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QUESTION NO: 1

A patient on diuretics has had vomiting and diarrhea for the past 3 days. Which of the following is this patient most at risk for developing?

A. Hypokalemia and cardiac arrhythmias

B. Hypercalcemia and polyuria

C. Dehydration and hyperglycemia

D. Hyperalimentation and heart block

ANSWER: A

Explanation:

Hypokalemia and cardiac arrhythmias is correct. Three days of vomiting and diarrhea can cause substantial fluid and electrolyte losses, including potassium depletion. Gastrointestinal potassium loss is particularly important with diarrhea, while vomiting contributes to volume depletion and can promote renal potassium excretion through activation of the renin-angiotensin-aldosterone system. Many commonly prescribed diuretics, especially loop and thiazide diuretics, further increase urinary potassium loss. The combined effects make clinically significant hypokalemia a major concern.

Potassium is essential for normal cardiac electrical conduction and myocardial repolarization. When serum potassium falls, cardiac cells become more electrically unstable, increasing the risk of dysrhythmias. Clinical assessment should therefore include prompt measurement of serum electrolytes, renal function, fluid status, and an ECG when hypokalemia is suspected or symptoms are present. Management includes treating ongoing gastrointestinal losses, reviewing the diuretic regimen, and replacing potassium safely according to severity and renal function. The Merck Manual discusses gastrointestinal and renal causes of potassium loss and the potential for arrhythmias in hypokalemia: Hypokalemia. Additional clinical guidance is available from StatPearls: Hypokalemia.

QUESTION NO: 2

The physician orders 20 u of U-100 regular insulin. The only syringe on hand is a 1 ml tuberculin syringe. How many milliliters should be administered?

A. 0.02 ml

B. 0.2 ml

C. 1 ml

D. 2 ml

ANSWER: B

Explanation:

0.2 ml is correct. U-100 insulin has a concentration of 100 units per milliliter. To calculate the volume needed, divide the prescribed dose by the concentration: 20 units ÷ 100 units/mL = 0.2 mL. Therefore, the nurse would draw up 0.2 mL in the 1 mL tuberculin syringe. A 1 mL tuberculin syringe is calibrated in milliliters, typically with 0.01 mL graduations, so 0.2 mL can be measured as the 0.20 mL mark. Insulin is a high-alert medication, and safe administration requires independently verifying the prescribed dose, insulin concentration, calculation, and syringe measurement according to organizational medication-safety procedures. Although insulin syringes are normally preferred because their unit markings reduce risk of dosing errors, the prescribed dose can be accurately converted to volume when a tuberculin syringe is the only available device. The U.S. Food and Drug Administration identifies U-100 insulin as containing 100 units of insulin per milliliter, which supports this conversion. See the FDA insulin-concentration safety communication and the Institute for Safe Medication Practices insulin safety recommendations.

QUESTION NO: 3

A young patient is extremely irritable due to meningitis. It would be most important for the nurse to:

A. Use low-level lighting in the room

B. Ventilate the room

C. Eliminate strong odors

D. Allow frequent visitors

ANSWER: A

Explanation:

Use low-level lighting in the room is the priority intervention because meningeal inflammation commonly causes photophobia, headache, and marked sensitivity to environmental stimulation. In a young patient with meningitis, bright light can intensify discomfort and irritability by worsening photophobia and headache. Maintaining dim, calm lighting supports comfort, reduces sensory stimulation, and helps promote rest while the patient is being assessed and treated. Nursing care should provide a quiet, low-stimulation environment and cluster necessary care to minimize unnecessary disturbance, while continuing close observation for changes in neurologic status, level of consciousness, seizures, and signs of increased intracranial pressure. The Centers for Disease Control and Prevention identifies headache and photophobia among important meningitis manifestations, supporting the need to reduce light exposure when these symptoms are present. Prompt medical treatment, including prescribed antimicrobials when bacterial meningitis is suspected, remains essential; environmental measures such as low-level lighting are supportive comfort care and do not replace urgent treatment. See the CDC overview of meningitis and the Merck Manual discussion of acute bacterial meningitis.

