Detailed Answer Key
LVN-RN Med-Surg NCLEX Practice

1. A nurse in the emergency department is implementing a plan of care for a conscious client who has a suspected cervical cord injury. Which of the following immediate interventions should the nurse implement? (Select all that apply.)

- A. Hypotension
- B. Polyuria
- C. Hyperthermia
- D. Absence of bowel sounds
- E. Weakened gag reflex

Rationale: Hypotension is correct. Lack of sympathetic input can cause a decrease in blood pressure. The nurse should maintain the client's SBP at 90 mm Hg or above to adequately perfuse the spinal cord.Polyuria is incorrect. The nurse should check the client for bladder distention and inability to urinate due to ineffective function of the bladder muscles.Hyperthermia is incorrect. The nurse should monitor the client for hypothermia caused by a lack of lack of sympathetic input.Absence of bowel sounds is correct. Spinal shock leads to decreased peristalsis, which could cause the client to develop a paralytic ileus.Weakened gag reflex is correct. The nurse should monitor the client for difficulty swallowing, or coughing and drooling noted with oral intake.

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2. A nurse is admitting a client who has acute pancreatitis. Which of the following provider prescriptions should the nurse anticipate?

A. Initiate a low-residue diet.

Rationale: One of the manifestations of acute pancreatitis is abdominal pain. The nurse should anticipate the provider will prescribe withholding of foods and fluids. This serves to manage the client's pain by limiting gastrointestinal activity and stimulation of the pancreas.

- B. Pantoprazole 80 mg IV bolus twice daily

Rationale: The nurse should anticipate a provider's prescription for a proton pump inhibitor to decrease gastric acid production, which ultimately decrease pancreatic secretions.

C. Ambulate twice daily.

Rationale: The nurse should anticipate a provider prescription for bed rest during the acute stage of pancreatitis. Bed rest decreases the metabolic rate and the secretion of pancreatic enzymes.

D. Pancrelipase 500 units/kg PO three times daily with meals

Rationale: The nurse should identify that pancrelipase, an enzyme replacement medication, is used in the treatment of clients who have chronic pancreatitis. It is not used in the treatment of acute pancreatitis.

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3. A nurse is admitting a client who has active tuberculosis to a room on a medical-surgical unit. Which of the following

room assignments should the nurse make for the client?

A. A room with air exhaust directly to the outdoor environment

Rationale: A room with air exhaust directly to the outside environment eliminates contamination of other client-care areas. This type of ventilation system is referred to as an airborne infection isolation room.

B. A room with another nonsurgical client

Rationale: A two-bed room with another nonsurgical client exposes the other client to tuberculosis. A client who has tuberculosis should have a private room.

C. A room in the ICU

Rationale: A client who has active tuberculosis and no other comorbidities is not critically ill.

D. A room that is within view of the nurses' station

Rationale: The client's room should be well ventilated and private, but it is not necessary for it to be close to the nurses' station.

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4. A nurse is caring for a client who has a new diagnosis of urolithiasis. Which of the following should the nurse identify as an associated risk factor?

A. Hypocalcemia

Rationale: Hypercalcemia is a risk factor associated with urolithiasis.

B. BMI less than 25

Rationale: Obesity, or having a BMI that is greater than 29, has been found to be a risk factor for the development of urolithiasis.

C. Family history

Rationale: Family history is strongly correlated with the formation of urolithiasis. A nurse should assess a client who has kidney stones for familial tendencies toward stone formation.

D. Diuretic use

Rationale: Medications such as antacids, vitamin D, laxatives, and aspirin have been associated with the formation of urolithiasis. However, there is no indication that the use of diuretics place a client at an increased risk for stone formation.

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5. A nurse is conducting a primary survey of a client who has sustained life-threatening injuries due to a motor-vehicle crash. Identify the sequence of actions the nurse should take. (Move the actions into the box on the right, placing them in the selected order of performance. Use all the steps.)

C. Open the airway using a jaw-thrust maneuver.

D. Determine effectiveness of ventilator efforts.

B. Establish IV access.

A. Perform a Glasgow Coma Scale assessment.

E. Remove clothing for a thorough assessment.

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6. A nurse is reviewing the arterial blood gas values of a client who has chronic kidney disease. Which of the following sets of values should the nurse expect?

A. pH 7.25, HCO3- 19 mEq/L, PaCO2 30 mm Hg

Rationale: The nurse should expect a client who has renal failure to have metabolic acidosis, which is characterized by a low HCO_3-, a low pH, and a low or normal $PaCO_2$. Expected reference ranges for these laboratory values are as follows: pH 7.35 to 7.45, HCO_3- 21 to 28 mEq/L, and $PaCO_2$ 35 to 45 mm Hg.

B. pH 7.30, HCO3- 26 mEq/L, PaCO2 50 mm Hg

Rationale: These values indicate respiratory acidosis, which is associated with respiratory disorders, such as pulmonary edema and pneumonia.

C. pH 7.50, HCO3- 20 mEq/L, PaCO2 32 mm Hg

Rationale: These values indicate respiratory alkalosis, which is associated with hyperventilation.

