Practice Questions

1. A 13-year-old and her parent come to the clinic for an annual pediatric examination. The parent informs the nurse that the daughter started her period last year. What is the appropriate nursing response?

A. The nurse asks the client if she has any questions about preventing pregnancy.
B. The nurse counsels the client about the consequences of sexually transmitted infections.
C. The nurse documents that the age of menarche as twelve years.
D. 4. The nurse records that the age of menopause for the client is thirteen.

2. The school nurse is assessing a child with a newly placed cast on the right arm. The nurse notes that the fingers are slightly cooler than those on the left hand. What should the nurse do **next**?

A. Nothing, this is normal.
B. Ask the child if the cast feels tight.
C. Assess the fingertips on each hand for blanching.
D. Assess the radial pulse in the right wrist.

3. The nurse is determining immunizations for 5-year-old preparing for school. What immunizations does the child require? **Select all that apply.**

A. DTap
B. IPV
C. MMR
D. VAR
E. Hep A
F. IIV

4. The nurse is caring for a client who “doesn’t feel very well.” Assessment includes temperature 100.9˚F (38.3˚C); hear rate 110 bpm; respirations 24 breaths per minute. The nurse reviews the lab below. What actions should the nurse take **next**?

Lab	Normal	August 5	August 6
WBC	4,000-10,000 cells/mL	9,000	15,100 H
Hemoglobin	12-17 g/dL	11.0 L	10.9 L
Hematocrit	36-51%	38 L	34 L
RBC	4.2-5.9 cells/L	3.80 L	3.6 L

A. Evaluate which antibiotics the client is receiving.
B. Assess the blood pressure
C. Request a serum lactate.
D. Ask the client to describe ‘not feeling well.’

5. The nurse has finished delivering a bronchodilator via small volume nebulizer. Which documented assessment(s) indicates the treatment was effective? **Select all that apply.**

Time	BP (MAP)	HR	RR	Sat	Lung Sounds
Before Treatment	105/63 (77)	99	24	94% 2L NC	Expiratory Wheezes
After Treatment	118/70 (86)	112	20	94% 2 L NC	Clear to Ausculation

A. Blood pressure
B. Heart rate
C. Respiratory rate
D. Oxygen saturation
E. Lung sounds

6. A school nurse is told that the parent of a student said, “I feel like I’m going to have another seizure.” What should the school nurse do **next**?

A. Call 9-1-1.
B. Determine if the parent is in a safe environment.
C. Ask the parent to go to the hospital.
D. Perform a physical assessment on the parent.

7. A teenager with an absolute neutrophil count (ANC) of zero is exhausted and nauseated. Which nursing action(s) is/are priority? **Select all that apply.**

A. Administer antiemetics.
B. Complete a nutrition and hydration assessment.
C. Limit visitors to two at a time.
D. Place in a positive pressure room.
E. Assess for sources of bleeding.
F. Begin energy-conserving techniques.

8. The nurse receives hand-off report on each of these clients. Which client should the nurse assess **first**?

A. 6-month-old with neutropenia and a temperature of 101.7°F (38.7°C).
B. 17-year-old who is receiving the second dose of chemotherapy for bone cancer.
C. 2-year-old with petechiae all over the abdomen and back.
D. 18-year-old with a hemoglobin of 6.5 g/dL.

9. A nurse observes this rash while assessing an infant, recognizing that it is a result of urinary incontinence. What intervention should be added to the plan of care?

A. Leave the skin open to air as much as possible.
B. Apply lubricant jelly to the site three times each day.
C. Obtain a prescription for an antibiotic ointment.
D. Apply a cortisone cream.

10. A client is prescribed a diet that can be advanced as tolerated. How does the nurse recognize that the client is ready to be started on regular food? **Select all that apply.**

A. Bowel sounds are present.
B. Hunger is verbalized.
C. The client has been NPO for 5 days.
D. The albumin level is within the normal range.
E. The health care provider says so.

11. The nurse cares for a client who recently sustained a fall with tibial-fibula fracture. A cast was applied two hours ago. The nurse comes into the room and sees the image here. What action by the nurse is the **priority**?

A. Remove the crutches from the client.
B. Assess the circulation to the toes.
C. Apply ice to the ankle.
D. Elevate the casted leg on pillows.

