National Council Licensure Examination(NCLEX-RN)

NCLEX NCLEX-RN

Version Demo

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QUESTION NO: 1

A 4-year-old child is being discharged from the hospital after being treated for severe croup. Which one of the following instructions should the nurse give to the child's mother for the home treatment of croup?

A. Take him in the bathroom, turn on the hot water, and close the door.

B. Give him a dose of antihistamine.

C. Give large amounts of clear liquids if drooling occurs.

D. Place him near a cool mist vaporizer and encourage crying.

E. Keep him calm and seek emergency care if stridor at rest, worsening breathing, or drooling occurs.

ANSWER: E

Explanation:

"Keep him calm and seek emergency care if stridor at rest, worsening breathing, or drooling occurs." is the safest and most appropriate discharge instruction. Croup causes upper-airway narrowing that can worsen when a child is upset or crying; keeping the child comfortable, upright as tolerated, and calm helps limit increased work of breathing. A parent should be prepared to obtain urgent assessment if the child develops stridor while resting, increasing chest or neck retractions, marked agitation or lethargy, cyanosis, inability to drink, or drooling. Drooling can indicate difficulty handling secretions and requires prompt evaluation rather than oral fluids. Routine steam or hot-water bathroom treatment is not recommended: it has not shown reliable benefit for croup and exposes children to a meaningful risk of scald burns. Humidified air should not delay emergency care when respiratory distress is present. Parents should follow the discharge medication plan, encourage fluids only when the child can swallow comfortably, and use the stated warning signs to determine when immediate care is needed. The American Academy of Pediatrics' parent guidance identifies difficulty breathing, drooling or trouble swallowing, and stridor at rest as reasons to seek urgent medical attention. See HealthyChildren.org: Croup and NHS: Croup.

QUESTION NO: 2

A client has just received an epidural block. She is laboring on her right side. The nurse notes that her blood pressure has dropped from 132/68 to 78/42 mm Hg. The nurse's first action would be to:

A. Call the physician immediately and give dopamine IM

B. Turn her on her left side and recheck her blood pressure in 5 minutes

C. Administer oxytocin (Pitocin) immediately and increase the rate of IV fluids

D. Turn her to the left lateral position, increase the rate of IV fluids, and administer O2 by mask

ANSWER: D

Explanation:

Turn her to the left lateral position, increase the IV fluid rate, and administer oxygen by mask is correct because this client has acute, severe hypotension shortly after epidural analgesia. Neuraxial anesthesia can block sympathetic nerve activity, causing vasodilation, reduced venous return, and a rapid fall in maternal blood pressure. In pregnancy, a supine or right-sided position can also permit uterine compression of major vessels, further reducing venous return and uteroplacental blood flow. Immediate left lateral positioning relieves this compression and promotes maternal cardiac output and placental perfusion. Rapidly increasing prescribed IV fluids supports circulating volume and preload while the nurse continues frequent blood-pressure and fetal-status assessment. Supplemental oxygen is used in this NCLEX-style maternal resuscitation response to support maternal and fetal oxygenation during the acute hypotensive event. These measures are initiated promptly because a systolic pressure of 78 mm Hg represents clinically significant hypotension with potential compromise of uteroplacental perfusion. The nurse should simultaneously remain prepared to notify the anesthesia clinician and administer a prescribed vasopressor if hypotension does not resolve. Guidance on recognizing and managing hypotension associated with epidural anesthesia is available from StatPearls: Epidural Anesthesia and physiologic pregnancy positioning considerations are reviewed in StatPearls: Aortocaval Compression Syndrome.

QUESTION NO: 3

A parent told the public health nurse that her 6-year-old son has been taking tetracycline for a chronic skin condition. The parent asked if this could cause any problems for the child. What should the nurse explain to the parent?

A. Giving tetracycline to a child younger than 8 years may cause permanent staining of his teeth.

B. If you give tetracycline with milk, it may be absorbed readily.

C. The medication should be given to adults, not children.

D. Secondary infections of chronic skin disorders do not respond to antibiotics.

ANSWER: A

Explanation:

Giving tetracycline to a child younger than 8 years may cause permanent staining of his teeth. Tetracycline-class drugs can bind to calcium while teeth are developing and become deposited in dental tissues. In a 6-year-old child, this may produce permanent yellow, gray, or brown tooth discoloration and may also affect enamel development. Therefore, the nurse should recognize this as an important safety concern and advise the parent to contact the child's prescriber promptly to review whether the medication is appropriate and whether an alternative treatment is needed. The age cutoff is clinically important because permanent teeth continue developing during early childhood; conventional tetracycline is generally avoided in children younger than 8 years unless a clinician determines that the expected benefit outweighs the risk. This concern specifically applies to tetracycline exposure during tooth formation. Current medication information for tetracycline includes tooth discoloration as a pediatric precaution, as described by MedlinePlus. Additional clinical pharmacology information on tetracyclines and their effects on developing teeth is available from NCBI Bookshelf.

QUESTION NO: 4

Four days after admission for cirrhosis of the liver, the nurse observes the following when assessing a male client: increased irritability, asterixis, and changes in his speech pattern. Which of the following foods would be appropriate for his bedtime snack?

A. Fresh fruit

B. A milkshake

C. Saltine crackers and peanut butter

D. A ham and cheese sandwich

ANSWER: A

Explanation:

Fresh fruit is appropriate because the client's irritability, asterixis, and altered speech suggest overt hepatic encephalopathy. In cirrhosis, impaired hepatic detoxification and portosystemic shunting allow ammonia and other gut-derived neurotoxins to accumulate, contributing to neurologic manifestations. A bedtime snack that supplies carbohydrate supports caloric intake and helps limit fasting-related breakdown of the client's own muscle protein. Muscle is an important site for ammonia metabolism; preventing catabolism is therefore an important nutritional goal in cirrhosis and hepatic encephalopathy. Fresh fruit provides readily available carbohydrate with minimal protein and is consistent with the traditional acute-care nursing approach for a client exhibiting encephalopathy symptoms. Current liver-disease nutrition guidance also emphasizes adequate total energy intake, avoidance of prolonged fasting, and a late-evening snack for people with cirrhosis. Although long-term nutrition plans should be individualized and should not routinely impose severe protein restriction, the immediate snack choice for this symptomatic client should favor carbohydrate while the clinical team evaluates and treats precipitating factors. See the University of Washington Hepatitis C Online guidance on hepatic encephalopathy and the ESPEN practical guideline for clinical nutrition in liver disease.

QUESTION NO: 5

A client had a vaginal delivery 3 days ago and is discharged from the hospital on the 2nd day postpartum. She told the RN, “I need to start exercising so that I can get back into shape. Could you suggest an exercise I could begin with?’’ The RN could suggest which one of the following?

A. Push-ups

B. Jumping jacks

C. Leg lifts

D. Kegel exercises

ANSWER: D

Explanation:

Kegel exercises are appropriate to begin during the early postpartum period after an uncomplicated vaginal delivery. These exercises involve repeatedly contracting and relaxing the pelvic-floor muscles, which support the bladder, uterus, and bowel. Pregnancy and vaginal birth can stretch and weaken these muscles; gentle pelvic-floor activation promotes awareness and restoration of muscle tone while avoiding excessive physical strain during initial recovery. The client can identify the contraction as the same tightening used to stop the flow of urine, but should perform the exercises when not urinating. A practical starting approach is to tighten the pelvic-floor muscles, hold briefly, fully relax, and repeat several times throughout the day, advancing duration and repetitions as comfort permits. Early postpartum teaching should also reinforce that activity progression is individualized and guided by physical comfort, healing, bleeding, and any clinician-specific restrictions. The American College of Obstetricians and Gynecologists notes that pelvic-floor exercises can be started in the immediate postpartum period and that postpartum exercise should be resumed gradually. See ACOG: Exercise After Pregnancy and NICHD: Pelvic Floor Disorders—Treatments.

QUESTION NO: 6

A 42-year-old client on an inpatient psychiatric unit comments that he was brought to the hospital by his wife because he had taken too many pills and states, “I just couldn’t take it anymore.” The nurse’s best response to this disclosure would be:

A. “You shouldn’t do things like that, just tell someone you feel bad.”

B. “Tell me more about what you couldn’t take anymore.”

C. “I’m sure you probably didn’t mean to kill yourself.”

D. “How long have you been in the hospital.”

ANSWER: B

Explanation:

“Tell me more about what you couldn’t take anymore.” is the best therapeutic response because it acknowledges the client’s statement without judgment and gives him an opportunity to describe the stressors, emotions, hopelessness, and circumstances surrounding the overdose. A broad, open-ended invitation promotes communication and helps establish a supportive nurse-client relationship, which is particularly important after a possible suicide attempt. The client’s wording suggests severe emotional distress and potential suicidal intent; therefore, allowing him to elaborate is an appropriate immediate therapeutic communication technique. As the conversation continues, the nurse should promptly conduct a focused, direct suicide-risk assessment, including asking about current thoughts of suicide, intent, plan, access to means, prior attempts, and protective factors. Direct, empathetic discussion of suicide does not create suicidal thoughts and is essential for identifying immediate safety needs. The National Institute of Mental Health emphasizes direct screening and assessment when suicide risk is suspected, and The Joint Commission identifies suicide-risk assessment as a critical component of safe behavioral health care. See the NIMH Ask Suicide-Screening Questions Toolkit and The Joint Commission Suicide Prevention resources.

QUESTION NO: 7

After the fetal activity test (nonstress test) is completed, the RN is looking at the test results on the monitor strip. The RN observes that the fetal heart accelerated 5 beats/min with each fetal movement. The accelerations lasted ≥15 seconds and occurred 3 times during the 20- minute test. The RN knows that these test results will be interpreted as:

A. A reactive test

B. A nonreactive test

C. An unsatisfactory test

D. A negative test

ANSWER: B

Explanation:

A nonreactive test is the correct interpretation because the fetal heart rate accelerations described do not reach the standard amplitude required for a reactive nonstress test. For a fetus at or beyond 32 weeks' gestation, a reactive nonstress test requires at least two qualifying accelerations within a 20-minute period. Each qualifying acceleration must rise at least 15 beats/min above the established baseline and last at least 15 seconds, measured from the beginning of the acceleration to its return to baseline. Although this tracing has three accelerations and each lasts at least 15 seconds, the rise is only 5 beats/min with fetal movement. Therefore, the accelerations do not meet reactive criteria. A nonreactive result identifies that the expected qualifying accelerations were not demonstrated during the testing interval and requires clinical follow-up based on the overall maternal-fetal assessment and local protocol. Interpretation should also account for gestational age, because before 32 weeks the commonly used acceleration criterion is 10 beats/min for 10 seconds rather than the 15-by-15 standard; however, a 5-beats/min rise does not meet either criterion. See ACOG: Special Tests for Monitoring Fetal Well-Being and StatPearls: Antenatal Fetal Surveillance.

QUESTION NO: 8

A 19-year-old client has sustained a C-7 fracture, which resulted in his spinal cord being partially transected. By 2 weeksâ€™ postinjury, his neck has been surgically stabilized, and he has been transferred from the intensive care unit. A potential life-threatening complication the nurse monitors the client for is:

A. Autonomic dysreflexia

B. Bradycardia

C. Central cord syndrome

D. Spinal shock

ANSWER: A

Explanation:

Autonomic dysreflexia is correct because this client has a cervical spinal cord injury, which is above the thoracic level at which this emergency is most likely to occur. After the acute phase of injury, disruption of descending autonomic control can allow an irritating stimulus below the level of injury to trigger an unopposed sympathetic response. Common triggers include bladder distention, a blocked urinary catheter, bowel impaction, tight clothing, pressure injury, or another painful stimulus that the client may not perceive normally.

The hallmark is sudden, severe hypertension. The nurse should also recognize possible headache, flushing and sweating above the injury level, nasal congestion, anxiety, and changes in heart rate. Severe hypertension can rapidly lead to seizure, retinal hemorrhage, stroke, cardiac complications, or death; therefore, prompt recognition is essential. Initial nursing actions include raising the client to an upright position, loosening restrictive clothing, checking for and removing the triggering stimulus, especially bladder or bowel problems, monitoring blood pressure frequently, and administering prescribed rapid-acting antihypertensive therapy if needed. This condition commonly emerges after spinal shock has resolved, making surveillance especially relevant during rehabilitation and ongoing care. See StatPearls: Autonomic Dysreflexia and the Model Systems Knowledge Translation Center guidance.

QUESTION NO: 9

Which of the following risk factors associated with breast cancer would a nurse consider most significant in a client's history?

A. Menarche after age 13

B. Nulliparity

C. Maternal family history of breast cancer

D. Early menopause

ANSWER: C

Explanation:

Maternal family history of breast cancer is the most significant finding because a family history, particularly breast cancer in a first-degree relative such as a mother, sister, or daughter, is associated with a substantially increased likelihood of breast cancer. The nurse should clarify which relatives were affected, their ages at diagnosis, whether more than one relative has had breast or ovarian cancer, and whether a known pathogenic genetic variant is present. Cancer occurring at a younger age or clustering of breast and ovarian cancers within a family can indicate hereditary breast-and-ovarian cancer risk, including possible BRCA-related risk.

This history is clinically important because it guides individualized risk assessment, genetic counseling referral when indicated, and decisions about enhanced surveillance. The American Cancer Society identifies a strong family history and inherited gene mutations as factors that may place a person in a high-risk screening category; high-risk individuals may need breast MRI in addition to mammography based on their overall risk assessment. A thorough family history should include both maternal and paternal relatives, although the maternal history described is clearly a meaningful risk finding. See the American Cancer Society breast cancer risk-factor guidance and the CDC overview of breast cancer risk factors.

QUESTION NO: 10

A 16-year-old client with anorexia nervosa is on an inpatient psychiatric unit. She has a fear of gaining weight and is refusing to eat sufficient amounts to maintain body weight for her age, height, and stature. To assist with the problem of powerlessness and plan for the client to no longer need to withhold food to feel in control, the nurse uses the following strategy:

A. Establish a structured environment with routine tasks and activities. Also, serve meals at the same time each day.

B. Distract the client during meals to get her to eat because she must take in sufficient amounts to keep from starving.

C. Do frequent room checks to be sure that the client is not hiding food or throwing it away.

D. Listen attentively and participate in in-depth discussions about food, because these actions may encourage her to eat.