D. pH 7.55, HCO3- 30 mEq/L, PaCO2 31 mm Hg

Rationale: These values indicate metabolic alkalosis, which is associated with severe emesis or gastric suctioning.

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7. A nurse is assessing a client who has fluid overload. Which of the following findings should the nurse expect? (Select all that apply.)

A. Increased heart rate

B. Increased blood pressure

C. Increased respiratory rate

D. Increase hematocrit

E. Increased temperature

Rationale: **Increased heart rate is correct.** The nurse should expect the client who has fluid volume excess to have tachycardia and increased cardiac contractility in response to the excess fluid.

Increased blood pressure is correct. The nurse should expect the client who has fluid volume excess to have increased blood pressure and bounding pulse in response to the excess fluid.

Increased respiratory rate is correct. The nurse should expect the client who has fluid volume excess to have increase in respiratory rate and moist crackles heard in lungs.

Increased hematocrit is incorrect. The nurse should expect the client who has fluid volume deficit to have an elevated hematocrit because of hemoconcentration.

Increase temperature is incorrect. The nurse should expect the client who has fluid volume deficit to have an increase in temperature due to fluid loss.

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8. A nurse is caring for a client who has HIV. Which of the following laboratory values is the nurse's priority?

A. Positive Western blot test

Rationale: The client is already identified as HIV positive. Therefore, another value is the priority.

B. CD4-T-cell count 180 cells/mm3

Rationale: A CD4-T-cell count of less than 180 cells/mm^3 indicates that the client is severely immunocompromised and is at high risk for infection. Therefore, this value is the priority for the nurse to report to the provider.

C. Platelets 150,000/mm3

Rationale: The client's platelet count is within the expected reference range. Therefore, another value is the priority.

D. WBC 5,000/mm3

Rationale: The client's WBC count is within the expected reference range. Therefore, another value is the priority.

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9. A nurse is caring for an adolescent client who has a newly applied fiberglass cast for a fractured tibia. Which of the following is the priority action for the nurse to take?

A. Perform a neurovascular assessment.

Rationale: The greatest risk to the client is neurovascular injury. Therefore, the priority action is to perform a neurovascular assessment. This consists of assessing the involved extremity (the lower leg) at the most distal point (the foot) for circulation (color), motion (movement), and sensation, and can be remembered by the acronym "C-M-S check."

B. Explain the discharge instructions to the client and parents.

Rationale: It is important to explain discharge instructions to the client and parents. However, this is not the priority action.

C. Provide reassurance to the client and parents.

Rationale: It is important to provide reassurance to the client and parents. However, this is not the priority

action.

D. Apply an ice pack to the casted leg.

Rationale: It is important to apply an ice pack to the casted leg. However, this is not the priority action.

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10. A nurse is caring for an adolescent who has hemophilia A and is scheduled for wisdom teeth extractions. Prior to the procedure, the nurse should anticipate that the client will receive which of the following products?

A. Recombinant

Rationale: The underlying problem of hemophilia is a deficiency of clotting factors. Therefore, clients who have hemophilia are given recombinant to replace the deficient factor as a prophylactic measure before an invasive procedure, surgery, or when actively bleeding.

B. Packed RBCs

Rationale: Packed RBCs cannot provide the necessary clotting agents required for a client who has hemophilia A and is scheduled for an invasive procedure.

C. Prophylactic antibiotics

Rationale: Prophylactic antibiotics cannot provide the necessary clotting agents required for a client who has hemophilia A and is scheduled for an invasive procedure.

D. Fresh frozen plasma

Rationale: Fresh frozen plasma cannot provide the necessary clotting agents required for a client who has hemophilia A and is scheduled for an invasive procedure.

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11. A nurse is administering a tap water enema to a client who is constipated. During the administration of the enema, the client states he is having abdominal cramps. Which of the following actions should the nurse take to relieve the client's discomfort?

A. Lower the height of the solution container.

Rationale: If nausea or cramping occurs, the flow of water should momentarily be slowed or stopped by lowering the device or clamping the tubing. This allows the intestinal spasm to pass while leaving the catheter in place. The nurse should then continue administering the enema at a slower rate once the cramping has passed.

B. Encourage the client to bear down.

Rationale: Bearing down will cause early release of the fluid, decreasing the effectiveness of the enema.

C. Allow the client to expel some fluid before continuing.

Rationale: Allowing the client to expel solution too early in the procedure will decrease the effectiveness of the enema.

D. Stop the enema and document that the client did not tolerate the procedure.

Rationale:

Cramping is a normal response to an enema. There are actions the nurse can take to decrease the cramping.

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12. A nurse is completing discharge teaching with a client following arthroscopic knee surgery. Which of the following instructions should the nurse include in the teaching?

A. Remain on bedrest for the first 24 hr.

Rationale: When the client has recovered from sedation, the client will be allowed to walk, as tolerated, but should be instructed not to overuse or strain the joint for a few days.

B. Keep the leg in a dependent position.

Rationale: Elevating the affected area in the postoperative period (12 – 24 hr) reduces pain and swelling.