QUESTION NO: 4

A patient becomes angry and threatens to leave the hospital unless the physician reviews the reason for the patient's delay in discharge. The patient has a medication order for agitation available p.m.. but refuses the medication and requests a drink of orange juice instead. What should the nurse do?

A. Secretly slip the p.r.n. medication into the orange juice and give it to the patient

B. Give the patient the orange juice and tell the patient that a staff member is attempting to call the physician

C. Inform the patient that staff is unable to force anyone to stay in the hospital

D. Inform the patient that nothing can be done until the morning

ANSWER: B

Explanation:

“Give the patient the orange juice and tell the patient that a staff member is attempting to call the physician” is the most appropriate nursing action because it respects the patient’s immediate preferences and right to refuse a PRN medication while addressing the underlying concern driving the agitation: uncertainty about the discharge delay. The nurse should use calm, therapeutic communication, meet the reasonable request for juice if clinically appropriate, and take prompt steps to contact the physician or responsible provider for clarification and review. This approach can reduce distress, preserve rapport, and support shared decision-making without coercion or deception. A competent adult patient generally has the right to decline treatment, including medication, after receiving appropriate information. The nurse must therefore honor the refusal, assess for safety concerns, document the patient’s statements and actions taken, and escalate communication through the appropriate clinical chain if the physician cannot be reached or the patient’s condition changes. Patient-centred care includes responding respectfully to concerns and facilitating access to information needed for informed decisions. The American Nurses Association’s Code of Ethics emphasizes respect for patient dignity, autonomy, and advocacy: https://codeofethics.ana.org/. Guidance on informed consent and a patient’s right to refuse treatment is also available from the American Medical Association: https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent.

QUESTION NO: 5

A patient with allergic rhinitis reports severe nasal congestion, sneezing, and watery eyes at various times of the year. To teach the patient to control these symptoms the nurse advises the patient to:

A. Avoid all over the counter intranasal sprays

B. Limit the use of nasal decongestant sprays to 10 days

C. Use oral decongestants at bedtime to prevent symptoms during the night

D. Keep a diary of when an allergic reaction occurs and what precipitates it

ANSWER: D

Explanation:

Keeping a diary of when an allergic reaction occurs and what precipitates it is an important self-management strategy for allergic rhinitis. Symptoms that occur at varying times of year commonly reflect exposure to seasonal aeroallergens, such as tree, grass, or weed pollens, although indoor exposures such as dust mites, molds, and animal dander can also contribute. A symptom-and-exposure diary helps the patient identify meaningful patterns: the timing of congestion, sneezing, and watery eyes; locations where symptoms occur; outdoor activities; weather or pollen conditions; pets; cleaning; and response to treatments. Once likely triggers are recognized, the patient and clinician can develop targeted avoidance measures and plan medication use appropriately during anticipated exposure periods. This approach also provides useful information for follow-up assessment and, when needed, referral for allergy testing or consideration of allergen immunotherapy. The American Academy of Allergy, Asthma & Immunology recommends reducing exposure to relevant allergens as a key component of allergic rhinitis management, while the National Institute of Allergy and Infectious Diseases notes that identifying triggers supports prevention and symptom control. See AAAAI: Allergic Rhinitis and NIAID: Allergic Rhinitis.

QUESTION NO: 6

A patient receiving an IV infusion of potassium chloride complains of burning at the IV site. The nurse notes redness and swelling around the insertion site. The FIRST action is to:

A. Slow the infusion rate

B. Stop the infusion

C. Apply a pressure dressing to the site

D. Flush the catheter with normal saline

ANSWER: B

Explanation:

Stop the infusion is the first action because burning, redness, and swelling at an IV site suggest infiltration or possible extravasation. Potassium chloride is irritating to tissues, and continued administration into surrounding tissue can cause significant local injury. The nurse should immediately stop the infusion, assess the site and the patient’s symptoms, leave the catheter in place initially if extravasation management requires aspiration or antidote administration under local protocol, and notify the appropriate clinician. The affected limb should be managed according to the medication-specific extravasation policy, and a new IV site should be established as needed to continue essential therapy safely. See ISMP recommendations for potassium chloride and StatPearls: Extravasation Injury.