ANSWER: A

Explanation:

Establish a structured environment with routine tasks and activities. Also, serve meals at the same time each day. This approach is appropriate because a predictable inpatient milieu provides external structure, consistency, and emotional safety while the adolescent is medically and psychologically vulnerable. Anorexia nervosa commonly involves a distorted need to obtain control through eating-related behaviors. Consistent routines, clearly communicated expectations, and scheduled meals reduce uncertainty and help shift control away from starvation behaviors toward safer, developmentally appropriate choices. The nurse can involve the client in manageable aspects of daily planning when clinically appropriate, reinforcing autonomy without allowing food refusal to direct care. A structured setting also supports coordinated implementation by the interprofessional team, including nutritional rehabilitation, monitoring, therapeutic support, and family involvement. This approach is consistent with evidence-based care for adolescents with eating disorders, which emphasizes nutritional restoration within organized, supportive treatment settings. The American Academy of Child and Adolescent Psychiatry describes nutritional rehabilitation and structured treatment as central components of care for youth with eating disorders. See the AACAP Eating Disorders guide and the National Institute of Mental Health overview of eating disorders.

QUESTION NO: 11

A 9-month-old infant is being examined in the general pediatric clinic for a routine well-child checkup. His immunizations are up to date, and his mother reports that he has had no significant illnesses or injuries. Which of the following signs would lead the nurse to believe that he has had a cerebral injury?

A. Hyperextension of the neck with evidence of pain on flexion

B. Holding the head to one side and pointing the chin toward the other side

C. Holding the head erect and in the midline when in a vertical position

D. Significant head lag when raised to a sitting position

ANSWER: D

Explanation:

Significant head lag when raised to a sitting position is the finding that warrants concern for cerebral injury or another neurologic/developmental disorder in a 9-month-old infant. Head control normally develops early in infancy: by approximately 4 months, infants should have little to no head lag during a pull-to-sit maneuver, and they progressively gain stable midline head control thereafter. At 9 months, persistent marked head lag is not an expected developmental finding. It can reflect inadequate axial muscle control associated with central nervous system dysfunction, including cerebral injury, and requires prompt developmental and neurologic evaluation. The nurse should document the finding, assess the infant's overall tone, symmetry, motor milestones, and interaction, and communicate the concern to the pediatric provider so that appropriate referral and early-intervention services can be arranged if indicated. Developmental surveillance at every health visit is a core pediatric practice because identification of motor delays permits timely assessment and support. The American Academy of Pediatrics describes motor development and head control as key components of developmental surveillance; the CDC also identifies failure to hold the head steady as a developmental concern requiring discussion with a clinician. See the CDC 9-month developmental milestones and the American Academy of Pediatrics developmental surveillance guidance.

QUESTION NO: 12

A client is dilated 8 cm and entering the transition phase of labor. Common behaviors of the laboring woman during transition are:

A. Frustration, vague in communication

B. Seriousness, some difficulty following directions

C. Calmness, follows directions easily

D. Excitement, openness to instructions

ANSWER: A

Explanation:

Frustration, vague in communication is correct because 8 cm cervical dilation places the client in the transition portion of the first stage of labor, which generally occurs from approximately 8 to 10 cm. Contractions are typically very strong, frequent, and demanding during this period. The intensity of pain, fatigue, and the physical effort required to cope can make the client feel overwhelmed or as if control is being lost. Observable behaviors may include irritability, restlessness, fearfulness, difficulty concentrating, indecisiveness, and reduced ability to clearly state needs or process conversation. A client may therefore communicate vaguely, become frustrated, or need brief, simple, calm directions and continuous reassurance from the nurse. Nursing care should focus on remaining present, using concise coaching, supporting breathing and relaxation efforts, encouraging position changes as appropriate, and providing reassurance that the client is progressing through a normal but challenging phase of labor. The American College of Obstetricians and Gynecologists describes the first stage as ending at complete cervical dilation and recognizes the increasing intensity of labor as dilation advances. See ACOG: How to Tell When Labor Begins and Merck Manual: Labor.

QUESTION NO: 13

A 6-year-old child returned to the surgical floor 20 hours ago after an appendectomy for a gangrenous appendix. His mother tells the nurse that he is becoming more restless and is anxious. Assessment findings indicate that the child has atelectasis. Appropriate nursing actions would include:

A. Allowing the child to remain in the position of comfort, preferably semi-or high-Fowler position

B. Administering analgesics as ordered

C. Having the child turn, cough, and deep breathe every 1–2 hours

D. Remaining with the child and keeping as calm and quiet as possible

ANSWER: C

Explanation:

Having the child turn, cough, and deep breathe every 1–2 hours is appropriate because these measures directly promote postoperative lung expansion and secretion clearance. After abdominal surgery, residual effects of anesthesia, pain-related splinting, immobility, and shallow breathing can reduce alveolar ventilation. This can cause dependent alveoli to collapse, producing atelectasis and contributing to restlessness or anxiety if oxygenation and respiratory work are affected. Regular position changes improve ventilation distribution and help mobilize secretions. Deep breathing increases inspiratory volume and supports alveolar recruitment, while coughing helps clear secretions that can obstruct smaller airways and worsen collapse. The nurse should coach the child using age-appropriate instructions and may support the abdominal incision with a pillow or blanket during coughing to improve comfort and participation. These interventions are particularly important in the first postoperative days, when pulmonary complications are a significant risk. Atelectasis management includes interventions that increase lung expansion, such as deep breathing, coughing, early mobilization, and, when prescribed, incentive spirometry. See StatPearls: Atelectasis and AHRQ resources on preventing postoperative pulmonary complications.

QUESTION NO: 14

A 22-year-old single woman was admitted to the psychiatric hospital by her mother, who reported bizarre behavior. Except for going to work, she spends all her time in her room and expresses concern over neighbors spying on her. She has fears of the telephone being “bugged.” Her diagnosis is schizophrenia. One nurse per shift is assigned to work with the client. The primary reason for this plan would be to:

A. Protect her from suicide

B. Enable her to develop trust

C. Supervise her medication regimen

D. Involve her in groups for social interaction

ANSWER: B

Explanation:

Enable her to develop trust is correct because a consistent nurse assignment promotes a stable, predictable therapeutic relationship for a client experiencing paranoid delusions. The client’s fears that neighbors are spying on her and that the telephone is bugged reflect suspiciousness and impaired ability to trust others. Working repeatedly with the same nurse reduces the number of unfamiliar interactions the client must interpret and gives the nurse an opportunity to communicate calmly, maintain dependable boundaries, and demonstrate reliability over time. This consistency supports the client’s sense of safety without validating the delusional belief. Trust is a fundamental condition for therapeutic engagement: as the client becomes more comfortable with the nurse, she is more likely to discuss concerns, accept reality-based support, participate in care, and develop coping strategies. Schizophrenia can include delusions and social withdrawal, both of which may interfere with interpersonal functioning and treatment participation. A planned, consistent staff approach is therefore especially valuable during acute hospitalization. The National Institute of Mental Health describes delusions and social withdrawal as common features of schizophrenia: NIMH: Schizophrenia. The importance of therapeutic communication and a trusting nurse-client relationship is also summarized in StatPearls: Therapeutic Communication.

QUESTION NO: 15

The following medications were noted on review of the clientâ€™s home medication profile. Which of the medications would most likely potentiate or elevate serum digoxin levels?

A. KCl

B. Thyroid agents

C. Quinidine

D. Theophylline

ANSWER: C

Explanation:

Quinidine is correct because it has a clinically significant pharmacokinetic interaction with digoxin that can substantially increase serum digoxin concentrations. Quinidine inhibits P-glycoprotein, an important transporter involved in digoxin absorption, distribution, and renal and biliary elimination. This decreases digoxin clearance and may also increase its bioavailability, resulting in higher circulating digoxin levels. The increase can be large enough to place a client at risk for digoxin toxicity, particularly when other risks such as impaired renal function, advanced age, or electrolyte disturbances are present. When quinidine is started for a client receiving digoxin, the prescriber commonly reduces the digoxin dose and obtains serum digoxin concentrations and clinical assessments for toxicity. Nursing monitoring should include apical pulse, cardiac rhythm, gastrointestinal symptoms, changes in vision, and neurologic changes, while recognizing that serum concentrations must be interpreted with the timing of the last dose and the client's overall condition. Digoxin interaction information is available in the NCBI Bookshelf digoxin review and in the DailyMed digoxin prescribing information.

QUESTION NO: 16

Before giving methergine postpartum, the nurse should assess the client for:

A. Decreased amount of lochial flow

B. Elevated blood pressure

C. Flushing

D. Afterpains

ANSWER: B

Explanation:

Elevated blood pressure is the essential assessment before administering methylergonovine (Methergine) postpartum. Methylergonovine is an ergot alkaloid uterotonic that produces sustained, powerful uterine contractions to prevent or treat postpartum hemorrhage caused by uterine atony. It also causes vasoconstriction, which can increase systemic vascular resistance and precipitate dangerous hypertension. Therefore, the nurse should obtain and evaluate the client's blood pressure before each dose and withhold the medication, then notify the prescribing clinician, if hypertension is present or the blood pressure is above the parameters specified by the prescription or institutional protocol. This precaution is particularly important in a client with hypertensive disorders of pregnancy, such as preeclampsia, because severe hypertension can lead to serious complications including stroke or seizures. The FDA prescribing information lists hypertension and toxemia as contraindications and directs clinicians to monitor blood pressure carefully, especially when the drug is administered intravenously. Postpartum hemorrhage requires prompt assessment and management, but medication selection must account for maternal contraindications. See the FDA Methergine prescribing information and the NCBI StatPearls review of postpartum hemorrhage.

QUESTION NO: 17

A 2-year-old child with a scalp laceration and subdural hematoma of the temporal area as a result of falling out of bed should be prevented from:

A. Crying

B. Falling asleep

C. Rolling from his back to his tummy

D. Sucking his thumb

ANSWER: A

Explanation:

Crying should be prevented as much as feasible because a subdural hematoma can increase intracranial pressure through bleeding and mass effect within the fixed space of the skull. Vigorous or prolonged crying raises intrathoracic pressure and can impede cerebral venous drainage, which may further elevate intracranial pressure. In a young child with an acute head injury, nursing care should therefore emphasize a calm, low-stimulation environment and prompt comfort measures. The nurse can reduce distress by keeping the caregiver nearby, addressing pain as prescribed, using quiet reassurance, clustering necessary care, and avoiding unnecessary handling or procedures that provoke agitation.

Preventing crying does not mean expecting a toddler to remain completely silent or withholding appropriate assessment. Rather, it means actively minimizing sustained agitation while monitoring neurologic status, level of consciousness, pupil response, motor function, vital signs, and signs of worsening intracranial pressure. This approach supports cerebral perfusion and helps limit secondary brain injury while the child receives ongoing evaluation and treatment. Guidance on pediatric traumatic brain injury and monitoring for deterioration is available from the CDC clinical guidance for pediatric mild traumatic brain injury and the Merck Manual overview of traumatic brain injury.

QUESTION NO: 18

A client has a history of alcoholism. He is currently diagnosed with cirrhosis of the liver. The nurse would expect him to be on which type of diet?

A. High protein and high calorie

B. High calorie and high carbohydrate

C. Low-fat 2-g sodium diet

D. High protein and high fat

ANSWER: B

Explanation:

High calorie and high carbohydrate is the best answer because cirrhosis, particularly when associated with alcohol use, commonly causes malnutrition and depleted glycogen stores. The diseased liver has limited capacity to store and release glycogen, so the client may shift into catabolism during relatively short periods without food. Adequate calories, with carbohydrates serving as an important energy source, help spare body protein and reduce breakdown of muscle and other tissues for energy. Nursing care should therefore anticipate nutrition support that meets increased energy needs, often using regular meals and snacks while monitoring weight, intake, glucose status, and manifestations of liver dysfunction. Current liver-nutrition guidance emphasizes preventing malnutrition and maintaining energy intake in cirrhosis; it also supports individualized nutrition planning based on complications and tolerance. In contemporary practice, protein is usually not routinely restricted in stable cirrhosis, but the diet choice given that most directly addresses the classic exam priority of preventing tissue catabolism is high calorie and high carbohydrate. See the AASLD guidance on malnutrition, frailty, and sarcopenia in cirrhosis and the ESPEN clinical nutrition guideline for liver disease.

QUESTION NO: 19

A group of nursing students at a local preschool day care center are going to screen each child's fine and gross motor, language, and social skills. The students will use which one of the most widely used screening tests?

A. Revised Prescreening Developmental Questionnaire

B. Goodenough Draw-a-Person Screening Test

C. Denver Developmental Screening Test

D. Caldwell Home Inventory

ANSWER: C

Explanation:

The Denver Developmental Screening Test is correct because it was designed as a brief developmental screening instrument for children from birth through age 6 years. Its domains align directly with the skills the students plan to assess: personal-social functioning, fine-motor–adaptive abilities, language, and gross-motor skills. The revised version, Denver II, is commonly referenced in pediatric and nursing education and provides a structured method for comparing a child's observed developmental behaviors with age-based expectations. A screening test helps identify children who may need more comprehensive developmental evaluation; it does not establish a diagnosis by itself. In a preschool day-care setting, its concise administration and coverage of several developmental domains make it appropriate for an initial assessment of children's developmental progress. The American Academy of Pediatrics emphasizes the importance of developmental surveillance and standardized screening to identify developmental concerns early and facilitate timely referral and intervention. Additional background on developmental screening is available from the American Academy of Pediatrics and the Centers for Disease Control and Prevention.

QUESTION NO: 20

A client is experiencing mucosal cell damage secondary to chemotherapy. Because of mucosal ulcers, eating has become increasingly uncomfortable for her. Which of the following interventions would be most effective in getting her to eat?

A. Local anesthetics or mouth washes applied to ulcers 30 minutes prior to meals

B. A bland, moist, soft diet

C. Staying with the client and providing distraction during meals

D. Cleaning the mouth carefully with lemon glycerin swabs and milk of magnesia before meals

ANSWER: B

Explanation:

A bland, moist, soft diet is the most effective intervention because chemotherapy-related oral mucositis causes inflammation, ulceration, and significant pain with chewing and swallowing. Soft foods require minimal chewing and are less likely to mechanically traumatize fragile ulcerated tissue. Moist foods also reduce dryness and friction, making them easier to swallow and more tolerable when saliva production is reduced or oral tissues are inflamed. Choosing bland foods avoids strong acidic, salty, spicy, or highly seasoned flavors that can intensify burning and pain at ulcer sites. By reducing oral discomfort during meals, this dietary approach directly supports calorie, protein, and fluid intake at a time when maintaining nutrition is important for healing, treatment tolerance, and infection prevention. Appropriate examples include smooth cereals, yogurt, pudding, mashed foods, soups that are not hot, and well-moistened protein foods, individualized to the client's preferences and swallowing ability. The National Cancer Institute recommends soft, bland foods and foods with extra moisture for people with mouth sores from cancer treatment. The American Cancer Society likewise advises soft, moist foods to help manage mouth sores and preserve nutritional intake. See the National Cancer Institute's guidance on mouth sores and the American Cancer Society's nutrition guidance for mouth sores.