C. Apply ice to the affected area.

Rationale: Arthroscopy is a surgical procedure used to visualize, diagnose and treat problems inside a joint. Applying ice to the affected area in the immediate postoperative period (first 24 hr) reduces pain and swelling.

D. Begin active range of motion.

Rationale: Although the client will be allowed to walk as tolerated, joint use should be minimized for the first few days to reduce postoperative pain and swelling.

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13. A nurse is caring for a client who has emphysema. Which of the following findings should the nurse expect to assess in this client? (Select all that apply.)

A. Dyspnea

B. Bradycardia

C. Barrel chest

D. Clubbing of the fingers

E. Deep respirations

Rationale: Dyspnea is correct. Emphysema is a lung disease involving damage to the alveoli in which they become weakened and collapse. Dyspnea is seen in clients with emphysema as the lungs try to increase the amount of oxygen available to the tissues. Bradycardia is incorrect. With emphysema, the heart rate will increase as the heart tries to compensate for less oxygen to the tissues. Barrel chest is correct. Clients with emphysema lose lung elasticity; the diaphragm becomes permanently flattened by hyperinflation of the lungs; the muscles of the rib cage become rigid; and the ribs flare outward. This produces the barrel chest typical of emphysema clients. Clubbing of the fingers is correct. Clubbing results from chronic low arterial-oxygen levels. The tips of the fingers enlarge and the nails become extremely curved from front to back. Deep respirations is incorrect. Clients with emphysema lose lung elasticity and have muscle fatigue; consequently, respirations become increasingly shallow.

14. A nurse is assessing a client who is admitted for elective surgery and has a history of Addison's disease. Which of the following findings should the nurse expect?

A. Hyperpigmentation

Rationale: Addison's disease is an endocrine disorder that occurs when the adrenal glands do not produce enough of the hormone cortisol, and in some cases, the hormone aldosterone. The disease is characterized by weight loss, muscle weakness, fatigue, low blood pressure, and hyperpigmentation (darkening) of the skin in both exposed and non-exposed parts of the body.

B. Intention tremors

Rationale: Intention tremors may be seen in multiple sclerosis, a neuromuscular disorder that primarily affects the central nervous system.

C. Hirsutism

Rationale: Addison's disease results in loss of body hair, called vitiligo.

D. Purple striations

Rationale: Purple striations on the skin of the abdomen, thighs, and breasts are a common manifestation in Cushing's syndrome. Hyperpigmentation can be seen as well.

15. A nurse is assessing a client who sustained a basal skull fracture and notes a thin stream of clear drainage coming from the client's right nostril. Which of the following actions should the nurse take first?

A. Test the drainage for glucose.

Rationale: This is the priority nursing action. Because of the high risk of cerebral spinal fluid (CSF) leak in clients with basal skull fractures, the nurse should realize there is a possibility that the clear fluid coming from the client's nostril is CSF, which will test positive for glucose.

B. Suction the nostril.

Rationale: Although this action may eventually be required, the nurse does not have all the information necessary before implementing this action.

C. Notify the physician.

Rationale: Although this action may eventually be necessary, the nurse does not yet have all the information that the physician will require.

D. Ask the client to blow his nose.

Rationale: Although this action may eventually be indicated, the nurse does not have all the information necessary before implementing this action.

16. A nurse is caring for a client who is receiving total parenteral nutrition via a peripherally inserted central catheter

(PICC). When assessing the client, the nurse notes swelling of the client's arm above the PICC insertion site. Which of the following actions should the nurse take first?

A. Measure the circumference of both upper arms.

Rationale: The first action the nurse should take using the nursing process is to assess the client. The nurse should measure the arm and compare the result with the circumference of the other arm. If the arm is swollen, the nurse should notify the provider who inserted the PICC line. Swelling could indicate formation of a clot above the site or even catheter rupture.

B. Notify the provider who inserted the PICC line.

Rationale: The nurse should notify the provider to prescribe removing the catheter or initiating other treatment, such as low-dose thrombolytic therapy; however, there is another action the nurse should take first.

C. Remove the PICC line.

Rationale: It might become necessary to remove the PICC line, because swelling could indicate clot formation or catheter rupture; however, there is another action the nurse should take first.

D. Apply a cold pack to the client's upper arm.

Rationale: It might become necessary to apply a cold pack to the client's upper arm to help relieve the edema; however, there is another action the nurse should take first.

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17. 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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18. A nurse is assessing a client who is 48 hr postoperative following abdominal surgery. Which of the following findings should the nurse report to the provider?

A. Blood pressure 102/66 mm Hg

Rationale: The nurse should identify this finding as within the expected reference range.

B. Straw-colored urine from an indwelling urinary catheter

Rationale: Straw-colored urine is an expected finding. More information is needed to determine whether to take action in this case.

C. Yellow-green drainage on the surgical incision

Rationale: Thick yellow-green drainage is indicative of an infection and should be reported immediately.

D. Respiratory rate 18/min

Rationale: The nurse should identify this finding as within the expected reference range.

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19. A nurse is reviewing the EKG strip of a client who has prolonged vomiting. Which of the following abnormalities on the client's EKG should the nurse interpret as a sign of hypokalemia?

