Phosphorous is correct. A client who has CKD is at risk for hyperphosphatemia due to a reduction in excretion of phosphorous by the kidneys.Sodium is correct. A client who has CKD is at risk for hypernatremia, edema, and hypertension due to sodium retention.

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44. A nurse is caring for an adolescent who has spina bifida and is paralyzed from the waist down. Which of the following statements by the client should indicate to the nurse a need for further teaching?

- A. "I only need to catheterize myself twice every day."

  Rationale: The client has paralysis from the level of the defect down. In the majority of cases, this condition affects bladder and bowel continence. Catheterization should be performed every 4 hr. Infrequent emptying of the bladder can result in stasis and urinary tract infections.

- B. "I carry a water bottle with me because I drink a lot of water."

  Rationale: Extra fluids help to maintain fluid balance and flush the body's urinary system. Since the client who has spina bifida is at an increased risk for urinary tract infection, maintaining an increased fluid intake is appropriate.

- C. "I use a suppository every night to have a bowel movement."

  Rationale: Using a suppository to stimulate a bowel movement every 1 to 2 days is appropriate.

- D. "I do wheelchair exercises while watching TV."

  Rationale: Wheelchair exercises maintain skin condition and upper body strength. Since the client who has spina bifida is at an increased risk for impaired skin integrity, frequently shifting positions

while in the wheelchair is appropriate.

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45. A nurse is caring for a client who is dying of metastatic breast cancer. She has a prescription for an opioid pain medication PRN. The nurse is concerned that administering a dose of pain medication might hasten the client's death. Which of the following ethical principles should the nurse use to support the decision not to administer the medication?

A. Utilitarianism

Rationale: Utilitarianism refers to actions that are right when they contribute to the greatest good.

B. Nonmaleficence

Rationale: Nonmaleficence is the duty to do no harm. The ethical mandate of nonmaleficence is that health care workers refrain from intentionally inflicting harm to clients.

C. Fidelity

Rationale: Fidelity is the duty to keep one's promises or word. It refers to the obligation to be faithful to the agreements, commitments, and responsibilities that one has made to oneself and others.

D. Veracity

Rationale: Veracity is the duty to tell the truth. It means that one does not intentionally deceive or mislead clients.

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46. A nurse is teaching a client who has diabetes about which dietary source should provide the greatest percentage of calories. Which of the following statements indicates the client understands the teaching?

A. “Most of my calories each day should be from fats.”

Rationale: The client who has diabetes should limit the intake of fats.

B. “I should eat more calories from complex carbohydrates than anything else.”

Rationale: The client who has diabetes should consume the majority of calories from complex carbohydrates, such as whole grains, fruits, and vegetables.

C. “Simple sugars are needed more than other calorie sources.”

Rationale: The client who has diabetes should limit intake of simple sugars, such as foods containing sucrose.

D. “Protein should be my main source of calories.”

Rationale: The client who has diabetes should consume 10% to 35% of total calories from protein sources.

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47. A nurse tells another nurse that she thinks he did not provide adequate care for a client who underwent hip arthroplasty. Which of the following responses by the nurse demonstrates assertiveness?

A. "I feel as though I met the standard of care. Would you tell me more about your concerns?"

Rationale: Communicating assertively is expressing thoughts in an open, honest, and direct manner that demonstrates respect for self and others. The use of "I" statements, maintaining eye contact, and congruent verbal and facial expressions are all components of assertiveness skills. The nurse demonstrates respect for the opinion of the other nurse by asking for feedback and the reason for the concerns.

B. "You shouldn't make accusations. Your nursing care doesn't always set a good example."

Rationale: This response is aggressive because the nurse is directly insulting the other nurse.

C. "I am at a loss for words. I always do my best to give good care to my clients."

Rationale: This response is submissive because the nurse is accepting the opinion of the other nurse without regard to his own opinions.