QUESTION NO: 21

A 42-year-old male client has been treated at an alcoholic rehabilitation center for physiological alcohol dependence. The nurse will be able to determine that he is preparing for discharge and is effectively coping with his problem when he shares with her the following information:

A. “I know that I will not ever be able to socially drink alcohol again and will need the support of the AA group.”

B. “I know that I can only drink one or two drinks at social gatherings in the future, but at least I don’t have to continue AA.”

C. “I really wasn’t addicted to alcohol when I came here, I just needed some help dealing with my divorce.”

D. “It really wasn’t my fault that I had to come here. If my wife hadn’t left, I wouldn’t have needed those drinks.”

ANSWER: A

Explanation:

“I know that I will not ever be able to socially drink alcohol again and will need the support of the AA group.” demonstrates effective coping and readiness for discharge because the client acknowledges the chronic, relapsing nature of alcohol dependence and recognizes that abstinence, rather than controlled social drinking, is necessary for his recovery plan. This statement also shows insight into the personal risk of alcohol use and acceptance of responsibility for maintaining recovery after leaving the structured rehabilitation setting.

Seeking continued Alcoholics Anonymous support reflects appropriate use of a community-based recovery resource. Mutual-support groups can help individuals sustain recovery by providing regular peer contact, encouragement, accountability, and a network that supports alcohol-free living. A safe discharge plan for a client recovering from physiological alcohol dependence includes a clear commitment to avoiding alcohol and arranging ongoing treatment or recovery supports. The National Institute on Alcohol Abuse and Alcoholism describes recovery support services, including mutual-help groups, as important resources for maintaining recovery. Alcoholics Anonymous likewise identifies abstinence from alcohol and support from other members as central to its program. See NIAAA: Treatment for Alcohol Problems and Alcoholics Anonymous: The AA Program.

QUESTION NO: 22

After performing a sterile vaginal exam on a client who has just been admitted to the unit in active labor and placed on an electronic fetal monitor, the RN assesses that the fetal head is at 21 station. She documents this on the monitor strip. Fetal head at 21 station means that the fetal head is located where in the pelvis?

A. One centimeter below the ischial spines

B. One centimeter above the ischial spines

C. Has not entered the pelvic inlet yet

D. Located in the pelvic outlet

ANSWER: A

Explanation:

One centimeter below the ischial spines is correct for a fetal head at +1 station. Fetal station describes the position of the presenting fetal part in relation to the maternal ischial spines, which are fixed bony landmarks in the midpelvis. The level of the ischial spines is assigned station 0. Positions above the spines are documented with negative numbers, whereas positions below the spines are documented with positive numbers. Therefore, a finding of +1 means the presenting part, usually the fetal head in a vertex presentation, has descended 1 cm below the ischial spines. This documents progress of descent through the maternal pelvis and is an important component of ongoing labor assessment, together with cervical dilation, effacement, fetal heart-rate evaluation, and contraction pattern. In the question text, “21 station” appears to be a formatting rendering of +1 station. The terminology and relationship of positive fetal station to descent below the ischial spines are described in StatPearls: Normal Labor and in the Merck Manual’s management of normal labor.

QUESTION NO: 23

A 30-year-old client has just been treated in the ER for bruises and abrasions to her face and a broken arm from domestic violence, which has been increasing in frequency and intensity over the last few months. The nurse assesses her as being very anxious, fearful, bewildered, and feeling helpless as she states, “I don’t know what to do, I’m afraid to go home.” The best response by the nurse to the client would be:

A. “I wouldn’t want to go home either; call a friend who could help you.”

B. “Did you do something that could have made him so angry?”

C. “Let’s talk about people and resources available to you so that you don’t have to go home.”

D. “I’ll call the police and they will take care of him, and you can go home and get some rest.”

ANSWER: C

Explanation:

“Let’s talk about people and resources available to you so that you don’t have to go home.” is the best response because it provides immediate emotional support while helping the client identify practical, safety-focused alternatives. The client is in crisis, reports escalating violence, and explicitly states fear about returning home. A therapeutic nursing response acknowledges the seriousness of her concern without judgment, respects her autonomy, and collaborates with her on a plan that may include a domestic-violence advocate, emergency shelter, trusted support person, social worker, safety planning, transportation, and follow-up care. This approach does not pressure the client to make a particular legal or relationship decision; instead, it promotes informed choices and addresses the immediate need for safety. Trauma-informed care emphasizes establishing physical and emotional safety, offering choices, and partnering with the person receiving care. The nurse should also follow organizational policy and applicable reporting requirements, document findings objectively, assess for immediate danger, and facilitate connection with appropriate advocacy and community services. The National Domestic Violence Hotline provides confidential support and local resource connections at https://www.thehotline.org/. Guidance on trauma-informed approaches in health care is available from SAMHSA at https://www.samhsa.gov/trauma-violence.

QUESTION NO: 24

A 24-year-old male client is admitted with a diagnosis of sickle cell anemia. The nurse discusses his disease with him and emphasizes the following information:

A. He should monitor his sputum, stools, and urine for signs of bleeding.

B. His daily diet should include a large amount of fluid.

C. He should not be concerned about having to fly on a commuter airplane on a weekly basis.

D. He should not worry about having children because this disease is passed on only by female carriers.

ANSWER: B

Explanation:

“His daily diet should include a large amount of fluid.” is correct because maintaining good hydration is a core self-management measure for a person with sickle cell disease. Sickle-shaped erythrocytes can obstruct small blood vessels, causing painful vaso-occlusive episodes and impaired tissue perfusion. Dehydration reduces circulating plasma volume and increases blood viscosity, which promotes the conditions under which red blood cells are more likely to sickle and contribute to vascular obstruction. Adequate oral fluid intake supports intravascular volume, helps maintain blood flow, and can reduce a common, preventable trigger for pain crises. Nursing teaching should therefore emphasize regularly drinking water throughout the day, with increased attention during fever, hot weather, exercise, vomiting, diarrhea, or other circumstances that increase fluid losses. The client should individualize exact fluid goals with the health care team, particularly if another condition affects fluid balance, but the general teaching priority is consistent hydration. The Centers for Disease Control and Prevention identifies drinking plenty of water as a way to help prevent pain crises in sickle cell disease. The National Heart, Lung, and Blood Institute likewise includes hydration among practical measures for avoiding sickle cell disease complications. See the CDC overview of sickle cell disease and the NHLBI guidance for living with sickle cell disease.

QUESTION NO: 25

A male client has asthma and his physician has prescribed beclomethasone (Vanceril) 3 puffs tid in addition to his other medications. After taking his beclomethasone, the client should be instructed to:

A. Clean his inhaler with warm water and soak it in a10% bleach solution

B. Drink a glass of water

C. Sit and rest

D. Use his bronchodilator inhaler

ANSWER: B

Explanation:

Drink a glass of water is correct because beclomethasone is an inhaled corticosteroid. Some of the medication can remain in the mouth and throat after inhalation. Removing this residual medication by drinking water, rinsing the mouth, and preferably gargling before spitting out the water helps reduce local adverse effects, especially oral candidiasis (thrush), throat irritation, and hoarseness. This instruction is particularly important when beclomethasone is prescribed several times daily, because repeated exposure increases the opportunity for corticosteroid residue to affect the oral mucosa. The client should use the inhaler with correct technique and follow each dose with mouth rinsing; drinking water is an acceptable way to help clear medication from the oropharynx in the wording of this question. A spacer device, when compatible with the inhaler and prescribed or recommended, may also reduce medication deposition in the mouth and throat. Beclomethasone is used for long-term control of airway inflammation and should be taken consistently as directed, even when the client feels well. The U.S. National Library of Medicine advises patients using oral inhaled beclomethasone to rinse the mouth with water after each dose. See MedlinePlus: Beclomethasone Oral Inhalation and NHLBI: Asthma Treatment and Action Plans.

QUESTION NO: 26

A 58-year-old client on a general surgery unit is scheduled for transurethral resection of the prostate (TURP) in 2 hours. The nurse explains to the client that this procedure means:

A. Removal of the prostate tissue by way of a lower abdominal midline incision through the bladder and into the prostate gland

B. Removal of prostate tissue by a resectoscope that is inserted through the penile urethra

C. Removal of the prostate tissue by an open surgical approach through an incision between the ischial tuberosities, the scrotum, and the rectum

D. Removal of prostate tissue by an open surgical approach through a low horizontal incision, bypassing the bladder, to the prostate gland

ANSWER: B

Explanation:

Removal of prostate tissue by a resectoscope that is inserted through the penile urethra is correct because a transurethral resection of the prostate is performed using an endoscopic instrument passed through the urethra to reach the prostate. “Transurethral” identifies the route of access: the surgeon does not make an external abdominal, suprapubic, or perineal incision to enter the prostate. A resectoscope provides visualization, irrigation, and a wire loop or other instrument that removes obstructing portions of prostatic tissue. The purpose is generally to relieve urinary obstruction caused by benign prostatic hyperplasia by widening the prostatic urethral channel and improving urine flow. The nurse should use clear language when teaching the client: the instrument is inserted through the penis into the urethra, and excess prostate tissue is removed from inside the urinary passage. This accurately distinguishes the procedure’s minimally invasive transurethral approach from open prostate surgery. The National Institute of Diabetes and Digestive and Kidney Diseases describes TURP as a procedure in which a surgeon inserts a resectoscope through the urethra and removes prostate tissue causing obstruction. Additional procedural information is available from the NIDDK and the Mayo Clinic.

QUESTION NO: 27

A 28-year-old client comes to the clinic for her first prenatal examination. In relating her obstetrical history, she tells the nurse that she has been pregnant twice before. She had a “miscarriage” with the first pregnancy after 6 weeks. With the second pregnancy, she delivered twin girls at 31 weeks’ gestation. One of the twins was stillborn and the other twin died at 4 days of age. Using a five-digit system, the nurse records her as being:

A. 2-0-2-1-0

B. 2-2-2-1-2

C. 3-0-1-1-0

D. 2-1-1-0-0

ANSWER: C

Explanation:

3-0-1-1-0 is correct using the five-digit obstetric history format: total pregnancies, term births, preterm births, abortions, and living children. The current prenatal visit is for the client’s third pregnancy, so the first value is 3. She has had no births at term because the prior delivery occurred at 31 weeks of gestation; therefore, the term-birth value is 0. A delivery at 31 weeks is a preterm birth, making the third value 1. Although two infants were delivered in that pregnancy, a multifetal gestation counts as one pregnancy and one delivery event for these obstetric-history values. The pregnancy loss at 6 weeks is counted as one abortion because it occurred before fetal viability, yielding a fourth value of 1. Finally, neither twin is currently alive: one was stillborn and the other died at 4 days of age. Thus, the living-children value is 0. This notation accurately distinguishes pregnancy events from the number of fetuses or infants involved and documents the client’s current reproductive history. The Merck Manual’s obstetric-history guidance describes this five-number approach and notes that multiple births count as one pregnancy. The American College of Obstetricians and Gynecologists’ pregnancy timeline identifies 31 weeks as occurring before term gestation.

QUESTION NO: 28

One of the most reliable assessment tools for adequacy of fluid resuscitation in burned children is:

A. Blood pressure

B. Level of consciousness

C. Skin turgor

D. Fluid intake

E. Urine output

ANSWER: E

Explanation:

Urine output is the most reliable bedside indicator of whether fluid resuscitation is maintaining adequate renal perfusion in a child with significant burns. Major burns cause capillary leak and rapid intravascular volume loss during the early resuscitation phase. Because the kidneys respond promptly to reduced circulating volume, hourly urine output provides an objective, continuously measurable response to the child’s perfusion status and to adjustments in intravenous fluid therapy. A urinary catheter is commonly used in major burns so that output can be measured accurately each hour. For pediatric burn resuscitation, a commonly used goal is at least 1 mL/kg/hour in children weighing less than 30 kg; goals should be individualized according to the child’s size, clinical condition, and burn-care protocol. Trending urine output is more useful than relying on a single measurement, because fluid needs can change substantially during the first 24 hours after injury. Assessment of perfusion also includes the overall clinical picture, but urine output is the key endpoint used to titrate resuscitation fluids. See StatPearls: Burn Fluid Resuscitation and the American Burn Association resources.

QUESTION NO: 29

When teaching a mother of a 4-month-old with diarrhea about the importance of preventing dehydration, the nurse would inform the mother about the importance of feeding her child:

A. Fruit juices

B. Diluted carbonated drinks

C. Soy-based, lactose-free formula

D. Regular formulas mixed with electrolyte solutions

E. Regular, full-strength infant formula

ANSWER: E

Explanation:

Regular, full-strength infant formula is appropriate for most formula-fed infants with acute diarrhea and helps maintain nutritional intake while the child is rehydrated. The priority in preventing dehydration is prompt replacement of fluid and electrolyte losses with an oral rehydration solution when indicated, while continuing normal feeding. Infants should not have formula diluted or mixed with electrolyte solution, because changing the formula concentration can reduce calorie and nutrient intake and may create an inappropriate solute balance. Routine substitution with a lactose-free or soy-based formula is not necessary for uncomplicated acute diarrhea; temporary lactose restriction may be considered only when there is a specific clinical indication, such as suspected lactose intolerance or prolonged diarrhea. The Centers for Disease Control and Prevention advises that breastfed infants continue breastfeeding and formula-fed infants continue their usual formula after rehydration. Caregivers should be taught to offer fluids as directed, monitor wet diapers, intake, activity, tears, and mucous membranes, and obtain urgent evaluation for concerning signs such as lethargy, markedly decreased urine output, or inability to retain fluids. See the CDC guidance on managing acute gastroenteritis among children and the American Academy of Pediatrics' parent guidance on diarrhea.

QUESTION NO: 30

In caring at home for a child who just ingested a caustic alkali, the nurse would immediately tell the mother to:

A. Give vinegar, lemon juice, or orange juice

B. Phone the doctor

C. Take the child to the emergency room

D. Induce vomiting

E. Call Poison Control immediately for instructions and seek emergency evaluation

ANSWER: E

Explanation:

"Call Poison Control immediately for instructions and seek emergency evaluation" is the safest current recommendation after a child ingests a caustic alkali. Alkalis can cause severe, rapidly developing burns to the mouth, pharynx, esophagus, and stomach. Management depends on the exact substance, its concentration, the amount consumed, the time since exposure, and the child's symptoms. Poison Control specialists can rapidly identify the product, assess the immediate risk, give substance-specific first-aid directions, and direct the caregiver to emergency services or an emergency department when needed. In the United States, Poison Control is available 24 hours a day at 1-800-222-1222; caregivers should call 911 if the child has trouble breathing, loss of consciousness, seizures, or other life-threatening symptoms. Current poison-management guidance specifically avoids home chemical neutralization because acid-base reactions can generate heat and worsen tissue injury. The child should not be given anything by mouth unless instructed by a poison specialist or clinician. Prompt expert triage is essential because serious internal injury may occur even when visible oral injury or early symptoms seem limited. See Poison Control: Caustic cleaners and MedlinePlus: Poisoning first aid.