A. Abnormally prominent U wave

Rationale: Although U waves are rare, their presence can be associated with hypokalemia, hypertension and heart disease. For a client who has hypokalemia, the nurse should monitor the EKG strip for a flattened T wave, prolonged PR interval, prominent U wave, or ST depression.

B. Elevated ST segment

Rationale: The nurse should identify ST depression as an indication of hypokalemia.

C. Wide QRS

Rationale: The nurse should identify a widened QRS as an indication of hyperkalemia.

D. Inverted P wave

Rationale: Inverted P waves are associated with junctional rhythms.

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20. A nurse is monitoring a client who was admitted with a severe burn injury and is receiving IV fluid resuscitation therapy. The nurse should identify a decrease in which of the following findings as an indication of adequate fluid replacement?

A. BP

Rationale: Fluid resuscitation is provided to prevent hypovolemia; therefore, the nurse should identify a drop in blood pressure as a need for additional fluid.

B. Heart rate

Rationale:

When a client's circulating fluid volume is low, the heart rate increases to maintain adequate blood pressure. Therefore, the nurse should identify a decrease in heart rate as in indication of adequate fluid replacement.

C. Urine output

Rationale: Fluid resuscitation is provided to prevent hypovolemia; therefore, the nurse should identify a drop in urine output as a need for additional fluid.

D. Weight

Rationale: Fluid resuscitation is provided to prevent hypovolemia, and 1 L of water weighs about 1 kg (2.2 lb); therefore, the nurse should identify a drop in weight as a need for additional fluid.

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21. A client who has a history of myocardial infarction (MI) is prescribed aspirin 325 mg. The nurse recognizes that the aspirin is given due to which of the following actions of the medication?

A. analgesic

Rationale: Although aspirin does have an analgesic effect, cardiac clients who take 325 mg daily are taking it for a different purpose.

B. anti-inflammatory

Rationale: Although aspirin does have an analgesic effect, cardiac clients who take 325 mg daily are taking it for a different purpose.

C. antiplatelet aggregate

Rationale: Aspirin is used to decrease the likelihood of blood clotting. It also is used to reduce the risk of a second heart attack or stroke by inhibiting platelet aggregation and reducing thrombus formation in an artery, a vein, or the heart.

D. antipyretic

Rationale: Although aspirin does have an antipyretic effect, cardiac clients who take 325 mg daily are taking it for a different purpose.

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22. A nurse is caring for a client who is 1 day postoperative following a subtotal thyroidectomy. The client reports a tingling sensation in the hands, the soles of the feet, and around the lips. For which of the following findings should the nurse assess the client?

A. Chvostek's sign

Rationale: The nurse should suspect that the client has hypocalcemia, a possible complication following subtotal thyroidectomy. Manifestations of hypocalcemia include numbness and tingling in the hands, the soles of the feet, and around the lips, typically appearing between 24 and 48 hr after surgery. To elicit Chvostek's sign, the nurse should tap the client's face at a point just below and in front of the ear. A positive response would be twitching of the ipsilateral (same side only) facial muscles, suggesting neuromuscular excitability due to hypocalcemia.

B. Babinski's sign

Rationale: Babinski's sign is a diagnostic test for brain damage or upper motor neuron damage. It is positive if the toes flare up when the nurse strokes the plantar aspect of the foot.

C. Brudzinski's sign

Rationale: Brudzinski's sign is an indication of meningeal irritation, such as in clients who have meningitis. With the client supine, the nurse should place one hand behind his head and places her other hand on his chest. The nurse then raises the client's head with her hand behind his head, while the hand on his chest restrains him and prevents him from rising. Flexion of the client's lower extremities constitutes a positive sign.

D. Kernig's sign

Rationale: Kernig's sign is an indication of meningeal irritation, such as in clients who have meningitis. The nurse performs the maneuver with the client supine with his hips and knees in flexion. The inability to extend the client's knees fully without causing pain constitutes a positive test.

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23. A rehabilitation nurse is caring for a client who has had a spinal cord injury that resulted in paraplegia. After a week on the unit, the nurse notes that the client is withdrawn and increasingly resistant to rehabilitative efforts by the staff. Which of the following actions should the nurse take?

A. Inform the client that privileges are related to participation in therapy.

Rationale: This response does not address the holistic needs of the client and could be interpreted as a threat.

B. Limit visiting hours until the client begins to participate in therapy.

Rationale: Limiting visiting hours could increase the client's withdrawn affect.

C. Allow the client to control the timing and frequency of the therapy.

Rationale: This action could be harmful if the client chooses to minimize or eliminate aspects of therapy.

D. Establish a plan of care with the client that sets attainable goals.

Rationale: The nurse should develop a plan of care for this client with mutually set goals. This action invests the client in the rehabilitation process, which encourages feelings of ownership for it, and sees the goals as more attainable.

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24. A nurse is caring for a client who is undergoing a lumbar puncture. Which of the following is the priority action for the nurse take to maintain privacy for the client?

A. Close the door to the client's room.

Rationale: This is an appropriate action; however it is not the priority action.