QUESTION NO: 7

You have started work on a new ward. One of the patient's allocated to you has been on the ward for the last 7 months since she had a cerebrovascular accident (CVA). You notice that her nursing care plan says strict bed rest, but on assessment you can not see any reason why this patient can not sit out of bed for short periods. Your nursing action would be:

A. Check with the other nursing staff as to reasons behind the nursing care plan then update the plan based on your assessment

B. Follow the nursing care plan strictly as this would have been developed after a detailed and collaborative assessment

C. Seek physician's orders so that you have permission to move the patient

D. Try and move the patient without consulting with anyone to see how she manages

ANSWER: A

Explanation:

“Check with the other nursing staff as to reasons behind the nursing care plan then update the plan based on your assessment” is the appropriate action because a nursing care plan is a living clinical document that must reflect the patient’s current condition, assessed needs, risks, goals, and prescribed restrictions. Before changing activity arrangements, the nurse should establish whether strict bed rest is supported by a previously identified clinical concern, such as an unresolved medical restriction, haemodynamic instability, a mobility risk, or a treatment-related precaution that may not be immediately evident in the record. This involves communicating with the nurse in charge and relevant members of the treating team, reviewing the documentation, and completing a focused mobility and safety assessment. Once the rationale has been clarified and the patient is assessed as suitable, the plan should be updated to set safe, individualised activity goals, including any necessary supervision, transfer assistance, equipment, and monitoring. Accurate documentation and communication ensure continuity of care while enabling rehabilitation-oriented nursing care that supports function after stroke. This approach is consistent with professional accountability for ongoing assessment, collaborative practice, and maintaining current care records. See the Department of Health—Abu Dhabi’s healthcare policies and standards resources and the International Council of Nurses’ Code of Ethics for Nurses.

QUESTION NO: 8

A patient with pneumonia is coughing up purulent thick sputum. Which one of the following nursing measures is most likely helpful to loosen the secretions?

A. Postural drainage

B. Breathing humidified air

C. Percussion over the affected lung

D. Coughing and deep breathing exercises

ANSWER: B

Explanation:

Breathing humidified air is the most appropriate measure because humidification adds moisture to inspired air, helping hydrate dry, tenacious respiratory secretions. When sputum is thick, increasing its water content can reduce viscosity and make it easier for the patient to mobilize and expectorate through an effective cough. This is particularly relevant in pneumonia, where inflammatory airway secretions may become copious and difficult to clear. In nursing care, humidification may be delivered as prescribed through an appropriate oxygen-delivery or aerosol system, while the nurse also monitors respiratory effort, oxygen saturation, breath sounds, sputum amount and character, and the patient’s response. Adequate systemic hydration, when not contraindicated, also supports secretion clearance and should be encouraged or maintained according to the patient’s clinical status and fluid plan. The American Association for Respiratory Care notes that humidification is used to provide moisture to the respiratory tract and support secretion management in indicated patients. See the American Association for Respiratory Care clinical practice guidelines and the Merck Manual’s guidance on cough and respiratory secretions.

QUESTION NO: 9

A patient presents to the emergency department with diminished and thready pulses, hypotension and an increased pulse rate. The patient reports weight loss, lethargy, and decreased urine output. The lab work reveals increased urine specific gravity. The nurse should suspect:

A. Renal failure

B. Sepsis

C. Pneumonia

D. Dehydration

ANSWER: D

Explanation:

Dehydration is the most likely finding because the presentation is characteristic of significant extracellular fluid-volume depletion, also termed hypovolemia. Fluid loss reduces circulating intravascular volume, leading to hypotension, weak or thready peripheral pulses, and compensatory tachycardia as the body attempts to maintain cardiac output and tissue perfusion. Weight loss is a useful clinical indicator of acute fluid loss, while lethargy may occur as reduced circulating volume compromises cerebral perfusion. Reduced renal perfusion activates water-conservation mechanisms, causing oliguria (decreased urine output). When the kidneys conserve water appropriately, the urine becomes more concentrated; therefore, urine specific gravity rises. Taken together, the cardiovascular findings, acute weight loss, low urine output, and concentrated urine strongly support dehydration. Prompt nursing priorities include assessment of hemodynamic status and mental status, accurate intake and output measurement, daily or serial weights when feasible, and timely fluid replacement as prescribed, with close reassessment of perfusion and urine output. The Merck Manual describes dehydration as body-water deficiency that can produce hypotension, tachycardia, oliguria, and concentrated urine. See Merck Manual: Dehydration and StatPearls: Adult Dehydration.

QUESTION NO: 10

During balloon inflation of an indwelling urinary catheter, the patient complains of pain and discomfort. The nurse should:

A. Continue the procedure and assure the patient

B. Aspirate the fluid and remove the catheter

C. Withdraw the balloon fluid, advance the catheter farther into the bladder, and then reinflate

D. Decrease the amount of injected fluid and secure

ANSWER: C

Explanation:

“Withdraw the balloon fluid, advance the catheter farther into the bladder, and then reinflate” is correct because pain during balloon inflation can indicate that the balloon is not fully inside the bladder and may be inflating in the urethra. The nurse should stop inflation immediately and deflate the balloon completely to prevent urethral trauma. After confirming urine drainage, the catheter should be advanced farther into the bladder before another careful attempt at balloon inflation. In adults, standard insertion technique is to advance the catheter after urine return is observed, helping ensure that the balloon has passed through the urethra and is positioned in the bladder. The balloon should be inflated only with the sterile water volume specified by the catheter manufacturer. This prompt response protects the patient from mucosal injury, pain, bleeding, and possible creation of a false passage. The Centers for Disease Control and Prevention recommends proper aseptic insertion and maintenance practices for indwelling urinary catheters, while procedural guidance emphasizes advancing the catheter adequately before balloon inflation. See the CDC recommendations for prevention of catheter-associated urinary tract infection and the NCBI overview of bladder catheterization.

QUESTION NO: 11

A patient arrived to the Post Anesthesia Care Unit (PACU) complaining of pain after undergoing a right total hip arthroplasty. Which of the following should the nurse do to assess the patient's level of pain?

A. Determine the patient's position during surgery and how long the patient was in this position

B. Inspect the dressing, note type and amount of drainage, and insure bandage adhesive is not pulling on skin

C. Ask anesthesiologist what type of anesthesia patient received and last dose of pain medication

D. Note location, intensity and duration of pain and last dose and time of pain medication

ANSWER: D

Explanation:

"Note location, intensity and duration of pain and last dose and time of pain medication" is correct because a pain assessment in the PACU must establish the patient's own report of the pain experience and provide the information needed to select, safely time, and evaluate analgesic treatment. The nurse should ask the patient where the pain is located, quantify its intensity using an appropriate validated scale such as the Numeric Rating Scale, and clarify its onset, duration, pattern, and relevant characteristics. In the immediate postoperative setting, determining when analgesia was last administered and its effect is essential to avoid undertreatment while also preventing unsafe cumulative opioid or sedative effects. Pain should be reassessed and documented after an intervention to determine whether the patient's stated comfort goal and functional needs are being met. The American Society of Anesthesiologists emphasizes routine assessment and documentation of pain intensity and response to therapy in perioperative care. The Joint Commission likewise identifies assessment, treatment, reassessment, and documentation as core elements of effective pain management. See the American Society of Anesthesiologists acute pain management guideline and Joint Commission pain assessment and management guidance.