QUESTION NO: 31

A client is a depressed, 48-year-old salesman. A serious concern for the nurse working with depressed clients is the potential of suicide. The time that suicide is most likely to occur is:

A. In the acutely depressed state

B. When the depression starts to lift

C. In the denial phase

D. During a manic episode

ANSWER: B

Explanation:

“When the depression starts to lift” is correct because a person emerging from a severe depressive episode may regain enough energy, concentration, initiative, and capacity for planning before feelings of hopelessness, worthlessness, or suicidal thinking have fully resolved. This combination can increase the immediate ability to act on a previously formed suicidal plan. In the most profoundly depressed state, psychomotor retardation, extreme fatigue, impaired concentration, and withdrawal may limit a client’s capacity to organize or carry out an attempt, although suicide risk must still be assessed continuously at every phase of depression.

Nursing care should therefore include repeated, direct assessment of suicidal ideation, intent, plan, access to lethal means, past attempts, and protective factors, particularly when treatment begins to improve sleep, appetite, activity, or affect. Observation level, environmental safety measures, collaborative safety planning, and prompt communication with the psychiatric team should be adjusted to the client’s current risk. The National Institute of Mental Health emphasizes that asking directly about suicide does not cause suicidal thoughts and is an important component of identifying risk. See the National Institute of Mental Health suicide FAQ and the Joint Commission suicide-prevention resources.

QUESTION NO: 32

A female client has experienced varying degrees of depression throughout her life. Now that she is postmenopausal, her depression has increased. She is unable to motivate herself to clean her house or even to get out of bed and get dressed in the morning. The client was begun on fluoxetine (Prozac) therapy. When educating her about fluoxetine, what might the nurse caution her about?

A. A daily dose of fluoxetine may be taken in the morning or evening.

B. Fluoxetine is not sedating; therefore, restrictions on driving and other hazardous activities are not necessary.

C. Rashes or pruritus usually occur early in the therapy and are treatable without discontinuing the medication.

D. It is safe to take over-the-counter or other prescription medications with fluoxetine.

E. Take the daily dose of fluoxetine in the morning because it can cause nervousness or insomnia if taken later in the day.

ANSWER: E

Explanation:

“Take the daily dose of fluoxetine in the morning because it can cause nervousness or insomnia if taken later in the day” is the appropriate teaching point. Fluoxetine is a selective serotonin reuptake inhibitor that may be activating for some clients, particularly early in treatment. Activation can present as anxiety, agitation, nervousness, or sleep disturbance. Morning administration is therefore commonly recommended when once-daily fluoxetine causes insomnia or interferes with sleep. This instruction is especially relevant for a client already experiencing marked functional effects of depression, because preserving adequate sleep supports recovery, safety, daytime functioning, and adherence to therapy. The nurse should explain that the medication should be taken consistently at the same time each day and that therapeutic improvement in depressive symptoms may require several weeks. The client should contact the prescriber if insomnia, agitation, or other adverse effects become persistent or severe rather than independently changing the dose or schedule. The U.S. prescribing

information identifies insomnia and anxiety among potential adverse effects and supports individualized timing of administration. See the FDA Prozac prescribing information and MedlinePlus fluoxetine drug information.

QUESTION NO: 33

A 26-year-old female client presents at 10 weeks' gestation. She currently is a G3 1-0-1-1. Her mother and grandmother have heart disease. Her grandmother also has insulin-dependent diabetes. The client's previous delivery was a term female infant weighing 9 lb 13 oz. The client is 5 ft 6 inches tall and her current weight is 130 lb. Based on her history, she is at risk for developing diabetes in pregnancy. Which of the following factors places her at risk for gestational diabetes?

A. Age>25 years

B. Maternal weight

C. Previous birth of an infant weighing>9 lb

D. Family history of heart disease

ANSWER: C

Explanation:

Previous birth of an infant weighing>9 lb is correct because the client previously delivered an infant weighing 9 lb 13 oz, which is substantially above 9 lb. A prior macrosomic infant is a recognized historical risk factor for gestational diabetes mellitus. Fetal overgrowth can occur when maternal glucose levels are elevated during a pregnancy, including when hyperglycemia was not diagnosed at the time. Therefore, this obstetric history warrants attention early in the current pregnancy and supports appropriate glucose screening according to the prenatal care plan.

Gestational diabetes is glucose intolerance first identified during pregnancy. Identifying people with risk factors at the initial prenatal assessment helps clinicians determine whether early evaluation for overt diabetes is indicated and reinforces the importance of routine gestational-diabetes screening later in pregnancy. The client's prior delivery history provides a specific, clinically meaningful indicator of risk because it documents a previous newborn with excessive birth weight. The Centers for Disease Control and Prevention includes having previously given birth to a baby weighing more than 9 pounds among factors associated with a greater likelihood of gestational diabetes. See the CDC overview of gestational diabetes and the National Institute of Diabetes and Digestive and Kidney Diseases guidance on gestational diabetes.

QUESTION NO: 34

Which one of the following is considered a reliable indicator for assessing the adequacy of fluid resuscitation in a 3-year-old child who suffered partial- and fullthickness burns to 25% of her body?

A. Urine output

B. Edema

C. Hypertension

D. Bulging fontanelle

ANSWER: A

Explanation:

Urine output is the most reliable bedside indicator of adequate fluid resuscitation in a child with a major burn because it reflects effective circulating volume and renal perfusion. Major burns cause substantial fluid shifts from the intravascular space into injured and surrounding tissues, particularly during the initial resuscitation period. The nurse therefore monitors urinary output closely, usually with an indwelling urinary catheter, and the health care team titrates prescribed intravenous crystalloid fluids in response to this physiologic measure. For pediatric burn resuscitation, the usual target is at least 1 mL/kg/hour of urine output for children weighing less than 30 kg; a 3-year-old will generally fall within this group. Consistently meeting this target supports that perfusion is sufficient to deliver blood flow to the kidneys and other vital organs.

Assessment must be ongoing and interpreted with the child's overall clinical condition, including vital signs, mental status, peripheral perfusion, and laboratory findings, but urine output remains a central resuscitation endpoint. The American Burn Association's burn-shock resuscitation guideline discusses urine-output-directed fluid titration, and pediatric burn guidance identifies the higher weight-based target used in small children. See the American Burn Association Clinical Practice Guidelines for Burn Shock Resuscitation and the Merck Manual overview of burn management.

QUESTION NO: 35

A common complication of cirrhosis of the liver is prolonged bleeding. The nurse should be prepared to administer?

A. Vitamin C

B. Vitamin K

C. Vitamin E

D. Vitamin A

ANSWER: B

Explanation:

Vitamin K is appropriate because it is required for hepatic synthesis of several coagulation factors, including factors II, VII, IX, and X, as well as proteins C and S. In cirrhosis, impaired bile production or flow and reduced hepatic reserve can contribute to vitamin K deficiency and decreased production of vitamin K-dependent clotting factors. This may be reflected by a prolonged prothrombin time or elevated international normalized ratio and can contribute to clinically significant bleeding.

Administration of vitamin K, often by a parenteral route when absorption is a concern, can help correct coagulopathy when deficiency is contributing. The nurse should assess for manifestations of bleeding, monitor ordered coagulation studies, and administer the medication as prescribed. Although severe hepatocellular dysfunction may limit the liver's ability to respond fully, vitamin K remains the indicated therapy in this question because it addresses a reversible deficiency affecting clotting-factor production. The National Library of Medicine describes vitamin K's essential role in activating clotting proteins, and Merck Manual notes that vitamin K deficiency can cause impaired coagulation and bleeding. See NCBI Bookshelf: Vitamin K Deficiency and Merck Manual: Vitamin K Deficiency.

QUESTION NO: 36

The nurse is admitting a client with folic acid deficiency anemia. Which of the following questions is most important for the nurse to ask the client?

A. "Do you take aspirin on a regular basis?"

B. "Do you drink alcohol on a regular basis?"

C. "Do you eat red meat?"

D. "Have your stools been normal?"

ANSWER: B

Explanation:

"Do you drink alcohol on a regular basis?" is the priority question because regular alcohol use is a major, clinically relevant contributor to folate deficiency. Alcohol use may displace nutritious, folate-containing foods from the diet and can impair intestinal folate absorption, hepatic storage, and folate metabolism. These effects can deplete body folate stores and contribute to the impaired DNA synthesis that produces megaloblastic anemia. Identifying the client's alcohol intake during admission helps the nurse establish a likely cause, assess nutritional risk, plan appropriate education and referral, and anticipate the need for broader assessment of liver disease, withdrawal risk, and other alcohol-related complications. Folate deficiency may develop relatively quickly when intake is inadequate because body stores are limited. A nonjudgmental, specific assessment of the amount and frequency of alcohol consumption provides information essential to safe,

individualized care. The National Institutes of Health notes that alcohol interferes with folate absorption and metabolism and is associated with low folate status. NIH Office of Dietary Supplements: Folate—Health Professional Fact Sheet The Merck Manual also identifies alcohol use disorder as a cause of folate deficiency. Merck Manual: Folate Deficiency

QUESTION NO: 37

At 12 hours postvaginal delivery, a female client is without complications. Which of the following assessment findings would warrant further nursing interventions?

A. Apical pulse of 52 bpm

B. Uterine fundus palpable left of midline

C. No bowel movement since delivery

D. Oral temperature of 100.4◦F

ANSWER: B

Explanation:

Uterine fundus palpable left of midline warrants further nursing intervention because a fundus that is not centered in the midline during the immediate postpartum period commonly indicates bladder distention. As the bladder fills, it can displace the uterus laterally, often to one side, and prevent effective uterine contraction. A displaced uterus should prompt the nurse to assess for bladder fullness and assist the client to void; if the client cannot void adequately, further evaluation and interventions such as bladder scanning or catheterization may be needed according to clinical findings and orders. Emptying the bladder allows the uterus to return toward the midline and contract firmly. Effective uterine contraction is essential after delivery because it compresses the maternal blood vessels at the placental site and limits postpartum blood loss. The nurse should also reassess fundal position, tone, lochia, and bleeding after bladder emptying to confirm that uterine involution and hemostasis are adequate. Postpartum assessment guidance emphasizes evaluating fundal tone and location and addressing bladder distention promptly as part of hemorrhage prevention and early recognition. See the Merck Manual Professional Edition postpartum-care guidance and the American College of Obstetricians and Gynecologists postpartum hemorrhage information.

QUESTION NO: 38

A client who is 7 months pregnant is diagnosed with pyelonephritis. The nurse anticipates the physician ordering:

A. Oxytocin

B. Magnesium sulfate (MgSO4)

C. Ampicillin

D. Tetracycline

ANSWER: C

Explanation:

Ampicillin is the intended correct answer because it is a penicillin-class antibiotic that has historically been used to treat susceptible bacterial urinary infections during pregnancy and is not associated with known teratogenic effects. Pyelonephritis in pregnancy requires prompt antimicrobial treatment because untreated upper urinary tract infection can lead to serious maternal illness and adverse obstetric outcomes. The nurse should anticipate antibiotic therapy, obtain or review urine culture and susceptibility results, monitor the client's temperature, flank pain, hydration status, and fetal status, and administer the prescribed medication as scheduled. In current practice, pregnant clients with pyelonephritis are generally initially managed in the inpatient setting with parenteral antibiotics that penetrate renal tissue; treatment is then adjusted to culture results and continued for a total of 14 days. Ampicillin may be selected when the causative organism is susceptible, although local resistance patterns and culture findings guide the final regimen. The American College of Obstetricians and Gynecologists describes pyelonephritis as requiring empiric parenteral antimicrobial therapy with renal-tissue penetration,

followed by targeted therapy based on culture data. See ACOG's guidance on urinary tract infections in pregnant individuals and StatPearls: Urinary Tract Infection in Pregnancy.

QUESTION NO: 39

A client has chronic obstructive pulmonary disease. She is slowly losing weight, and her daughter is very concerned about increasing her nutrition. The nurse helps the daughter devise a plan of care for her mother. The plan of care should include which of the following interventions to promote nutrition?

A. Offer her oral hygiene before and after meals.

B. Encourage her to consume milk products.

C. Encourage her to engage in an activity before a meal to stimulate her appetite.

D. Restrict her fluid intake to three glasses of water a day.

ANSWER: A

Explanation:

"Offer her oral hygiene before and after meals." is correct because meticulous mouth care can make eating more comfortable and appealing for a client with chronic obstructive pulmonary disease who is losing weight. Dyspnea, mouth breathing, inhaled medications, oxygen therapy, and retained respiratory secretions can contribute to dry mouth, an unpleasant taste, odor, or oral discomfort. These factors may reduce appetite and make a person less willing to eat enough to meet increased energy needs. Oral hygiene before a meal removes secretions and unpleasant tastes, moistens and freshens the mouth, and can improve the client's sense of well-being so that she is better prepared to eat. Care after meals promotes continuing oral comfort and helps maintain oral health. Supporting intake through comfortable, enjoyable meals is especially important because unintended weight loss in chronic obstructive pulmonary disease can worsen weakness and reduce respiratory-muscle reserve. Nursing care should therefore incorporate routine oral assessment and hygiene as a practical, low-risk strategy to support nutritional intake. The National Heart, Lung, and Blood Institute notes that chronic obstructive pulmonary disease commonly affects breathing and daily functioning, making supportive symptom management important: NHLBI COPD overview. Additional nutrition guidance for people living with chronic obstructive pulmonary disease is available from the COPD Foundation.

QUESTION NO: 40

A client has been in labor for 10 hours. Her contractions have become hypoactive and slowed in duration. The fetus is at 0 station, cervix is dilated 8 cm and effaced 90%. The physician orders an oxytocin (Pitocin) infusion to be started at once. The RN begins the oxytocin infusion. It is important that the RN discontinue the infusion if which one of the following occur?

A. The client's contractions are < 2 minutes apart.

B. Duration of the contractions are 60 seconds.

C. The uterus relaxes between contractions.

D. The client complains that she is tired.

ANSWER: A

Explanation:

The client's contractions are < 2 minutes apart is correct because excessively frequent uterine contractions during oxytocin augmentation can reduce the time available for uterine relaxation and restoration of uteroplacental blood flow. Each contraction temporarily decreases placental perfusion; therefore, an adequate resting interval is necessary to support fetal oxygenation. Contractions occurring more frequently than every 2 minutes may indicate uterine tachysystole, particularly when the pattern exceeds five contractions in 10 minutes averaged over 30 minutes. In this situation, the nurse should promptly stop the oxytocin infusion, assess the uterine activity and fetal heart rate pattern, reposition the client as appropriate, and notify the obstetric clinician according to institutional protocol. Oxytocin is a high-alert medication in labor

because excessive uterine stimulation may lead to fetal hypoxemia, fetal heart rate abnormalities, and, in severe circumstances, uterine injury. The FDA prescribing information for Pitocin directs clinicians to discontinue the infusion when uterine hyperactivity or fetal distress occurs. Nursing surveillance during infusion titration is therefore essential to identify unsafe contraction frequency early and prevent compromised fetal oxygenation. See the FDA Pitocin prescribing information and NCBI StatPearls: Oxytocin.