12. The nurse is teaching a group of pre-teen girls about life balance and proper nutrition during times of stress. Which statement by the nurse should be included?

A. “During times of stress, it is easy to make unhealthy food choices. It is important to balance the unhealthy food choices with adding more exercise.”
B. “Exercising strenuously several times a day can help to release the stress you feel. Since you will be consuming more calories, you must eat more.”
C. “To maintain a healthy lifestyle during times of stress, it is important to continue to eat healthy and exercise regularly.”
D. “Exercising routinely and making healthy food choices will eliminate stress.”

13. As a nurse is preparing medications for a younger client with a new diagnosis of an incurable, chronic illness, the client tells the nurse, “I just cannot handle taking all of these medications every day, I feel like an old person.” What should be the nurse’s **next** action?

A. Stop preparing the medications and pull up a chair beside the bed.
B. Ask the client to prepare the medications.
C. Ask the client if they know why the medications are important.
D. Pause the medication preparation and ask the client to share more.

14. The nurse is admitting a client who does not speak the same language. When assessing the client’s normal level of self-care, what actions should the nurse take?

A. Smell for body odor and cleanliness of hair, nails, and teeth.
B. Observe what the client is capable of doing independently when given hygiene supplies.
C. Ask a family member how independent the client is at home.
D. Obtain an interpreter to assist with translation.

15. During a clinic visit, a teen shares with the nurse that at night she gets out of bed several dozen times to be sure her bedroom door is locked. How should the nurse respond?

A. “It sounds to me like you are having obsessive-compulsive thoughts. Are there other things you do this with?”
B. “Sometimes victims of rape and violence will do that. Have you ever had that happen to you?”
C. “Do you feel unsafe?”
D. “Why would you do that?”

16. Upon assessment of a pre-teen, the nurse identifies that the client has a body mass index (BMI) of 15 kg/m2, and teeth enamel corrosion. What should the nurse do? **Select all that apply.**

A. Place the pre-teen on a daily calorie count.
B. Obtain a 24-hour food recall assessment.
C. Ask the parents if they are ever concerned about their child’s eating.
D. Ask the pre-teen how they feel about their weight.
E. Ask the pre-teen how often he/she brushes his/her teeth.

Answer Key

1. A 13-year-old and her parent come to the clinic for an annual pediatric examination. The parent informs the nurse that the daughter started her period last year. What is the appropriate nursing response?
   - **A.** The nurse asks the client if she has any questions about preventing pregnancy. **Nothing indicates the teen is sexually active.**
   - **B.** The nurse counsels the client about the consequences of sexually transmitted infections. **Nothing indicates that the teen is sexually active.**
   - **C.** The nurse documents that the age of menarche as twelve years. **The onset of menses is recorded as the age of menarche.**
   - **D.** 4. The nurse records that the age of menopause for the client is thirteen. **The age of menopause is when a woman has not had a menses for 12 months.**

     THIN Thinking: Nursing Process — Assessment of the start of menarche is a normal part of a female pre-teen assessment. Assessment. NCLEX® : Health Promotion and Maintenance QSEN: Evidence-based Practice.

2. The school nurse is assessing a child with a newly placed immobilizer on the right arm for a hairline fracture. The nurse notes that the fingers are slightly cooler than those on the left hand. What should the nurse do next?
   - **A.** Nothing, this is normal. **Further assessment is required to determine if there is a problem.**
   - **B.** Ask the child if the immobilizer feels tight. **A child's perception of tight will vary and is not reliable.**
   - **C.** Assess the fingertips on each hand for blanching. **This assessment will determine capillary refill which can determine if there is a perfusion issue.**
   - **D.** Assess the radial pulse in the right wrist. **The pulse determines adequate arterial blood flow but not capillary blood flow.**

     THIN Thinking: Identify Risk to Safety — If the fingers in a casted extremity are cooler than the opposite extremity, it could be a problem. The nurse should be concerned with perfusion to the extremity, and further assessment is necessary. Safe Practice. NCLEX® : Reduction of Risk Potential. QSEN: Safety.