QUESTION NO: 12

The nurse teaches a patient recovering from a total hip replacement that it is important to avoid:

A. Putting a pillow between the legs while sleeping

B. Sitting with the legs crossed

C. Abduction exercises of the affected leg

D. Bearing weight exercises on the affected leg for 6 weeks

ANSWER: B

Explanation:

Sitting with the legs crossed is the key activity to avoid during early recovery from a total hip replacement because crossing the legs moves the operated hip into adduction, bringing the leg toward or across the body's midline. This position can place excess stress on the healing soft tissues surrounding the prosthetic joint and may increase the risk of hip dislocation, particularly when posterior hip precautions have been prescribed. Nursing teaching should emphasize maintaining proper hip alignment during sitting, transfers, sleep, and daily activities. The patient should keep the knees and thighs apart rather than allowing the operated leg to cross over the other leg. A pillow or abduction wedge between the legs when resting or sleeping can help maintain this alignment and reinforce the precaution. Hip precautions must ultimately be individualized to the surgical approach, surgeon's instructions, implant stability, and the patient's recovery plan; however, avoiding leg crossing is a standard and clinically important instruction for patients who are following posterior hip precautions. The American Academy of Orthopaedic Surgeons describes precautions intended to reduce dislocation risk after hip replacement, including avoiding positions that place the hip at risk. See AAOS: Activities After a Hip Replacement and Johns Hopkins Medicine: Hip Replacement Recovery.

QUESTION NO: 13

In caring for a woman and baby day 3 postnatally, she tells you that her baby has not had a bowel action since delivery. Your appropriate response would be:

A. Reassure the mother that it is quite normal for a baby to not move their bowels until day 5 after a few days of milk feeding

B. Start a bowel chart, document all findings, and wait another 48 hours before reporting to the physician

C. Encourage more frequent warm baths for the neonate with gentle abdomen massages

D. Tell the mother that you will let the physician know, so the baby can be checked for any obstruction

ANSWER: D

Explanation:

“Tell the mother that you will let the physician know, so the baby can be checked for any obstruction

” is the appropriate response because a newborn should ordinarily pass meconium shortly after birth. Most term newborns do so within the first 24 hours, and delayed passage beyond 48 hours warrants prompt clinical assessment. At day 3 with no bowel action since delivery, the nurse should recognize this as a potentially significant finding rather than a normal feeding-related variation. The immediate priority is to communicate the finding to the responsible clinician and ensure the baby is assessed for intestinal obstruction or conditions associated with delayed meconium passage, while continuing appropriate nursing observation. Assessment may include a focused history and physical examination, including feeding tolerance, vomiting, abdominal distension, and anal patency, with diagnostic investigations directed by the physician or neonatal team. Timely escalation supports early identification and management of conditions such as Hirschsprung disease, meconium ileus, or an anorectal malformation. This response also appropriately acknowledges the mother’s concern and explains the next step in a calm, clear manner. See the Merck Manual discussion of delayed meconium passage and StatPearls guidance on meconium.

QUESTION NO: 14

Which of the following correctly describes wound packing in a wet to dry dressing?

A. Pack gauze into the wound tightly

B. Overlap the wound edges with wet packing

C. Pack the wound with slightly moistened gauze

D. Use gauze well saturated with saline for packing the wound

ANSWER: C

Explanation:

“Pack the wound with slightly moistened gauze” is correct because a wet-to-dry dressing uses gauze moistened with sterile normal saline and gently placed into the wound bed so it contacts the wound surfaces without exerting pressure. The gauze should be damp rather than dripping wet; excess fluid is wrung out before placement. As the dressing dries, it can adhere to surface debris and devitalized tissue, which may be removed with the dressing during a prescribed dressing change. Packing should fill dead space gently and support contact with the wound bed while avoiding pressure that could impair perfusion or damage healing tissue. The dressing is then covered with an appropriate dry secondary dressing to protect the area and manage moisture. This technique is a form of mechanical debridement and should be used only when clinically indicated and ordered, with assessment of the wound, patient comfort, and the current plan of care. Current wound-care guidance generally favors moisture-retentive approaches when appropriate because they support moist wound healing; nevertheless, when wet-to-dry packing is specifically prescribed, slightly moistened sterile gauze describes the correct preparation. See NCBI StatPearls: Wound Dressings and NCBI Bookshelf.