QUESTION NO: 41

A 35-year-old client is receiving psychopharmacological treatment of his major depression with tranylcypromine sulfate (Parnate), a monoamine oxidase (MAO) inhibitor. The nurse teaches the client that while he is taking this type of antidepressant, he needs to restrict his dietary intake of:

A. Potassium-rich foods

B. Tryptophan

C. Tyramine

D. Saturated fats

ANSWER: C

Explanation:

Tyramine is correct because tranylcypromine is a nonselective, irreversible monoamine oxidase inhibitor. Monoamine oxidase normally metabolizes tyramine, a naturally occurring compound found at high levels in many aged, fermented, cured, smoked, pickled, or spoiled foods and in some alcoholic beverages. When monoamine oxidase is inhibited, dietary tyramine may not be adequately broken down. It can then enter the circulation and trigger a marked release of norepinephrine, causing severe vasoconstriction and a rapid, dangerous increase in blood pressure.

The nurse should teach the client to follow the prescribed tyramine-restricted diet throughout treatment and for the period specified by the prescriber after tranylcypromine is stopped, because enzyme activity recovers gradually after irreversible MAO inhibition. Clients should be instructed to seek urgent care for possible hypertensive-crisis symptoms, including sudden severe headache, palpitations, chest pain, neck stiffness, nausea or vomiting, sweating, or visual changes. The FDA prescribing information for Parnate specifically warns about hypertensive reactions associated with tyramine-containing foods and beverages. See the FDA Parnate prescribing information and NCBI StatPearls: Monoamine Oxidase Inhibitors.

QUESTION NO: 42

A 1000-mL dose of D5W 1â□„2 normal saline is to be infused in 8 hours. The drop factor for the tubing is 60 gtt/min. How many drops per minute should the nurse administer?

A. 75 gtt/min

B. 100 gtt/min

C. 125 gtt/min

D. 150 gtt/min

ANSWER: C

Explanation:

125 gtt/min is correct. To calculate a gravity IV flow rate, first convert the prescribed infusion time to minutes: 8 hours × 60 minutes per hour = 480 minutes. The standard formula is total volume in mL × tubing drop factor in gtt/mL, divided by total time in minutes. Substituting the prescribed values gives 1,000 mL × 60 gtt/mL ÷ 480 minutes = 125 gtt/min. Because the calculation results in a whole number, no rounding is needed. Although the question labels the tubing factor as “gtt/min,” a tubing drop factor is conventionally expressed as drops per milliliter (gtt/mL); the stated value of 60 indicates microdrip tubing. The nurse should regulate and reassess the infusion so the ordered volume is delivered over the full 8-hour interval,

while monitoring the IV site and the client's response. This method of dimensional calculation is used for manual gravity infusions; when an electronic infusion pump is used, the equivalent pump setting would be 125 mL/hr. See Open RN for nursing medication-administration learning resources and NCBI Bookshelf nursing clinical procedures for IV therapy guidance.

QUESTION NO: 43

A 47-year-old male client is admitted for colon surgery. Intravenous antibiotics are begun 2 hours prior to surgery. He has no known infection. The rationale for giving antibiotics prior to surgery is to:

A. Provide cathartic action within the colon

B. Reduce the risk of wound infection from anaerobic bacteria

C. Relieve the client's concern regarding possible infection

D. Reduce the risk of intraoperative fever

ANSWER: B

Explanation:

Reduce the risk of wound infection from anaerobic bacteria is correct because this is prophylactic antimicrobial therapy: antibiotics are administered before a surgical incision when infection is not present in order to reduce the likelihood of a postoperative surgical-site infection. Colon procedures involve entry into the bowel, which contains a high concentration of microorganisms, including anaerobic organisms. This makes colorectal surgery a clean-contaminated procedure with a meaningful risk of contamination of the operative field. Appropriate preoperative antibiotics provide tissue drug levels at the time bacteria may enter the wound, reducing the risk that contamination will progress to infection. The timing described—administration within the period before surgery—supports the goal of having effective antimicrobial concentrations present when the incision is made. Selection of an agent for colorectal surgery should provide coverage for expected intestinal flora, including gram-negative and anaerobic bacteria, and follow institutional surgical-prophylaxis protocols. The Centers for Disease Control and Prevention recommends administering prophylactic antimicrobial agents only when indicated and timing administration so bactericidal concentrations are established when the incision is made. The American Society of Health-System Pharmacists also identifies colorectal procedures as requiring prophylaxis directed at likely bowel organisms. See the CDC surgical-site infection guidance and the ASHP clinical practice guidelines for antimicrobial prophylaxis in surgery.

QUESTION NO: 44

The nurse is assisting a 4th-day postoperative cholecystectomy client in planning her meals for tomorrowâ€™s menu. Which vitamin is the most essential in promoting tissue healing?

A. Vitamin C

B. Vitamin B1

C. Vitamin D

D. Vitamin A

ANSWER: A

Explanation:

Vitamin C is the most essential vitamin for promoting postoperative tissue healing because it is required for collagen synthesis. Collagen is a major structural protein in skin, connective tissue, blood vessels, and healing wounds. After surgery, the body needs adequate vitamin C to form and stabilize new collagen within the incision, support capillary integrity, and help restore damaged tissue. Adequate intake also supports normal immune function, which is important during recovery while the surgical wound is healing. For a client recovering from a cholecystectomy, meal planning can include vitamin C-rich foods that are tolerated within the prescribed postoperative diet, such as citrus fruits, strawberries, kiwi, tomatoes, broccoli, sweet peppers, and potatoes. If dietary intake is inadequate or nutritional risk is present, the health care team may evaluate

the need for supplementation. The National Institutes of Health notes that vitamin C is necessary for biosynthesis of collagen and that inadequate vitamin C can impair wound healing. This direct role in collagen formation makes vitamin C particularly important for healing a postoperative incision. See the NIH Office of Dietary Supplements vitamin C fact sheet and NCBI StatPearls overview of vitamin C for further clinical detail.

QUESTION NO: 45

A client is 6 weeks pregnant. During her first prenatal visit, she asks, “How much alcohol is safe to drink during pregnancy?” The nurse’s response is:

A. Up to 1 oz daily

B. Up to 2 oz daily

C. Up to 4 oz weekly

D. No alcohol

ANSWER: D

Explanation:

No alcohol is the correct response because no amount, type, or timing of alcohol use has been established as safe during pregnancy. Alcohol crosses the placenta, and the developing fetus cannot process alcohol in the same way as an adult. Exposure can disrupt fetal growth and brain development and may lead to fetal alcohol spectrum disorders, which can involve lifelong physical, behavioral, learning, and cognitive effects. Risk is not limited to heavy drinking, and it is not possible to identify a reliably safe threshold for an individual pregnancy. Therefore, teaching should clearly recommend complete abstinence throughout pregnancy, including early pregnancy when major fetal structures are developing. The nurse should communicate this recommendation nonjudgmentally and offer support if stopping alcohol use is difficult. The Centers for Disease Control and Prevention states that there is no known safe amount of alcohol use during pregnancy and no safe time to drink alcohol during pregnancy. The American College of Obstetricians and Gynecologists likewise advises avoidance of alcohol for the entire pregnancy. See the CDC guidance on alcohol use during pregnancy and ACOG information on alcohol and women.

QUESTION NO: 46

Which of the following nursing orders should be included in the plan of care for a client with hepatitis C?

A. The nurse should use standard precautions when obtaining blood samples.

B. Total bed rest should be maintained until the client is asymptomatic.

C. The client should be instructed to maintain a low semi-Fowler position when eating meals.
A high Fowler position may decrease the tendency to vomit. (D) The buildup of bilirubin in the client’s skin may cause pruritus. Alcohol is a drying agent.

D. The nurse should administer an alcohol backrub at bedtime.

ANSWER: A

Explanation:

The nurse should use standard precautions when obtaining blood samples. Hepatitis C virus is transmitted primarily through exposure to infectious blood, so safe handling of blood and prevention of bloodborne exposure are essential components of nursing care. Standard precautions apply to every client, regardless of known infection status, and include hand hygiene and appropriate use of personal protective equipment when contact with blood or other potentially infectious materials is anticipated. During venipuncture or blood collection, the nurse should wear gloves when indicated, use safety-engineered devices, avoid recapping needles, immediately dispose of sharps in an approved puncture-resistant container, and promptly manage any occupational exposure according to facility policy. These practices protect both the nurse and other clients while maintaining safe, routine clinical care. The Centers for Disease Control and Prevention identifies hepatitis C as a bloodborne

infection and emphasizes that health care personnel should follow standard precautions to prevent exposure to bloodborne pathogens. See the CDC guidance on Standard Precautions and the CDC overview of hepatitis C.

QUESTION NO: 47

A 16-year-old diabetic girl has been selected as a cheerleader at her school. She asks the nurse whether she should increase her insulin when she is planning to attend cheerleading practice sessions lasting from 8 to 11 AM. The most appropriate answer would be:

A. “You should ask your doctor about this.”

B. “Yes, increase your insulin by 1 U for each hour of practice because exercise causes the body to need more insulin.”

C. “No, do not increase your insulin. Exercise will not affect your insulin needs.”

D. “No, do not increase your insulin; exercise generally increases insulin sensitivity, and a snack or insulin adjustment may be needed according to the diabetes plan and blood glucose level.”

ANSWER: D

Explanation:

“No, do not increase your insulin; exercise generally increases insulin sensitivity, and a snack or insulin adjustment may be needed according to the diabetes plan and blood glucose level” is correct. Sustained cheerleading practice is significant physical activity, and contracting muscles take up more glucose during exercise. In people using insulin, activity also commonly increases insulin sensitivity, meaning that the same amount of insulin may have a greater glucose-lowering effect. Therefore, increasing insulin before several hours of practice could increase the risk for exercise-associated hypoglycemia rather than prevent it.

The adolescent should follow an individualized plan developed with the diabetes care team, including checking glucose before, during, and after prolonged activity and having rapid-acting carbohydrate readily available. A carbohydrate snack before or during practice can be appropriate when glucose is low or trending downward, when the activity is prolonged, or when insulin on board is expected to lower glucose. The exact carbohydrate intake and any reduction in meal or correction insulin depend on her glucose readings, insulin regimen, meal timing, and prior responses to exercise. The American Diabetes Association provides guidance on exercise-related glucose management at https://diabetes.org/health-wellness/fitness/getting-started-safely, and the CDC discusses physical activity and diabetes at https://www.cdc.gov/diabetes/living-with/physical-activity.html.

QUESTION NO: 48

A violent client remains in restraints for several hours. Which of the following interventions is most appropriate while he is in restraints?

A. Give fluids if the client requests them.

B. Assess skin integrity and circulation of extremities before applying restraints and as they are removed.

C. Measure vital signs at least every 4 hours.

D. Release restraints every 2 hours for client to exercise.

ANSWER: D

Explanation:

Release restraints every 2 hours for client to exercise. is the most appropriate intervention because restraint use requires ongoing, active protection of the client’s physical needs and safety. Periodically releasing the restraints permits assessment of the restrained areas and allows range-of-motion activity, repositioning, and attention to comfort, elimination, hydration, and circulation. These actions reduce risks associated with immobility and prolonged pressure, including impaired circulation, skin injury, stiffness, and loss of joint mobility. For a violent or highly agitated client, release must be performed safely: the

nurse should maintain close observation, use adequate staff assistance, and typically release one extremity at a time when needed to prevent injury to the client or staff. The client's clinical condition, behavior, and the organization's policy determine whether monitoring and care must occur even more frequently. Restraints are a last-resort safety intervention, must be discontinued at the earliest possible time, and require ongoing evaluation rather than simply leaving the client restrained. Federal hospital requirements specify that restrained patients must be monitored and assessed at intervals established by hospital policy, and care should preserve the patient's safety, dignity, and well-being. See the CMS Conditions of Participation for Patient Rights and AHRQ resources on restraint reduction and patient safety.

QUESTION NO: 49

On the first postpartal day, a client tells the nurse that she has been changing her perineal pads every 1/2 hour because they are saturated with bright red vaginal drainage. When palpating the uterus, the nurse assesses that it is somewhat soft, 1 fingerbreadth above the umbilicus, and midline. The nursing action to be taken is to:

A. Gently massage the uterus until firm, express any clots, and note the amount and character of lochia

B. Catheterize the client and reassess the uterus

C. Begin IV fluids and administer oxytocic medication

D. Administer analgesics as ordered to relieve discomfort

ANSWER: A

Explanation:

Gently massage the uterus until firm, express any clots, and note the amount and character of lochia is the priority action. Saturation of perineal pads every 30 minutes with bright-red lochia indicates excessive postpartum bleeding. The soft, elevated fundus is consistent with inadequate uterine contraction, or uterine atony, which is a leading cause of postpartum hemorrhage. Immediately performing gentle fundal massage stimulates myometrial contraction. A firmly contracted uterus compresses the blood vessels at the placental implantation site, functioning as a physiologic "living ligature" to limit blood loss. Expressing clots after massage helps remove blood that may be retained in the lower uterine segment and permits a more accurate assessment of ongoing bleeding. The nurse should also quantify and document the amount and characteristics of lochia, reassess fundal tone and position, obtain assistance, and promptly communicate persistent bleeding or inadequate uterine response to the obstetric provider. These actions support rapid recognition and management of postpartum hemorrhage while further interventions are prepared if needed. Guidance from the American College of Obstetricians and Gynecologists identifies uterine atony as a common cause of postpartum hemorrhage, and the Merck Manual describes uterine massage as an initial measure to address atony.

QUESTION NO: 50

A physician tells the nurse that he wants to orally intubate a client with a No. 8 endotracheal tube. The finding of normal breath sounds on the right side of the chest and diminished, distant breath sounds on the left side of the chest of a newly intubated client is probably due to:

A. A left hemothorax

B. A right hemothorax

C. Intubation of the right mainstem bronchus

D. An inadequate mechanical ventilator

ANSWER: C

Explanation:

Intubation of the right mainstem bronchus is the most likely cause of normal right-sided breath sounds with diminished, distant left-sided breath sounds immediately after intubation. The right mainstem bronchus is wider, shorter, and more vertically aligned with the trachea than the left mainstem bronchus. Consequently, an endotracheal tube advanced too far

can preferentially enter the right mainstem bronchus. Ventilation is then directed primarily to the right lung, while the left lung receives little or no ventilation, producing markedly reduced breath sounds on the left during auscultation.