B. Pull the curtains around the client's bed.

Rationale:

Pulling the curtains around the client's bed assures privacy for the client should someone open the door or enter the room.

C. Ask family members to leave the room.

Rationale: This is an appropriate action; however it is not the priority action.

D. Use sterile drapes to cover the client.

Rationale: This is an appropriate action during a procedure, when some areas of the body are exposed; however it is not the priority action.

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25. 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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26. A nurse is caring for a middle adult female client who reports that her menstrual periods have become irregular and she has been having hot flashes. The nurse should expect the client to have which of the following manifestations associated with early menopause?

A. Urinary retention

Rationale: After menopause, the bladder and urethra can weaken or shrink, which leads to urinary incontinence.

B. Decreased blood pressure

Rationale: Many women experience an increase in blood pressure during the peri--menopausal years.

C. Dryness with intercourse

Rationale: Menopause, the cessation of a woman's menstrual periods, occurs when the ovaries stop making estrogen. Because of the changes in the vagina, some women can have dryness, discomfort, or pain during sexual intercourse.

D. Elevation in body temperature above 37.8&deg C (100&deg F)

Rationale: Hot flashes are a manifestation of menopause, but they are related to hormonal changes, not body temperature elevation.

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27. 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.

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28. A nurse is caring for a client who is being treated with a cesium implant. The client tells the nurse, "I feel so isolated and alone in this room." After acknowledging the client's feelings of loneliness, which of the following responses should the nurse provide?

A. "I will come and sit with you for 10 minutes each hour."

Rationale: Sitting with the client hourly creates excessive exposure to the radiation source.

B. "Do you have a cell phone you can talk to friends and family on?"

Rationale: A client who has a radiation implant must remain in radiation isolation. Time and distance are the factors that reduce exposure to the source. After acknowledging the client's feelings of loneliness and recognizing the sense of social isolation, this solution provides an appropriate, safe means of meeting the client's need for contact.

C. "I'll ask the charge nurse to admit someone to your room for company."

Rationale:

A client who has a radiation implant must remain in radiation isolation.

D. "You're scheduled for discharge in 2 days so this isolation will be over soon."

Rationale: This response implies that the client's feelings of loneliness are not valid.

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29. A nurse in a clinic is interviewing a client who has a possible diagnosis of endometriosis. Which of the following findings in the client's history should the nurse recognize as consistent with a diagnosis of endometriosis?

A. A history of pelvic inflammatory disease (PID).

Rationale: A history of PID is not related to the diagnosis of endometriosis.

B. Abdominal bloating starting several days before menses.

Rationale: Many women report experiencing uncomfortable abdominal bloating just prior to their menstrual cycle. However, this is not a symptom of endometriosis.

C. An atypical Papanicolaou smear at her last clinic visit.

Rationale: Atypical cells in a Papanicolaou smear are not associated with endometriosis.

D. Dysmenorrhea that is unresponsive to NSAIDs.

Rationale: Endometriosis is a condition in which the type of tissue that lines the uterus implants in locations outside the uterus. This typically causes pelvic pain around the time of the menstrual period but can cause pain at other times in the cycle. THe discomfort is often unrelieved by the use of NSAIDs.

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30. A nurse is caring for a client who has Parkinson's disease and is taking diphenhydramine 25 mg PO TID. Which of the following therapeutic outcomes should the nurse expect to see?

A. Delay in disease progression

Rationale: Diphenhydramine may be helpful in controlling symptoms in the early stage of the disease; however, it will not delay disease progression.

B. Improved bladder function

Rationale: Antihistamines, like diphenhydramine, have a mild anticholinergic effect and may cause urinary retention.

C. Relief of depression

Rationale: Relief of depression is not associated with the use of antihistamines or anticholinergics.

D. Decreased tremors

Rationale: Clients who have Parkinson's disease often experience trembling, muscle rigidity, difficulty walking, and problems with balance and coordination. Antihistamines, like diphenhydramine, have a mild anticholinergic effect and may be helpful in controlling tremors in the early stage of

the disease.

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31. A nurse is caring for an adolescent client who has a long history of diabetes mellitus and is being admitted to the emergency department confused, flushed, and with an acetone odor on the breath. Diabetic ketoacidosis is suspected. The nurse should anticipate using which of the following types of insulin to treat this client?

    A. NPH insulin

    Rationale: Isophane NPH insulin is intermediate-acting. It has an onset of action of 1 to 3 hr and is not appropriate for emergency treatment of ketoacidosis.

    B. Insulin glargine

    Rationale: Insulin glargine is a long-acting insulin, with an onset of 2 to 4 hr. It is not appropriate for emergency treatment of ketoacidosis.

    C. Insulin detemir

    Rationale: Insulin detemir is an intermediate-acting insulin. It has an onset of action of 1 hr and is not appropriate for emergency treatment of ketoacidosis.

    D. Regular insulin

    Rationale: Regular insulin is classified as a short-acting insulin. It can be given intravenously with an onset of action of less than 30 min. This is the insulin that is most appropriate in emergency situations of severe hyperglycemia or diabetic ketoacidosis.

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32. A nurse is caring for a client who has a new diagnosis of myasthenia gravis. For which of the following manifestations should the nurse monitor?