3. The nurse is determining immunizations for a 5-year-old preparing for school. Use the immunization record in Case 2 of this chapter to determine which immunizations the child requires. Select all that apply.
   - **A.** DTap. **Yes, this is required between ages 4 and 6.**
   - **B.** IPV. **Yes, this is required between ages 4 and 6.**
   - **C.** MMR **Yes, this is required between ages 4 and 6.**
   - **D.** VAR. **Yes, this is required between ages 4 and 6.**
   - **E.** Hep A. **No. this series was completed at 2 years of age.**
   - **F.** IIV. **Yes, this is required annually.**

THIN Thinking: Identify Risk to Safety — Delivery of immunizations needs to be according to the American Academy of Pediatrics recommendation, which is supported by the Center for Disease Control. Safe Practice. NCLEX®: Health Promotion and Maintenance. QSEN: Evidence-based Practice.

4. The nurse is caring for a client who "doesn't feel very well." Assessment includes temperature 100.9°F (38.3°C); heart rate 110; respirations 24 breaths per minute. The nurse reviews the labs below. What actions should the nurse take next?
   - **A.** Evaluate which antibiotics the client is receiving. **Yes, this is important but not the first action.**
   - **B.** Take the blood pressure. **The client is showing classic symptoms of systemic inflammatory response syndrome (SIRS) and evaluation of the BP will determine if he/she is developing septic shock.**
   - **C.** Request a serum lactate level. **An elevated lactate level is a sign of hypoperfusion to muscles and a sign of septic shock.**
   - **D.** Ask the client to describe 'not feeling well.' **This will not improve the situation; the nurse needs to act quickly.**

   THIN Thinking: Help Quick — The nurse should recognize the signs of SIRS and act quickly to prevent sepsis and septic shock. Assessment of blood pressure, confirming diagnosis with a lactate level, and reviewing antibiotic therapy is a part of the process to prevent further injury and death. NCLEX®: Physiological Adaptation. QSEN: Evidence-based Practice.

5. The nurse has finished delivering a bronchodilator via small volume nebulizer. Which documented assessment(s) indicates the treatment was effective? Select all that apply.
   - **A.** Blood pressure. **The blood pressure increased slightly, does not show medication effectiveness.**
   - **B.** Heart rate. **Heart rate increased as a side effect of the medication but does not show effectiveness.**
   - **C.** Respiratory rate. **A decrease in the respirations shows less effort of breathing.**
   - **D.** Oxygen saturation. **Numbers unchanged so do not show effectiveness.**
   - **E.** Lung sounds. **The wheezes are gone, the bronchodilator was effective.**

   THIN Thinking: Nursing Process — Evaluation of a medication's effectiveness is an important aspect of care. Understanding the medication and its purpose will allow the nurse to identify when it's effective. Evaluation. NCLEX®: Pharmacological and Parenteral Therapies. QSEN: Evidence-based Practice.

6. A school nurse is told that the parent of a student said, "I feel like I'm going to have another seizure." What should the school nurse do next?
   - **A.** Call 9-1-1. **This may not be necessary: additional information should be collected first.**
   - **B.** Determine if the parent is in a safe environment. **Safety is the highest priority.**
   - **C.** A teenager with an absolute neutrophil count (ANC) of zero is exhausted and nauseated. Which nursing action(s) is/are priority? Select all that apply. 1. Administer antiemetics. This provides comfort. 2. Complete a nutrition and hydration assessment. This will determine if additional

nutrition or hydration needs addressing. 3. Limit visitors to two at a time. Visitors should be restricted since the client is at such a high risk for infection.Ask the parent to go to the hospital. **Safety must be provided first.**

D. Perform a physical assessment on the parent. **Safety is the highest priority. Additionally, it would not be appropriate for the nurse to perform a physical assessment since the parent is not under this nurse's care.**

THIN Thinking: Identify Risk to Safety — The priority for someone who "feels like they are going to have a seizure" is to place them in a safe environment. The parent is probably experiencing an aura. Safe Practice. NCLEX®: Safety and Infection Control. QSEN: Safety.

7. A teenager with an absolute neutrophil count (ANC) of zero is exhausted and nauseated. Which nursing action(s) is/are priority? Select all that apply.
   A. Administer antiemetics. **This provides comfort.**
   B. Complete a nutrition and hydration assessment. **This will determine if additional nutrition or hydration needs addressing.**
   C. Limit visitors to two at a time. **Visitors should be restricted since the client is at such a high risk for infection.**
   D. Place in a positive pressure room. **This will route air out of the room rather than into and decrease the risk of infection.**
   E. Assess for sources of bleeding. **ANC is related to infection, not bleeding.**
   F. Begin energy-conserving techniques. **This would help with the exhaustion and includes alternating activity with rest.**

   THIN Thinking: Identify Risk to Safety — The priority of care is to minimize the risk of infection since a simple infection could be deadly for this client. Practice Nursing. NCLEX®: Safety and Infection Control. QSEN: Safety.