This is an urgent post-intubation assessment finding. The nurse should recognize it promptly and collaborate to withdraw the tube to an appropriate tracheal depth, then reassess bilateral chest expansion and breath sounds. Correct placement should also be verified with continuous waveform capnography and chest radiography, which identifies the tube tip location relative to the carina. The American Heart Association notes that excessive insertion depth may result in mainstem bronchus intubation and recommends confirmation of tube placement with clinical assessment and capnography. See the American Heart Association CPR and ECC Guidelines and the Merck Manual guidance on airway establishment and control.

QUESTION NO: 51

A client is receiving IV morphine 2 days after colorectal surgery. Which of the following observations indicate that he may be becoming drug dependent?

A. The client requests pain medicine every 4 hours.

B. He is asleep 30 minutes after receiving the IV morphine.

C. He asks for pain medication although his blood pressure and pulse rate are normal.

D. He is euphoric for about an hour after each injection.

ANSWER: D

Explanation:

“He is euphoric for about an hour after each injection.” is the finding that may indicate emerging drug dependence because it suggests the client is experiencing and potentially seeking morphine’s mood-altering, rewarding effects in addition to its intended analgesic effect. Opioids activate central nervous system pathways that can produce euphoria; this reinforcing effect contributes to misuse risk and the development of opioid use disorder. In the postoperative setting, nurses should assess the client’s stated pain level, functional comfort, sedation level, respiratory status, and behavioral response to the medication. A pattern in which the client emphasizes a pleasurable “high” or appears primarily focused on the emotional effect of opioid administration warrants further assessment, objective documentation, and communication with the prescriber and pain-management team. It does not establish a diagnosis of substance use disorder by itself, particularly after only a short period of treatment, but it is a clinically meaningful cue that the medication’s reinforcing effects may be becoming prominent. The FDA identifies euphoria as an opioid effect and warns that morphine carries risks of misuse, abuse, and addiction. See the FDA morphine sulfate labeling and the CDC clinical guidance on opioid prescribing.

QUESTION NO: 52

In the client with a diagnosis of coronary artery disease, the nurse would anticipate the complication of bradycardia with occlusion of which coronary artery?

A. Right coronary artery

B. Left main coronary artery

C. Circumflex coronary artery

D. Left anterior descending coronary artery

ANSWER: A

Explanation:

Right coronary artery is correct because it commonly supplies the cardiac conduction system, particularly the sinoatrial node and the atrioventricular node. In the usual right-dominant coronary circulation, the right coronary artery gives rise to the artery supplying the atrioventricular node; it also supplies the sinoatrial node in a substantial proportion of people. Consequently, ischemia or infarction involving this vessel—often producing an inferior-wall myocardial infarction—can

reduce automaticity of the sinoatrial node or impair atrioventricular conduction. The client may therefore develop sinus bradycardia, junctional rhythms, or varying degrees of atrioventricular block. Bradycardia may be particularly clinically significant when it lowers cardiac output, producing hypotension, altered mental status, chest discomfort, or signs of poor perfusion. The nurse should promptly assess heart rate, rhythm, blood pressure, symptoms, and electrocardiographic changes, while preparing to follow bradycardia-management protocols when the client is unstable. Coronary dominance and nodal arterial supply vary between individuals, but the right coronary artery remains the classic vessel associated with nodal bradyarrhythmias in NCLEX-style clinical correlations. See StatPearls: Anatomy, Coronary Arteries and the American Heart Association CPR and ECC Guidelines.

QUESTION NO: 53

A 45-year-old male client was admitted to a chemical dependency treatment center following legal problems related to alcohol abuse. He states, “I know that alcohol is a problem for some people, but I can stop whenever I want to. I’m never sick or miss work, and no one can complain about me.” During the initial assessment, the best response by the nurse would be:

A. “The fact is you are an alcoholic or you wouldn’t be here.”

B. “I understand it took strength to admit yourself to the unit, and I will do my part to help you to stay alcohol- free.”

C. “If you can stop drinking when you want to, why don’t you stop?”

D. “It’s good that you can stop drinking when you want to.”

ANSWER: B

Explanation:

“I understand it took strength to admit yourself to the unit, and I will do my part to help you to stay alcohol- free.” is the best initial therapeutic response because it communicates acceptance, support, and willingness to establish a collaborative nurse-client relationship. The client is minimizing the impact of alcohol use, which can occur when an individual has not yet fully recognized the consequences of substance use. At this early assessment stage, a nonjudgmental approach is essential to reduce defensiveness and encourage continued engagement in treatment. Acknowledging the effort involved in entering treatment focuses on an existing strength without arguing about whether the client has alcohol use disorder or demanding that he justify his statements. The nurse also appropriately offers partnership and assistance while maintaining the client’s autonomy and responsibility for recovery. Therapeutic communication in substance-use care relies on empathy, respect, and a supportive stance that helps clients explore ambivalence and build motivation for change. This approach is consistent with SAMHSA’s description of motivational interviewing as a collaborative, person-centered style that elicits an individual’s own motivation and commitment to change. See SAMHSA’s Motivational Interviewing Guide and the NCBI Bookshelf overview of motivational interviewing in substance-use treatment.

QUESTION NO: 54

The cardiac client who exhibits the symptoms of disorientation, lethargy, and seizures may be exhibiting a toxic reaction to:

A. Digoxin (Lanoxin)

B. Lidocaine (Xylocaine)

C. Quinidine gluconate or sulfate (Quinaglute,Quinidex)

D. Nitroglycerin IV (Tridil)

ANSWER: B

Explanation:

Lidocaine (Xylocaine) is correct because neurologic changes are hallmark manifestations of systemic lidocaine toxicity. Although lidocaine may be administered intravenously as an antidysrhythmic in cardiac care, excessive serum concentrations can depress and then disrupt neurologic function. Early toxicity may include dizziness, drowsiness, confusion, disorientation, or altered mental status; progression can produce muscle twitching, tremors, and seizures. Lethargy together

with disorientation and seizures therefore represents a clinically significant pattern that warrants immediate assessment for lidocaine toxicity, stopping or holding the infusion as directed, maintaining airway and cardiopulmonary support, and promptly notifying the prescribing clinician or rapid-response team according to the client's status and institutional protocol. The risk is increased when drug clearance is reduced, including with impaired hepatic perfusion or liver dysfunction, and when dosing or infusion exposure is excessive. The U.S. prescribing information for lidocaine injection identifies neurologic adverse effects, including confusion, drowsiness, tremor, and convulsions, and emphasizes careful monitoring for systemic toxicity. See DailyMed: Lidocaine hydrochloride injection labeling and NCBI Bookshelf: Lidocaine.

QUESTION NO: 55

Parents should be taught not to prop the bottle when feeding their infants. In addition to the risk of choking, it puts the infant at risk for:

A. Otitis media

B. Asthma

C. Conjunctivitis

D. Tonsillitis

ANSWER: A

Explanation:

Otitis media is correct because bottle propping can allow milk or formula to pool in the infant's mouth and flow toward the nasopharynx while the infant feeds in a recumbent position. Infants have eustachian tubes that are shorter, more horizontal, and more easily obstructed than those of older children and adults. These anatomic characteristics can permit nasopharyngeal secretions and feeding material to enter or impair drainage from the middle ear, creating conditions that increase the likelihood of middle-ear inflammation and infection. Propped bottles can also result in prolonged sucking and exposure to fluid, especially when an infant falls asleep during feeding, which further supports teaching caregivers to hold the infant for feeds rather than leave a bottle in the crib. Parent education should emphasize responsive, supervised feeding and removal of the bottle when the infant is finished. The American Academy of Pediatrics advises against putting an infant to bed with a bottle, including because of the association with ear infections. See HealthyChildren.org: Bottle Feeding Basics and CDC: Ear Infection Basics.

QUESTION NO: 56

A nurse is caring for a client with a chest tube connected to a water-seal drainage system. Continuous bubbling is noted in the water-seal chamber. How should the nurse interpret this finding?

A. The lung has fully re-expanded.

B. An air leak is present.

C. The suction pressure is too low.

D. The drainage chamber should be emptied immediately.

ANSWER: B

Explanation:

An air leak is present is correct because continuous bubbling in the water-seal chamber is not expected and commonly indicates an air leak in the drainage system or from the client's pleural space. The nurse should assess the tubing connections, check the drainage system, and evaluate the insertion site and dressing. The nurse should not clamp the chest tube routinely because clamping can cause pressure to build within the pleural space. See StatPearls review of chest tube management.

QUESTION NO: 57

When giving discharge instructions to a 24-year-old client who had a short-arm cast applied for a fractured right ulna, the nurse recognizes the importance of telling him that the drying time for a plaster of Paris cast is approximately:

A. 30 minutes

B. 1–4 hours

C. 12–24 hours

D. 24–72 hours

ANSWER: D

Explanation:

24–72 hours is the appropriate teaching for drying of a plaster of Paris cast. Although plaster begins to set and becomes firm enough to maintain its shape relatively soon after application, it retains substantial moisture and requires considerably longer to dry fully. The exact drying period depends on factors such as the cast's thickness, the number of layers used, ambient humidity, air circulation, and the body area involved. During this interval, the client should protect the cast from moisture and handle it carefully, ideally with the palms of the hands rather than fingertips, because pressure can create indentations in a damp cast. The client should also avoid covering the cast with blankets or applying artificial heat, since these actions can interfere with normal drying and may increase the risk of thermal injury. Teaching about the prolonged drying period is particularly important at discharge because the client may mistake initial hardening for complete drying and inadvertently damage the cast. Patient guidance from the American Academy of Orthopaedic Surgeons notes that plaster casts generally require about 48–72 hours to dry completely, consistent with the expected 24–72-hour range. See AAOS: Care of Casts and Splints and MedlinePlus: Cast Care.

QUESTION NO: 58

In teaching the client about proper umbilical cord care, the nurse recommends that:

A. Petrolatum be placed around the cord after the sponge bath

B. A belly binder be applied to prevent umbilical hernia

C. The area be cleansed at diaper changes with alcohol and inspected for redness or drainage

D. The cord clamp be left on until the cord stump separates

E. Keep the cord stump clean and dry, fold the diaper below the stump, and allow it to fall off naturally

ANSWER: E

Explanation:

"Keep the cord stump clean and dry, fold the diaper below the stump, and allow it to fall off naturally" reflects current evidence-based umbilical cord care for a healthy newborn in a setting with routine hygienic birth practices. Dry cord care promotes normal drying and separation of the stump, which commonly occurs within 1 to 3 weeks. Parents should wash their hands before handling the area, expose the stump to air by folding the diaper down, and use sponge baths until the stump falls off and the site heals. If the cord becomes soiled with urine or stool, it may be cleaned gently with plain water and then patted dry. Routine application of topical products is not needed in this setting. Teaching should also include when to contact the health care provider: spreading redness of the surrounding skin, swelling, warmth, tenderness, foul odor, purulent drainage, fever, poor feeding, or lethargy may indicate infection and require prompt evaluation. A small amount of dried blood or minor spotting as the stump separates can occur normally. The American Academy of Pediatrics provides parent-focused guidance on keeping the stump dry and recognizing concerning signs in its Umbilical Cord Care resource. The World Health Organization also supports dry cord care where chlorhexidine is not specifically indicated: WHO recommendations on maternal and newborn care.

QUESTION NO: 59

A 23-year-old female client is brought to the emergency room by her roommate for repeatedly making superficial cuts on her wrists and experiencing wide mood swings. She is very angry and hostile. Her medical diagnosis is adjustment disorder versus borderline personality disorder. The client comments to the nurse, “Nobody in here seems to really care about the clients. I thought nurses cared about people!” The client is exhibiting the ego defense mechanism:

A. Reaction formation

B. Rationalization

C. Splitting

D. Sublimation

ANSWER: C

Explanation:

Splitting is correct. This defense mechanism involves perceiving oneself, other people, or situations in extreme, polarized categories—for example, entirely good or entirely bad—without integrating both positive and negative qualities at the same time. The client’s broad statement that nobody cares about clients reflects an all-bad appraisal of the nursing staff. Her expectation that nurses should care for people further highlights the abrupt contrast between an idealized view of what nurses should be and her current devalued view of the staff. This pattern is especially associated with borderline personality disorder, in which unstable interpersonal relationships, intense anger, affective instability, self-injurious behavior, and shifts between idealization and devaluation may occur. In the emergency setting, the nurse should recognize splitting as a behavior that can affect staff relationships and maintain clear, consistent limits and communication among team members. A consistent, nonjudgmental approach supports safety while avoiding reinforcement of polarized staff-client interactions. The National Institute of Mental Health describes borderline personality disorder as involving unstable moods, behavior, and relationships, including intense and unstable relationships. See NIMH: Borderline Personality Disorder and NCBI Bookshelf: Borderline Personality Disorder.

QUESTION NO: 60

Due to his prolonged history of alcohol abuse, an alcoholic client will most likely have deficiencies of which of the following nutrients?

A. Vitamin C and zinc

B. Folic acid and niacin

C. Vitamin A and biotin

D. Thiamine and pyridoxine

ANSWER: D

Explanation:

Thiamine and pyridoxine are the most likely deficiencies in a client with prolonged alcohol abuse. Thiamine (vitamin B1) deficiency is especially important in nursing care because alcohol use commonly combines inadequate dietary intake, impaired gastrointestinal absorption, reduced hepatic storage, and impaired conversion of thiamine to its active form. Thiamine is necessary for carbohydrate metabolism and normal neurologic function. In a malnourished client with alcohol use disorder, depletion can lead to Wernicke encephalopathy, characterized by confusion, gait ataxia, and ocular abnormalities. Because administering glucose increases thiamine demand, clinical practice prioritizes giving thiamine before or with glucose when deficiency is suspected.

Pyridoxine (vitamin B6) is also a water-soluble B-complex vitamin that may be deficient when chronic alcohol intake displaces nutritious food and disrupts absorption and metabolism. Vitamin B6 supports amino-acid metabolism, neurotransmitter synthesis, hemoglobin production, and neurologic function. Thus, the pairing of thiamine and pyridoxine best reflects the characteristic B-vitamin depletion associated with long-term alcohol misuse. The National Institute on Alcohol Abuse and Alcoholism discusses alcohol-related nutritional deficiencies at

https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/alcohols-effects-on-the-body, and Merck Manual provides clinical information on thiamine deficiency at https://www.merckmanuals.com/professional/nutritional-disorders/vitamin-deficiency-dependency-and-toxicity/thiamin-deficiency.

QUESTION NO: 61

A mother brings a 6-month-old infant and a 4-year-old child to the nursing clinic for routine examination and screening. Which of these plans by the nurse would be most successful?