    A. Confusion

    Rationale: Myasthenia gravis does not affect cognition, level of consciousness, or orientation.

    B. Weakness

    Rationale: Generalized weakness of the diaphragmatic and intercostal muscles may produce respiratory distress or predispose the client to respiratory infections.

    C. Increased intracranial pressure

    Rationale: Myasthenia gravis does not affect pressure within the brain.

    D. Increased urinary output

    Rationale: Myasthenia gravis does not cause increased urine output.

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33. A nurse is caring for a client who has chemotherapy- induced peripheral neuropathy. The nurse should expect the

client to report having experienced which of the following symptoms?

A. Extremities that turned blue when exposed to cold

Rationale: Extremities that turn blue when exposed to cold is a symptom of Raynaud's phenomenon, a disorder that causes constriction of the blood vessels in the fingers, toes, ears, and nose.

B. Tingling feeling in the extremities

Rationale: Peripheral neuropathy is a neurological disorder resulting from damage to the peripheral nerves. It may be caused by diseases of the nerves, systemic illnesses, or it may be a side-effect from chemotherapy. If a sensory nerve is damaged, the client is likely to experience pain, numbness, tingling, burning, or a loss of feeling in the extremities.

C. Jerking movements of the extremities

Rationale: Jerking movements, such as ataxia, may be seen with many neurologic conditions affecting the client's ability to produce a smooth movement.

D. Spasms of the extremities

Rationale: Involuntary spasms may be found with such conditions as cerebral palsy, trauma, cerebral infection, and certain degenerative disorders.

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34. A nurse is caring for a client who who has had a stroke involving the right hemisphere. Which of the following alterations in function should the nurse expect?

A. Difficulty reading

Rationale: The left hemisphere is the center for language, mathematic skills and thinking analytically. A client who is unable to read following a stroke would have involvement of the left hemisphere.

B. Inability to recognize his family members

Rationale: The right hemisphere is involved with visual and spatial awareness. A client who is unable to recognize faces would have involvement with the right hemisphere.

C. Right hemiparesis

Rationale: The motor nerve fibers of the brain cross in the medulla, and a motor deficit on one side of the body reflects damage to the upper motor neurons on the opposite side of the brain. A client who has right hemiparesis would have involvement of the left hemisphere.

D. Aphasia

Rationale: The left hemisphere is the center for language, mathematic skills and thinking analytically. A client who is unable to speak or understand language following a stroke would have involvement of the left hemisphere.

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35. While performing an admission assessment for a client, the nurse notes that the client has varicose veins with ulcerations and lower extremity edema with a report of a feeling of heaviness. Which of the following nursing

diagnoses should the nurse identify as being the priority in the client's care?

A. Impaired tissue perfusion

Rationale: When using the airway, breathing, and circulation (ABC) priority-setting framework, the nurse should identify impaired perfusion of tissues as the priority finding. The presence of varicose veins indicates venous reflux is present which inhibits perfusion to all the tissues. The nurse should note the client has signs of chronic venous insufficiency as well which include edema, a feeling of heaviness in the legs, and the presence of venous stasis ulcers.

B. Alteration in body image

Rationale: The nurse should address the client's alteration in body image because the client can consider the appearance of varicose veins, edema, and the ulcerations unattractive. However, another diagnosis is the priority.

C. Alteration in activity tolerance

Rationale: The nurse should assess the client for decreased ability to tolerate activity because the presence of varicose veins and edema can be painful and present a feeling of fullness in the legs. However, another diagnosis is the priority.

D. Impaired skin integrity

Rationale: The nurse should address the presence of venous stasis ulcers and edema because these factors can lead to infection, increased tissue breakdown, and delayed healing. However, another diagnosis is the priority.

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36. A nurse is planning care for a female client who has a T4 spinal cord injury and is at risk for acquiring urinary tract infections. Which of the following actions should the nurse include in the client's plan of care?

A. Cleanse the perineum from back to front.

Rationale: The perineum should be cleansed from front to back to limit the spread of bacteria from the perianal region to the urethra in female clients.

B. Obtain a prescription for an indwelling urinary catheter.

Rationale: Indwelling catheters are associated with a greatly increased risk for UTI and should be avoided whenever possible in a client who is at risk. Intermittent catheterization to empty the bladder of residual urine is more effective.

C. Encourage fluid intake at and between meals.

Rationale: Increased fluid intake dilutes the urine, reduces stasis, and greatly reduces the urinary bacterial count. Consequently, the risk of nosocomial (hospital-acquired) UTI is reduced, even for a client who has a spinal cord injury.

D. Offer the client the bedpan every 2 hr.

Rationale: The client will be unable to completely empty her bladder by herself.

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37. A nurse is caring for a client following an abdominal surgery. The client has a prescription for dressing changes every 4 hr and as needed. Which of the following objects should the nurse use to reduce skin irritation around the incision area?

A. Montgomery straps

Rationale: Montgomery straps are adhesive strips that are applied to the skin on either side of the surgical wound. The strips have holes so the two sides of the dressing can be tied together and re-opened for dressing changes without having to remove the adhesive strips. If Montgomery straps are unavailable, the nurse can place strips of hydrocolloid dressing on either side of the wound and place the tape across the dressing onto the hydrocolloid strips.