8. The nurse receives hand-off report on each of these clients. Which client should the nurse assess first?
   A. 6-month-old with neutropenia and a temperature of 101.7°F (38.7°C). **Client is most vulnerable because of young age and neutropenia.**
   B. 17-year-old who is receiving the second dose of chemotherapy for bone cancer. **Nothing indicates the client is unstable.**
   C. 2-year-old with petechiae all over the abdomen and back. **Their risk is bleeding since petechiae indicate thrombocytopenia, but nothing indicates there is active bleeding occurring.**
   D. 18-year-old with a hemoglobin of 6.5 g/dL. **It is anticipated that this client will require packed red blood cells, but nothing in the question stipulates instability.**

   THIN Thinking: Identify Risk to Safety — The 6-month-old is most fragile and most sick. Change in condition will happen quickly, and the nurse needs to be prepared. Safe Practice. NCLEX®: Safety and Infection Control. QSEN: Patient-centered Care.

9. A nurse observes this rash while assessing an infant, recognizing that it is a result of urinary incontinence. What intervention should be added to the plan of care?
   A. Leave the skin open to air as much as possible. **Rashes from urinary incontinence, for a child or adult, need to be treated with a dry environment.**
   B. Apply lubricant jelly to the site three times each day. **This will not dry the rash but maintain moisture.**
   C. Obtain a prescription for an antibiotic ointment. **Nothing indicates that this is a bacterial infection.**
   D. Apply a cortisone cream. **Nothing indicates this is an allergic rash.**

   THIN Thinking: Nursing Process — The nurse should assess the situation and provide the best option for skin care. Given that this rash is only within the diaper area suggests that the risk is a result of a diaper rash. Implementation. NCLEX®: Basic Care and Comfort. QSEN: Patient-centered Care.

10. A client is prescribed a diet that can be advanced as tolerated. How does the nurse recognize that the client is ready to be started on regular food? Select all that apply.
   A. Bowel sounds are present. **Bowel sounds must be present for the client to eat regular food.**
   B. Hunger is verbalized. **There will be an increase in appetite when food needs to be introduced.**
   C. The client has been NPO for 5 days. **The length of time the client is without food does not determine when it can be introduced.**
   D. The albumin level is within the normal range. **A low albumin level indicates poor nutrition.**
   E. The health care provider says so. **The nurse can determine when to advance the diet once the prescription is written.**

   THIN Thinking: Nursing Process — The advancement of a diet is often the decision of the nurse. A focused assessment will help to determine when the diet can safely be advanced. Assessment. NCLEX®: Reduction of Risk Potential. QSEN: Patient-centered Care.

11. The nurse cares for a client who recently sustained a fall with tibial-fibula fracture. A cast was applied two hours ago. The nurse comes into the room and sees the image here. What action by the nurse is the priority?
   A. Remove the crutches from the client. **The crutches are not the priority concern as the client is not getting out of bed.**
   B. Assess the circulation to the toes. **Assessment is the priority.**
   C. Apply ice to the ankle. **This will take place after elevation occurs.**
   D. Elevate the casted leg on pillows. **Elevation of the extremity will decrease edema and swelling and should be performed after assessment.**

   THIN Thinking: Nursing Process — The priority is an assessment before actions. Assessment. NCLEX®: Physiological Adaptation. QSEN: Patient-centered Care.

12. The nurse is teaching a group of pre-teen girls about life balance and proper nutrition during times of stress. Which statement by the nurse should be included?