D. "What do you have against me? It must be something or you wouldn't be criticizing my care."

Rationale: This response is aggressive because the nurse is disregarding and insulting the other nurse.

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48. A charge nurse is observing a nurse insert an indwelling urinary catheter into a female client. For which of the following actions by the nurse should the charge nurse intervene?

A. The nurse separates the client's labia with her dominant hand.

Rationale: The nurse should use her non-dominant hand to separate the labia, or to hold the penis in male clients. The dominant hand is the hand that should handle the catheter during insertion and when filling the balloon. If the nurse separated the labia with her dominant hand, it would be more difficult to insert the catheter in a sterile environment and could result in introduction of bacteria into the urinary tract.

B. The nurse coats the indwelling urinary catheter with lubricant.

Rationale: The nurse should coat the catheter tip with a water-soluble lubricant to reduce the risk for tissue trauma and discomfort.

C. The nurse provides perineal care prior to inserting the urinary catheter.

Rationale: The nurse should provide perineal care prior to inserting the urinary catheter. Providing perineal care to the client prior to insertion of the urinary catheter allows the nurse time to visualize the meatus and to reduce the risk of introducing bacteria into the urinary tract.

D. The nurse applies the sterile drape prior to inserting the urinary catheter.

Rationale: The nurse should apply a sterile drape and should don sterile gloves prior to inserting the urinary catheter to reduce the risk of introducing bacteria into the urinary tract.

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49. A nurse has received morning report on the following four clients. Which of the following clients should the nurse assess first?

A. A client who was administered adalimumab for Crohn's disease, has a serum calcium level of 10 mg/dL, and reports a headache

Rationale: Crohn's disease is a chronic disorder and a serum calcium level of 10 mg/dL is within the expected reference range. Although the nurse should address the needs of this client, there is another client the nurse should assess first.

B. A client who was administered glipizide for type 2 diabetes mellitus and has a blood glucose of 68 mg/dL

Rationale: When using the acute vs. chronic approach to client care, the nurse should first assess the client who has diabetes and takes glipizide. An adverse effect of glipizide is hypoglycemia and a blood glucose level of 68 mg/dL is below the expected reference range; therefore, this is the client the nurse should assess first.

C. A client who was administered erythromycin for acute glomerulonephritis and reports reddish-brown urinary output

Rationale: Expected findings for a client who has acute glomerulonephritis include hematuria, decreased urine output, and proteinuria. Although the nurse should address the needs of this client, there is another client the nurse should assess first.

D. A client who was administered acyclovir for cellulitis reports pain in the affected leg

Rationale: Expected findings for a client who has cellulitis include pain, erythema, and warmth in the affected area. Although the nurse should address the needs of this client, there is another client the nurse should assess first.

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50. A charge nurse is providing an inservice for staff nurses on the use of new IV pumps. Which of the following actions should the charge nurse take to best evaluate staff competency with the new equipment?

A. Ask each nurse to read the procedure and sign a form acknowledging competency.

Rationale: The charge nurse should ask each nurse to read the procedure and sign a form to acknowledge competency. However, evidenced-based practice indicates another action better evaluates competency with a psychomotor skill.

B. Allow time during the workday when each nurse can demonstrate proficiency.

Rationale: According to evidenced-based practice, the best action to evaluate competency with a psychomotor skill is by return demonstration. Ensuring that each nurse knows how to use the equipment through return demonstration is the best way to measure correct use of the new equipment. Prior to full implementation of any new equipment, the supervisory team should allow time for training and proficiency checks to ensure that client care is not compromised.

C. Require each nurse to take a written examination about the new equipment.

Rationale: The nurse should ask each nurse to take a written examination about the new equipment to acknowledge competency. However, evidenced-based practice indicates another action better evaluates competency with a psychomotor skill.

D. Verbally question the staff about the new equipment.

Rationale:

The nurse should verbally question the staff about the new equipment to acknowledge competency. However, evidenced-based practice indicates another action better evaluates competency with a psychomotor skill.