A. Examine the 4 year old first.

B. Provide time for play and becoming acquainted.

C. Have the mother leave the room with one child, and examine the other child privately.

D. Examine painful areas first to get them "over with."

ANSWER: A

Explanation:

"Examine the 4 year old first." is the most successful plan because the preschool-aged child is generally able to understand simple explanations, participate in the examination, and cooperate with routine screening more readily than a 6-month-old infant. Beginning with the child who can engage with the nurse helps establish a calm, organized clinic interaction and allows the infant to remain with the parent until the nurse is ready. The nurse can use age-appropriate communication, permit the 4-year-old to ask questions, and make the examination feel predictable, which supports cooperation and reduces anxiety. A successful pediatric assessment is individualized to developmental level and should promote family-centered care, including the parent's presence and involvement. The American Academy of Pediatrics' Bright Futures framework emphasizes developmentally appropriate, family-centered health supervision and screening throughout childhood. The Centers for Disease Control and Prevention also describes expected developmental abilities for preschool-aged children that support participation in simple health-care interactions. See American Academy of Pediatrics Bright Futures and CDC Developmental Milestones.

QUESTION NO: 62

Pregnant women with diabetes often have problems related to the effectiveness of insulin in controlling their glucose levels during their second half of pregnancy. The nurse teaches the client that this is due to:

A. Decreased glomerular filtration and increased tubular absorption

B. Decreased estrogen levels

C. Decreased progesterone levels

D. Increased human placental lactogen levels

ANSWER: D

Explanation:

Increased human placental lactogen levels is correct because this placental hormone rises as pregnancy progresses and contributes substantially to the insulin resistance that becomes most evident in the second half of pregnancy. Human placental lactogen, also called human chorionic somatomammotropin, promotes maternal lipolysis and increases circulating free fatty acids. This metabolic adaptation helps preserve maternal glucose availability for fetal use, but it also means the pregnant client must produce more insulin or receive more exogenous insulin to maintain target glucose levels. In a client with preexisting diabetes, or in one who cannot compensate adequately with increased insulin secretion, this progressive reduction in insulin effectiveness can lead to hyperglycemia and rising insulin requirements. Teaching should emphasize that changing insulin needs during pregnancy are expected physiologic effects of placental hormones and require frequent glucose monitoring and individualized adjustment of nutrition, activity, and medication therapy. The American Diabetes Association describes pregnancy as a state of progressive insulin resistance, particularly later in gestation, and notes the

importance of glucose management to reduce maternal and fetal risks. Additional physiologic context is available from the American Diabetes Association and NCBI StatPearls.

QUESTION NO: 63

During discharge planning, parents of a child with rheumatic fever should be able to identify which of the following as toxic symptoms of sodium salicylate?

A. Tinnitus and nausea

B. Dermatitis and blurred vision

C. Unconsciousness and acetone odor of the breath

D. Chills and an elevation of temperature

ANSWER: A

Explanation:

Tinnitus and nausea are important early manifestations of salicylate toxicity. Sodium salicylate is a salicylate medication, and excessive serum salicylate levels commonly produce gastrointestinal and neurologic symptoms. Ringing, buzzing, or other abnormal sounds in the ears may be an early and particularly characteristic warning sign. Nausea, often accompanied by vomiting, can also occur as toxicity develops. Parents should be taught to stop giving the medication and promptly contact the child's health care provider if these symptoms occur, because toxicity can progress and requires timely clinical assessment.

Discharge teaching should also emphasize administering the exact prescribed dose, avoiding duplicate products that contain salicylates, and keeping all medications out of children's reach. The child's clinician may monitor therapy when salicylates are used for inflammatory conditions such as rheumatic fever. Guidance from the Merck Manual on salicylate poisoning identifies tinnitus and nausea/vomiting among common findings. The NCBI StatPearls review of salicylate toxicity likewise describes tinnitus as a frequent early symptom, supporting its value in parent education.

QUESTION NO: 64

On an assessment of a client's mouth, the nurse notices white patches on the buccal mucosa. The nurse tries to obtain a sample for a culture, but the lesion cannot be rubbed off. The nurse would suspect that this lesion is:

A. Xerostomia

B. Candidiasis

C. Leukoplakia

D. Stomatitis

ANSWER: C

Explanation:

Leukoplakia is the correct finding because it typically presents as a persistent white or grayish patch on an oral mucous membrane that cannot be scraped or rubbed off. It commonly occurs on the buccal mucosa, tongue, floor of the mouth, or gingiva. In this assessment, the inability to remove the white lesion is the key distinguishing characteristic supporting leukoplakia. Leukoplakia is a clinical term for a white plaque that cannot be otherwise characterized and should be evaluated, particularly when it persists, because some lesions may show dysplasia or have malignant potential. Nursing care includes documenting the lesion's location, size, color, and duration; assessing relevant risks such as tobacco or alcohol use and chronic irritation; and ensuring appropriate referral for dental, oral-health, or medical evaluation. A definitive diagnosis may require biopsy rather than a culture, since leukoplakia is not primarily an infectious lesion. The National Cancer Institute notes that leukoplakia consists of white patches in the mouth that may be associated with tobacco use and can sometimes

become cancerous. See the National Cancer Institute definition of leukoplakia and the Merck Manual overview of oral growths.

QUESTION NO: 65

An IDDM client's condition stabilizes. He begins to receive a daily injection of NPH insulin at 6:30 AM. The nurse can most likely expect a hypoglycemic reaction to occur that same day at:

A. 8:30 AM–10:30 AM

B. 2:30 PM–4:30 PM

C. 7:30 PM–9:30 PM

D. 10:30 PM–11:30 PM

ANSWER: B

Explanation:

"2:30 PM–4:30 PM" is correct because hypoglycemia is most likely when an insulin preparation reaches its peak glucose-lowering effect. NPH (isophane) insulin is an intermediate-acting insulin. After a subcutaneous morning dose, its effect develops gradually and reaches a substantial peak several hours later. A dose given at 6:30 AM would therefore have an expected peak period in the midafternoon; 2:30 PM to 4:30 PM is approximately 8 to 10 hours after administration and fits the classic peak range used in nursing medication teaching and test questions.

During this peak period, the nurse should ensure that the client has access to an appropriate meal or snack, assess for manifestations of low blood glucose, and reinforce prompt treatment procedures if symptoms occur. Individual timing can vary with the dose, injection site, food intake, physical activity, concurrent illness, and renal or hepatic function. Nonetheless, anticipating the midafternoon peak allows proactive glucose monitoring and hypoglycemia prevention. MedlinePlus identifies NPH insulin as intermediate acting and emphasizes that insulin timing must be coordinated with meals and monitoring: MedlinePlus: Insulin Isophane. Product information and current labeling can also be reviewed through DailyMed's insulin isophane listings.

QUESTION NO: 66

When inspecting a cardiovascular client, the nurse notes that he needs to sit upright to breathe. This behavior is most indicative of:

A. Pericarditis

B. Anxiety

C. Congestive heart failure

D. Angina

ANSWER: C

Explanation:

Congestive heart failure is correct because needing to sit upright to breathe describes *orthopnea*, a classic manifestation of heart failure. When a client with impaired cardiac pumping lies flat, venous blood from the lower extremities and abdomen returns more readily to the thorax. This increased venous return raises pulmonary vascular volume and pressure. In left-sided heart failure, the left ventricle cannot effectively handle this additional volume, so fluid can accumulate in the pulmonary interstitial and alveolar spaces. The resulting pulmonary congestion reduces lung compliance and impairs gas exchange, producing dyspnea that is relieved by elevating the head and torso. Clients may sleep on multiple pillows or move to a chair to obtain relief. During cardiovascular assessment, the nurse should specifically ask about orthopnea, the number of pillows required for sleep, paroxysmal nocturnal dyspnea, exercise tolerance, weight gain, peripheral edema, and cough. These findings help identify the severity and progression of fluid congestion and guide timely clinical evaluation. The

American Heart Association identifies shortness of breath when lying flat as a symptom of heart failure, and the Merck Manual describes orthopnea as dyspnea occurring while lying flat that is relieved by sitting or standing. See the American Heart Association's warning signs of heart failure and the Merck Manual overview of heart failure.

QUESTION NO: 67

A male client had a right below-the-knee amputation 4 days ago. His incision is healing well. He has gotten out of bed several times and sat at the side of the bed. Each time after returning to bed, he has experienced pain as if it were located in his right foot. Which nursing measure indicates the nurse has a thorough understanding of phantom pain and its management?

A. Phantom pain is entirely in the client's mind. The client should be instructed that the pain is psychological and should not be treated.

B. The basis for phantom pain may occur because the nerves still carry pain sensation to the brain even though the limb has been amputated. The pain is real, intense, and should be treated.

C. The cause of phantom pain is unknown. The nurse should provide the client with support, promote sleep, and handle the injured limb smoothly and gently.

D. Phantom pain is caused by trauma, spasms, and edema at the incisional site. It will decrease when postoperative edema decreases. It should be treated with nonnarcotic medication whenever possible.

ANSWER: B

Explanation:

The basis for phantom pain may occur because the nerves still carry pain sensation to the brain even though the limb has been amputated. The pain is real, intense, and should be treated. This response demonstrates an appropriate, validating nursing understanding of phantom limb pain: the client perceives pain in the absent foot, and that perception is genuine rather than imagined. Although the precise mechanisms are complex and involve peripheral nerve changes as well as spinal cord and brain processing, the nursing priority is to assess the pain carefully, acknowledge the client's report, and provide or advocate for timely pain management.

In the immediate postoperative period, treatment is individualized according to severity, characteristics, functional impact, and prescribed therapies. Nursing care includes documenting location and intensity, monitoring response to interventions, administering prescribed analgesics, and using supportive nonpharmacologic measures as appropriate. Prompt recognition and treatment can improve comfort, facilitate mobility and rehabilitation, and help preserve sleep and coping. Clinical references describe phantom limb pain as painful sensations perceived in a missing body part and emphasize that management may require a multimodal approach. See Merck Manual Professional: Phantom Limb Pain and StatPearls: Phantom Limb Pain.

QUESTION NO: 68

A postoperative TURP client is ordered continuous bladder irrigations. Later in the evening on the first postoperative day, he complains of increasing suprapubic pain. When assessing the client, the nurse notes diminished flow of bloody urine and several large blood clots in the drainage tubing. Which one of the following should be the initial nursing intervention?

A. Call the physician about the problem.

B. Irrigate the Foley catheter.

C. Change the Foley catheter.

D. Administer a prescribed narcotic analgesic.

ANSWER: B

Explanation:

Irrigate the Foley catheter. is the initial intervention because the assessment findings indicate impaired catheter patency from clot obstruction during continuous bladder irrigation after transurethral resection of the prostate. Increasing suprapubic pain with reduced drainage is consistent with urine and irrigation fluid being retained in the bladder, creating distention. Restoring drainage promptly is the priority because ongoing obstruction can worsen discomfort and bladder distention and may compromise the intended postoperative drainage process.

For a client receiving continuous bladder irrigation, the nurse should first assess the system for dependent loops, kinks, and obstruction, then perform manual catheter irrigation as prescribed and according to facility policy to dislodge clots and re-establish outflow. The irrigation should be performed gently using the ordered sterile technique and solution, with careful measurement and documentation of irrigation instilled and drainage returned. Once patency is restored, the nurse can reassess pain, urine color, clot burden, and the rate of continuous irrigation. Postoperative guidance recognizes clot retention and reduced urinary drainage as issues requiring prompt management to maintain catheter drainage after TURP. See Merck Manual: Transurethral Resection of the Prostate and StatPearls: Continuous Bladder Irrigation.

QUESTION NO: 69

A 42-year-old client on an inpatient psychiatric unit comments that he was brought to the hospital by his wife because he had taken too many pills and states, “I just couldn’t take it anymore.” The nurse’s best response to this disclosure would be:

A. “You shouldn’t do things like that, just tell someone you feel bad.”

B. “Tell me more about what you couldn’t take anymore.”

C. “I’m sure you probably didn’t mean to kill yourself.”

D. “How long have you been in the hospital.”

E. “Are you thinking about killing yourself now?”

ANSWER: E

Explanation:

“Are you thinking about killing yourself now?” is the best response because the client has disclosed a recent potentially lethal self-harm act and expresses overwhelming distress. The nurse’s immediate priority is a focused, direct suicide-risk assessment to establish whether there is current suicidal ideation and an immediate threat to safety. Asking explicitly and calmly about suicide is therapeutic: it communicates willingness to discuss painful thoughts without judgment, helps the client feel heard, and supplies essential information for determining the level of observation, environmental safety measures, and urgent psychiatric intervention required. Direct questioning does not implant the idea of suicide; instead, it is a recommended, evidence-based approach when warning signs or a recent attempt are present. After determining whether current suicidal thoughts are present, the nurse should continue assessment of intent, plan, access to means, prior attempts, protective factors, and immediate safety needs, while maintaining close supervision and following unit protocols. The National Institute of Mental Health recommends asking directly about thoughts of killing oneself as part of suicide screening, and The Joint Commission identifies assessment of suicide risk as a critical patient-safety practice. See NIMH Ask Suicide-Screening Questions Toolkit and The Joint Commission Suicide Prevention Resources.

QUESTION NO: 70

A neonate was admitted to the hospital with projectile vomiting. According to the parents, the baby had experienced vomiting episodes after feeding for the last 2 days. A medical diagnosis of hypertrophic pyloric stenosis was made. On assessment, the infant had poor skin turgor, sunken eyeballs, dry skin, and weight loss. Identify the number-one priority nursing diagnosis.

A. Fluid volume deficit

B. Altered nutrition

C. Altered bowel elimination

D. Anxiety

ANSWER: A

Explanation:

Fluid volume deficit is the priority nursing diagnosis because the infant has multiple clear assessment findings of clinically significant dehydration: poor skin turgor, sunken eyes, dry skin, and weight loss after persistent post-feeding projectile vomiting. Hypertrophic pyloric stenosis obstructs gastric emptying, so repeated emesis causes ongoing losses of fluid and gastric electrolytes. In a neonate, limited physiologic reserves and a relatively high body-water requirement mean dehydration can progress rapidly to impaired perfusion, electrolyte disturbances, acid-base imbalance, and circulatory compromise. Priority setting therefore focuses first on supporting circulation and restoring hydration before definitive surgical management of the obstruction. Nursing care includes close assessment of hydration status, daily weight, strict intake and output, urine output, vital signs, serum electrolyte results, and response to prescribed fluid and electrolyte replacement. The infant is commonly kept without oral feedings while stabilization occurs, with intravenous therapy administered as prescribed. Prompt recognition and correction of the fluid deficit helps prepare the infant safely for pyloromyotomy and reduces the risk of complications associated with dehydration. See the Merck Manual discussion of hypertrophic pyloric stenosis and StatPearls review of pyloric stenosis.

QUESTION NO: 71

A 6-year-old child is attending a pediatric clinic for a routine examination. What should the nurse assess for while conducting a vision screening?