A. "During times of stress, it is easy to make unhealthy food choices. It is important to balance the unhealthy food choices with adding more exercise." **Participating in more exercise will not eliminate unhealthy food choices. Healthy diet and exercise are needed for a life balance.**

B. "Exercising strenuously several times a day can help to release the stress you feel. Since you will be consuming more calories, you must eat more." **Adequate daily exercise is appropriate but excessive exercise is not healthy and can become an obsession, especially with this age group.**

C. "To maintain a healthy lifestyle during times of stress, it is important to continue to eat healthy and exercise regularly." **This statement provides a life balance.**

D. "Exercising routinely and making healthy food choices will eliminate stress." **Stress cannot be eliminated, but the girls should find a way to manage it with diet, exercise, and other stress-relieving options.**

THIN Thinking: Nursing Process — It is important for the nurse to encourage the pre-teens to find a balance of healthy diet, exercise, and stress management. Implementation. NCLEX®: Health Promotion and Maintenance. QSEN: Patient-centered Care.

13. As a nurse is preparing medications for a younger client with a new diagnosis of an incurable, chronic illness, the client tells the nurse, "I just cannot handle taking all of these medications every day, I feel like an old person." What should be the nurse's next action?

A. Stop preparing the medications and pull up a chair beside the bed. **There is not enough information to determine if there is a deeper message. The statement is a valid one and may or may not indicate a lack of coping.**

B. Ask the client to prepare the medications. **This would not be appropriate.**

C. Ask the client if they know why the medications are important. **Teaching is important, but this is not the appropriate time.**

D. Pause the medication preparation and ask the client to share more. **This demonstrates that the client has the nurse's attention but allows the nurse to further evaluate if the client is experiencing ineffective coping.**

THIN Thinking: Nursing Process — The statement by the client may require further conversation. If it identified to be a larger issue, the nurse will pull up a chair and have a conversation. Evaluation. NCLEX®: Psychosocial Integrity. QSEN: Patient-centered Care.

14. The nurse is admitting a client who does not speak the same language. When assessing the client's normal level of self-care, what actions should the nurse take?

A. Smell for body odor and cleanliness of hair, nails, and teeth. **Someone that is unkept may or may not be performing self-care.**

B. Observe what the client is capable of doing independently when given hygiene supplies. **The assessment of the client's performance will allow the nurse to assess their level of independence.**

C. Ask a family member how independent the client is at home. **The family may or may not know if they are not living in the household.**

D. Obtain an interpreter to assist with translation. **This is not a first choice since there are other ways to determine the level of functioning.**

THIN Thinking: Nursing Process — Assessment of how the client performs self-care is a better indicator of their level of independence than asking family or the client. Analysis. NCLEX®: Basic Care and Comfort. QSEN: Patient-centered Care.

15. During a clinic visit, a teen shares with the nurse that at night she gets out of bed several dozen times to be sure her bedroom door is locked. How should the nurse respond?
    - **A.** "It sounds to me like you are having obsessive-compulsive thoughts. Are there other things you do this with?" **The nurse should not label the behavior; it will make the client feel worse.**
    - **B.** "Sometimes victims of rape and violence will do that. Have you ever had that happen to you?" **This is an aggressive statement, and the client may not be truthful.**
    - **C.** "Do you feel unsafe?" **This is a more open statement that demonstrates caring.**
    - **D.** "Why would you do that?" **Sounds blaming.**

    THIN Thinking: Identify Risk to Safety — The nurse needs to inquire further to see if there is an issue of safety. If the teen says she feels safe, then the nurse can begin to explore the compulsive behaviors. Safe Practice. NCLEX®: Psychosocial Integrity. QSEN: Safety.

16. Upon assessment of a pre-teen, the nurse identifies that the client has a body mass index (BMI) of 15 kg/m2, and teeth enamel corrosion. What should the nurse do? Select all that apply.
    - **A.** Place the pre-teen on a daily calorie count. **This could help to identify if nutritional intake is adequate.**
    - **B.** Obtain a 24-hour food recall assessment. **This could help to identify if nutritional intake is adequate.**
    - **C.** Ask the parents if they are ever concerned about their child's eating. **Since this child is a minor, it is acceptable to involve the family with your concerns.**
    - **D.** Ask the pre-teen how they feel about their weight. **The teens respond can help to determine if anorexia and/or bulimia are a concern.**
    - **E.** Ask the pre-teen how often he/she brushes his/her teeth. **This is not pertinent to the situation.**

    THIN Thinking: Nursing Process — The nurse needs to assess further to see if there is an issue of an eating disorder. Assessment. NCLEX®: Psychosocial Integrity. QSEN: Patient-centered Care.