B. Enzymes

Rationale: The nurse should use enzymes to debride a wound that contains eschar.

C. Alcohol swabs

Rationale: The nurse should recognize that alcohol has a drying effect on the skin.

D. A transparent dressing

Rationale: The nurse should use a transparent dressing to protect a client from shearing forces. The transparent dressing should be used on intact skin. This type of dressing would cause damage each time it is removed, as the entire surface contains adhesive.

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38. A nurse is assessing a client who is admitted with hyperthyroidism. The client reports a weight loss of 5.4 kg (12 lb) in the last 2 months, increased appetite, increased perspiration, fatigue, menstrual irregularity, and restlessness. Which of the following actions should the nurse take to prevent a thyroid crisis?

A. Provide a quiet, low-stimulus environment.

Rationale: Thyroid crisis can occur in response to a stressor, so the nurse should minimize stressful stimuli in the client's environment.

B. Administer aspirin as prescribed for any sign of hyperthermia.

Rationale: The nurse should plan to administer acetaminophen for fever because aspirin displaces the thyroid hormone from plasma proteins and results in active thyroid hormone in the blood, which may exacerbate a thyrotoxic crisis.

C. Keep the client NPO.

Rationale: The nurse should encourage the client to eat a high-protein, high-calorie diet to maintain weight and prevent negative nitrogen balance. The nurse should also promote fluid intake to replace loss through diaphoresis and diarrhea.

D. Observe the client carefully for signs of hypocalcemia.

Rationale: The nurse should recognize hypocalcemia is a clinical finding in hypoparathyroidism, and calcium levels do not play a role in preventing thyrotoxic crisis.

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39. A nurse is caring for a client who has Cushing's syndrome. Which of the following interventions should the nurse expect to perform? (Select all that apply.)

- A. Assess blood glucose level
- B. Assess for neck vein distention
- C. Monitor for an irregular heart rate
- D. Monitor for postural hypotension
- E. Weigh the client daily

Rationale: Cushing's syndrome affects blood glucose levels by causing increased release of glucose from the liver and decreased sensitivity of insulin receptors. This can result in elevated blood glucose levels.

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40. 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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41. A nurse is reviewing laboratory values for a client who has systemic lupus erythematosus (SLE). Which of the following values should give the nurse the best indication of the client's renal function?

- A. Serum creatinine

Rationale: A renal function disorder reduces the excretion of creatinine, resulting in increased levels of blood creatinine. Creatinine is a specific and sensitive indicator of renal function.

- B. Blood urea nitrogen (BUN)

Rationale:

The BUN is used as a gross index of glomerular function and the production and excretion of urea. High-protein diets, rapid-protein catabolism, and dehydration are conditions that will cause an elevation in the BUN. This is not the best indication of the client's renal function.

C. Serum sodium

Rationale: Serum sodium is affected by urinary output but may also be falsely affected by hemodilution and hemoconcentration. This is not the best indication of the client's renal function.

D. Urine-specific gravity

Rationale: Due to the body's compensatory mechanisms and ability to maintain glomerular filtration rate (GFR) until 75% of renal function is lost, this is not the best indication of the client's renal function.

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42. 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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43. A nurse is teaching the partner of a client who had an acute myocardial infarction (MI) about the reason blood was drawn from the client. Which of the following statements should the nurse make regarding cardiac enzymes studies?

A. "These tests help determine the degree of damage to the heart tissues."

Rationale: Cardiac enzyme studies are obtained because the degree of enzyme elevation reflects the degree of damage to the myocardium. The enzymes most commonly measured are CPK and troponin. These enzymes have a characteristic rise and fall pattern after an MI. It may take 4 hr or more after the onset of manifestations for the test to become abnormal and up to 24 hr for the level to peak. Eventually, the levels in the blood fall back to normal. Consequently, serial blood tests must be taken from the client to document and evaluate enzyme levels.

B. "Cardiac enzymes will identify the location of the MI."

Rationale: The nurse should inform the partner and the client of the protocols and prescriptions for the client who has an MI to decrease anxiety. The nurse should include that the 12-lead electrocardiogram may be used to determine the location of the MI in the teaching.

C. "These tests will enable the provider to determine the heart structure and mobility of the heart valves."

Rationale: An echocardiogram is a diagnostic tool used to determine the heart structure and mobility of the heart valves. It can be used to diagnose cardiomyopathy, valvular disorders, aneurysms and left ventricular function.

D. "Cardiac enzymes assist in diagnosing the presence of pulmonary congestion."

Rationale: Pulmonary congestion, a complication of MI, is suspected when crackles or rales are auscultated in the chest. Should this occur, the nurse should inform the client and partner that it is diagnosed by chest x-ray.

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44. A nurse is caring for a client who was admitted with bleeding esophageal varices and has an esophagogastric balloon tamponade with a Sengstaken-Blakemore tube to control the bleeding. Which of the following actions should the nurse take?