QUESTION NO: 15

A patient has a serum potassium level of 2.8 mEq/L. Which electrocardiographic change should the nurse anticipate?

A. Peaked T waves

B. Prominent U waves

C. Widened QRS complexes

D. Shortened PR interval

ANSWER: B

Explanation:

Prominent U waves is correct because hypokalemia alters cardiac repolarization and can produce flattened or inverted T waves, ST-segment depression, prolonged QT interval, and visible U waves. A potassium level of 2.8 mEq/L is significantly low and can increase the risk of atrial and ventricular dysrhythmias, particularly in patients with heart disease or those receiving digoxin. The nurse should assess for weakness, muscle cramps, palpitations, and ECG changes; review potential causes such as vomiting, diarrhea, diuretic therapy, or inadequate intake; and administer potassium replacement as prescribed with appropriate monitoring. See StatPearls: Hypokalemia.

QUESTION NO: 16

A nurse has been working in a general hospital on the same medical unit for 6 years. The Behavioral Unit is desperately short staffed and the nurse is asked to work her shift in this other unit. What would be the expected response of the nurse to this request?

A. "I will go to the unit and hopefully the behavioral health staff members will assist me with my assignment."

B. "I cannot go. I have no previous behavioral health experience. I do not want to reduce the quality of patient care."

C. "I have no previous behavioral health experience. I am willing to go and help with any duties that are similar to those I perform on my unit."

D. "I should not be expected to float to another unit without a proper orientation. I will fill out an incident report if I am sent there."

ANSWER: C

Explanation:

“I have no previous behavioral health experience. I am willing to go and help with any duties that are similar to those I perform on my unit.” is the appropriate response because it balances the nurse’s professional responsibility to contribute during a staffing need with the duty to practice within demonstrated competence. A registered nurse is accountable for recognizing the limits of personal education, experience, and current competence, particularly when floated to an unfamiliar specialty area. The nurse may safely perform activities that are consistent with existing medical-unit knowledge and skills, while communicating limitations to the receiving unit’s charge nurse and seeking guidance, supervision, and assignment adjustment as needed. This approach supports continuity of care without implying that the nurse is qualified to independently undertake specialty behavioral-health assessments, interventions, or responsibilities for which preparation has not been provided. Safe float practice depends on matching patient assignments to the nurse’s competence, ensuring access to unit-specific support, and escalating concerns promptly if an assignment exceeds the nurse’s capabilities. The American Nurses Association emphasizes that nurses are accountable for their own practice and must act within the scope of their education and competence. See the American Nurses Association’s Scope and Standards of Practice and the NCSBN guidance on nursing accountability and delegation.

QUESTION NO: 17

When preparing to administer a medication the nurse should first:

A. Ensure that the medication is on the medication cart

B. Determine the expiry date of the medication

C. Check the patient's identification armband

D. Verify the physician order for accuracy

ANSWER: D

Explanation:

Verify the physician order for accuracy is the appropriate first action because a valid, complete medication order provides the authorized basis for every subsequent step in the medication-administration process. Before obtaining a drug, checking its expiry date, or approaching the patient for identification, the nurse must confirm the prescribed medication, dose, route, frequency or timing, indication where relevant, and any patient-specific parameters. This initial verification ensures the intended therapy is clear and clinically appropriate and allows the nurse to identify incomplete, illegible, contradictory, duplicate, or potentially unsafe orders before medication preparation begins.

Medication safety practice requires nurses to compare the current authorized prescription with the medication administration record and assess it in the context of the patient's allergies, condition, and relevant laboratory or monitoring requirements. Clarifying an order with the prescriber or pharmacist when necessary is part of safe verification and should occur before administration is initiated. The Institute for Safe Medication Practices emphasizes the importance of accurate prescribing and order review within the medication-use system, while The Joint Commission identifies accurate medication information and safe medication processes as core patient-safety priorities. See ISMP Recommendations and The Joint Commission Medication Safety resources.