A. Ambulate the client four times per day.

Rationale: The client must remain on bed rest while the Sengstaken-Blakemore tube is in place to prevent accidental dislodgment of the tube, which can cause asphyxia.

B. Encourage the client to consume clear liquids.

Rationale: The placement of the Sengstaken-Blakemore tube requires the client to be NPO.

C. Provide frequent oral and nares care.

Rationale: A client who has a Sengstaken-Blakemore tube in place is unable to swallow. If the client is alert, the nurse should encourage the client to spit saliva into a tissue or basin. If the client is not alert, gentle suctioning of the oral cavity and nares might be required to remove secretions.

D. Keep the client in a supine position.

Rationale: The supine position is contraindicated because a client who has a Sengstaken-Blakemore tube must have the head of the bed elevated at all times. If the client is placed in a supine position, it can contribute to the migration of the balloon up the esophagus, which can lead to an airway obstruction.

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45. A nurse is planning care for a client who has end-stage cirrhosis of the liver with encephalopathy. Which of the following interventions should the nurse plan to implement to decrease the client's ammonia level?

A. Administer diuretics.

Rationale: Diuretics do not help to decrease ammonia levels.

B. Restrict the client's intake of fluids.

Rationale: Restricting fluid intake does not help to decrease a client's ammonia level.

C. Reduce the client's intake of protein.

Rationale: Ammonia is formed in the gastrointestinal tract by the action of bacteria on protein. Limiting dietary protein intake can assist with decreasing the client's ammonia level. Protein is necessary for healing, so strict limitation of dietary protein is not recommended.

D. Administer vitamin K.

Rationale: Vitamin K does not help to decrease a client's ammonia level.

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46. A nurse is caring for a client who has a Jackson-Pratt (JP) drain in place after surgery for an open reduction and internal fixation. The nurse should understand that the JP drain was placed for which of the following purposes?

A. To prevent fluid from accumulating in the wound

Rationale: The purpose of a JP drain is to promote healing by draining fluid from a wound. This prevents pooling of blood and fluid, which can contribute to discomfort, delay healing, and provide a medium for infection. The JP drainage tube is threaded through the skin into the wound near the surgical incision and is held in place by sutures.

B. To limit the amount of bleeding from the surgical site

Rationale: A JP drain does not limit the amount of bleeding.

C. To provide a means for medication administration

Rationale: A JP drain does not provide a means for medication administration.

D. To eliminate the need for wound irrigations

Rationale: A JP drain is not used as a substitute for wound irrigation.

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47. A nurse is caring for a client who is scheduled to have a magnetic resonance imaging (MRI) scan. The client asks the nurse what to expect during the procedure. Which of the following statements should the nurse make?

A. "An MRI scan is not distorted by movement, so you do not have to lie still."

Rationale: An MRI scan is distorted by movement. It is important that the client is informed of the need to lie still during the procedure.

B. "An MRI scan is a short procedure and should take no longer than 30 minutes."

Rationale: An MRI scan is a lengthy procedure that lasts between 60 and 90 min.

C. "The MRI contrast dye contains iodine and can cause your skin to itch."

Rationale: MRI contrast dye does not contain iodine and therefore is not subject to hypersensitivity

reactions like contrast dye used in a traditional CT scan.

D. "An MRI scan is very noisy, and you will be allowed to wear earplugs while in the scanner."

Rationale: The nurse should instruct the client that many clients report being disconcerted by the loud thumping and humming noises produced by the scanner, and for that reason, earplugs are offered to reduce the discomfort.

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48. A nurse in a clinic is assessing a client who has AIDS and a significantly decreased CD4-T-cell count. The nurse should recognize that the client is at risk for developing which of the following infectious oral conditions?

A. Halitosis

Rationale: Halitosis (foul-smelling breath) is not an infectious oral condition and is frequently the result of poor dental health, poor oral hygiene, or gastrointestinal problems.

B. Gingivitis

Rationale: Gingivitis is inflammation of the gum or gingiva and is typically caused by irritation from dental plaque and poor oral hygiene.

C. Xerostomia

Rationale: Xerostomia (dry mouth) is typically an adverse effect of medications that have anticholinergic properties. It is not an infectious oral condition.

D. Candidiasis

Rationale: Although oral candidiasis can affect anyone, it occurs most often in infants, toddlers, older adults, and clients whose immune systems have been compromised by illness, such as AIDS, or medications.

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49. A nurse is caring for a client who has an indwelling urinary catheter. Which of the following actions should the nurse take to prevent infection?

A. Replace the catheter every 3 days.

Rationale: The nurse should avoid routine catheter changes. The catheter should be changed only to correct a problem, such as a leakage or a blockage.

B. Check the catheter tubing for kinks or twisting.

Rationale: The nurse should check the catheter for twisting or kinks in the tubing. These obstructions can affect the flow of urine causing pooling in the tubing that could backflow into the bladder.

C. Irrigate the catheter once each shift.

Rationale: The nurse should avoid irrigation of the catheter unless there is an obstruction.

D. Clean the perineal area with an antiseptic solution daily.

Rationale:

The nurse should clean the perineal area with soap and water at least twice per day.

50. 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.