A. Hearing test

B. Gait

C. Strabismus

D. Papilledema

ANSWER: C

Explanation:

Strabismus is correct because alignment of the eyes is an essential component of pediatric vision screening. Strabismus refers to misalignment of the eyes, such as an inward or outward deviation. A nurse can observe for an abnormal eye position while the child looks at a target and can use simple screening maneuvers, including assessment of the corneal light reflex and cover testing when appropriate. These observations help identify whether both eyes are fixing on the same object and maintaining coordinated alignment.

Early detection is important because persistent ocular misalignment in childhood can interfere with normal visual development. If one eye is consistently misaligned, the brain may suppress input from that eye, increasing the risk of amblyopia and reduced visual acuity. At age 6, a child should receive age-appropriate visual-acuity screening as well as assessment for ocular alignment abnormalities. A finding suggestive of strabismus warrants referral for a comprehensive eye evaluation so treatment can be initiated promptly if needed. The American Association for Pediatric Ophthalmology and Strabismus describes eye-alignment screening as part of pediatric eye assessment, and the American Academy of Pediatrics supports routine vision screening throughout childhood. See AAPOS vision screening guidance and American Academy of Pediatrics vision screening resources.

QUESTION NO: 72

When assessing a client, the nurse notes the typical skin rash seen with systemic lupus erythematosus. Which of the following descriptions correctly describes this rash?

A. Small round or oval reddish brown macules scattered over the entire body

B. Scattered clusters of macules, papules, and vesicles over the body

C. Bright red appearance of the palmar surface of the hands

D. Reddened butterfly shaped rash over the cheeks and nose

ANSWER: D

Explanation:

The characteristic cutaneous finding described in systemic lupus erythematosus is a reddened, butterfly-shaped rash across the cheeks and bridge of the nose. This is termed a malar rash. It commonly follows a facial distribution over the malar eminences and nasal bridge, often sparing the nasolabial folds. The rash may be flat or slightly raised and can become more noticeable after ultraviolet-light exposure, reflecting the photosensitivity that is common in lupus. Although not every person with systemic lupus erythematosus develops this manifestation, recognition of the classic malar distribution is important during a nursing skin assessment because it can provide a visible clue to autoimmune disease activity and supports further focused assessment for systemic manifestations. The nurse should also assess the client's report of photosensitivity, onset or changes in the rash, joint symptoms, fatigue, fever, renal symptoms, and prescribed treatment response. Authoritative clinical resources identify the malar or "butterfly" rash as a common lupus-related skin manifestation. See the Lupus Foundation of America overview of lupus and the National Institute of Arthritis and Musculoskeletal and Skin Diseases lupus information page.

QUESTION NO: 73

A mother continues to breast-feed her 3-month-old infant. She tells the nurse that over the past 3 days she has not been producing enough milk to satisfy the infant. The nurse advises the mother to do which of the following?

A. "Start the child on solid food."

B. "Nurse the child more frequently during this growth spurt."

C. "Provide supplements for the child between breastfeeding so you will have enough milk."

D. "Wait 4 hours between feedings so that your breasts will fill up."

ANSWER: B

Explanation:

"Nurse the child more frequently during this growth spurt." is correct. Around 3 months, infants commonly have a period of more rapid growth and may suddenly want to feed more often. This increased feeding is an important physiologic signal: frequent and effective milk removal stimulates prolactin-mediated milk production, allowing the parent's supply to adjust to the infant's increased needs. The appropriate nursing guidance is responsive, on-demand feeding, including offering the breast whenever the infant shows early hunger cues such as rooting, hand-to-mouth movements, or increased alertness. The mother can be reassured that temporarily frequent feeding does not necessarily mean her milk is inadequate; it often reflects normal adjustment of supply to demand. Continued direct breastfeeding and assessment of effective milk transfer, including audible swallowing and an appropriate pattern of wet diapers and weight gain, support maintenance of lactation. The Centers for Disease Control and Prevention notes that breast milk production works on a supply-and-demand basis, with more frequent breastfeeding or milk expression increasing production. The American Academy of Pediatrics also supports responsive feeding for breastfed infants. See CDC breastfeeding guidance and American Academy of Pediatrics guidance on infant feeding frequency.

QUESTION NO: 74

A mother who is breast-feeding her newborn asks the RN, "How can I express milk from my breasts manually?" The RN tells her that the correct method for manual milk expression includes using the thumb and the index finger to:

A. Alternately compress and release each nipple

B. Roll the nipple and gently pull the nipple forward

C. Slide the thumb and index finger forward from the outer border of the areola toward the end of the nipple

D. Compress and release each breast at the outer border of the areola

ANSWER: D

Explanation:

“Compress and release each breast at the outer border of the areola

” is correct because effective hand expression uses the thumb and fingers to form a gentle C-shape around the areola rather than manipulating the nipple itself. The parent should place the fingers a short distance behind the nipple, where breast tissue and milk ducts can be compressed, then press back toward the chest and gently compress the fingers together. Releasing the pressure and repeating this motion rhythmically stimulates milk flow. The hand should be repositioned around the breast as needed so that milk is expressed from different areas. This technique is useful in the early postpartum period to collect colostrum, relieve breast fullness, maintain milk production when separated from the infant, or provide milk when direct feeding is temporarily difficult. Manual expression should be comfortable; a firm but gentle compression-and-release motion helps protect sensitive nipple tissue while supporting milk removal. The CDC describes hand expression as placing the thumb and fingers around the breast, pressing back, compressing, and releasing in a repeated pattern. See the CDC guidance on expressing breast milk and MedlinePlus instructions for hand expression.

QUESTION NO: 75

The therapeutic blood-level range for lithium is:

A. 0.25–1.0 mEq/L

B. 0.6–1.2 mEq/L

C. 1.0–2.0 mEq/L

D. 2.0–2.5 mEq/L

ANSWER: B

Explanation:

0.6–1.2 mEq/L is the commonly accepted therapeutic serum lithium range for maintenance treatment, although the target may be individualized according to the clinical situation, patient response, age, renal function, and prescriber direction. Lithium has a narrow therapeutic index, so serum monitoring is essential to maintain efficacy while limiting toxicity. Levels are generally obtained as a trough concentration, approximately 12 hours after the most recent dose, once a stable dosing schedule has been established. In acute mania, clinicians may target the upper portion of the therapeutic range; lower targets may be appropriate for maintenance therapy or for patients with increased vulnerability to adverse effects. Nursing care includes confirming that prescribed laboratory monitoring occurs and recognizing that dehydration, sodium depletion, renal impairment, and interacting medications can increase lithium concentrations. The U.S. prescribing information notes therapeutic serum concentrations around 0.8–1.2 mEq/L for acute treatment and emphasizes individualized monitoring. See the FDA lithium carbonate prescribing information and StatPearls: Lithium for monitoring guidance and therapeutic-use context.

QUESTION NO: 76

Diagnostic assessment findings for an infant with possible coarctation of the aorta would include:

A. A third heart sound

B. A diastolic murmur

C. Pulse pressure difference between the upper extremities

D. Diminished or absent femoral pulses

ANSWER: D

Explanation:

Diminished or absent femoral pulses are a classic assessment finding in an infant with coarctation of the aorta. Coarctation is a congenital narrowing of the aorta, most commonly located near the insertion of the ductus arteriosus, distal to the arteries supplying the upper body. This obstruction restricts blood flow to the descending aorta and therefore reduces perfusion to the lower extremities. On physical examination, the nurse should compare brachial or radial pulses with femoral pulses. Femoral pulses may be weak, delayed compared with upper-extremity pulses (brachiofemoral delay), or not palpable in severe obstruction. The lower extremities may also appear cool or poorly perfused.

In neonates, symptoms can become more apparent as the ductus arteriosus closes because ductal flow may previously have helped supply blood to the descending aorta. A critical coarctation can then cause acute decreased systemic perfusion, feeding difficulty, tachypnea, lethargy, metabolic acidosis, or shock. Prompt recognition of weak or absent femoral pulses is therefore clinically important and warrants urgent cardiovascular evaluation, typically including four-extremity blood-pressure assessment and echocardiography. The American Heart Association describes weak pulses in the legs and higher arm than leg blood pressure as characteristic findings of coarctation. See the American Heart Association overview of coarctation of the aorta and the Merck Manual Professional discussion of coarctation.

QUESTION NO: 77

The nurse should know that according to current thinking, the most important prognostic factor for a client with breast cancer is:

A. Tumor size

B. Axillary node status

C. Client's previous history of disease

D. Client's level of estrogen-progesterone receptor assays

ANSWER: B

Explanation:

Axillary node status is the most important prognostic factor in the context of this question because it identifies whether breast cancer has spread from the primary tumor to regional lymph nodes. Pathologic examination of axillary lymph nodes provides essential staging information: the presence, number, and extent of involved nodes are strongly associated with the likelihood of distant recurrence and with overall survival. Node-negative disease generally indicates a more favorable prognosis than disease with cancer present in one or more axillary nodes; a greater nodal burden indicates a higher risk of systemic spread. This information also helps the oncology team determine the appropriate intensity of adjuvant treatment, such as systemic therapy and regional radiation, after surgery. In modern practice, prognosis is individualized using nodal status together with tumor size and grade, hormone-receptor and HER2 status, genomic testing when indicated, and the presence or absence of distant metastases. Nevertheless, among the factors presented, axillary nodal involvement remains the key indicator of regional spread and the best answer to the question. The National Cancer Institute describes lymph-node involvement as a core component of breast-cancer staging, and the American Cancer Society explains that nodal status is a major prognostic element used in treatment planning. See the National Cancer Institute breast cancer treatment overview and the American Cancer Society breast cancer staging guide.

QUESTION NO: 78

A 75-year-old client is hospitalized with pneumonia caused by gram-positive bacteria. Which one of the following best describes a gram-positive bacterial pneumonia?

A. Klebsiella pneumonia

B. Pneumococcal pneumonia

C. Legionella pneumophila pneumonia

D. Escherichia coli pneumonia

ANSWER: B

Explanation:

Pneumococcal pneumonia is the correct description because it is caused by *Streptococcus pneumoniae*, a gram-positive, encapsulated diplococcus. This organism is a leading bacterial cause of community-acquired pneumonia, particularly in older adults and in people with chronic illnesses or impaired immune function. In a client with pneumococcal pneumonia, inflammation and exudate in the alveoli can impair gas exchange, producing manifestations such as fever, cough, pleuritic chest discomfort, dyspnea, tachypnea, and decreased oxygen saturation. Older clients may also present atypically, including with acute confusion, weakness, or a decline in functional status. Identification of a gram-positive cause is clinically important because diagnostic testing, culture results, local resistance patterns, allergy history, and illness severity guide selection of antimicrobial therapy. Pneumococcal vaccination is also an important prevention measure for adults aged 50 years and older and for people with specified risk conditions. The Centers for Disease Control and Prevention identifies pneumococcal disease as infection caused by *S. pneumoniae* and provides current vaccination guidance at CDC: About Pneumococcal Disease and CDC: Pneumococcal Vaccine Recommendations.

QUESTION NO: 79

A male infant is to be discharged home this morning. Which instruction related to his cord care should be included in his mother's discharge teaching plan?

A. Keep the umbilical area moist with Vaseline until the stump falls off.

B. Keep the umbilical area covered at all times with the diaper.

C. Clean the umbilical cord with alcohol at each diaper change.

D. Clean the umbilical cord daily with soap and water during the bath.

E. Keep the cord stump clean and dry; fold the diaper below it and use plain water if it becomes soiled.

ANSWER: E

Explanation:

Keep the cord stump clean and dry; fold the diaper below it and use plain water if it becomes soiled. This reflects current evidence-based newborn umbilical-cord care for healthy infants in settings with routine hygienic birth practices. The stump should be exposed to air as much as possible, and the diaper should be folded down to prevent urine exposure, friction, and delayed drying. Parents can clean visible urine or stool gently with plain water and then allow the area to air-dry. They should wash their hands before handling the area and avoid applying ointments, antiseptics, or other products unless specifically directed by the newborn's clinician. Dry cord care supports natural separation of the stump, which commonly occurs within about one to three weeks. Discharge teaching should also prepare the parent to contact the clinician for concerning findings such as spreading redness around the base, swelling, tenderness, foul-smelling drainage, pus, fever, poor feeding, or lethargy. The American Academy of Pediatrics describes keeping the cord clean and dry and folding the diaper away from it as routine care. The World Health Organization likewise recommends dry cord care in facilities and communities with low neonatal-mortality settings. See the American Academy of Pediatrics guidance and the WHO umbilical cord care recommendation.

QUESTION NO: 80

A term neonate has experienced no distress at birth and has an Apgar score of 9. Her mother has asked to breastfeed her following delivery. Immediately after birth, the neonate was most susceptible to heat loss. The most appropriate intervention to conserve heat loss and promote bonding is to:

A. Place her under the radiant warmer

B. Dry her with blankets

C. Place her to her mother's breast

D. Place her on a heated pad

ANSWER: C

Explanation:

"Place her to her mother's breast" is correct because this stable, vigorous term neonate can be placed in immediate skin-to-skin contact with her mother, ideally prone on the mother's bare chest near the breast and covered with warm, dry linens. Skin-to-skin care supports thermoregulation: the mother's chest helps maintain the newborn's body temperature while limiting environmental heat loss during the vulnerable transition immediately after birth. It also facilitates early breastfeeding during the newborn's first period of alertness, when sucking and rooting behaviors are often strong. This intervention directly supports the mother's stated goal of breastfeeding and promotes attachment through close contact, sensory interaction, and responsive early care. For a well newborn with no need for resuscitation or intensive monitoring, uninterrupted skin-to-skin contact should begin as soon as possible after delivery and continue through the first feeding when feasible. The World Health Organization includes immediate skin-to-skin contact as essential newborn care and recommends it to support warmth and breastfeeding. The American Academy of Pediatrics likewise supports immediate and sustained skin-to-skin care for stable mother–newborn dyads. See the WHO Essential Newborn Care Course and the American Academy of Pediatrics guidance on skin-to-skin care.

QUESTION NO: 81

A child with celiac disease is being discharged from the hospital. The mother demonstrates knowledge of nutritional needs of her child when she is able to state the foods which are included in a:

A. Lactose-restricted diet

B. Gluten-restricted diet

C. Phenylalanine-restricted diet

D. Fat-restricted diet

ANSWER: B

Explanation:

Gluten-restricted diet is correct because celiac disease is an immune-mediated condition in which ingestion of gluten damages the mucosa of the small intestine. Gluten is a protein found in wheat, barley, and rye. Lifelong, strict avoidance of these grains allows intestinal inflammation to resolve, promotes nutrient absorption and normal growth, and reduces the risk of complications associated with ongoing intestinal injury. Teaching before discharge should emphasize choosing naturally gluten-free foods such as fruits, vegetables, meat, poultry, fish, eggs, beans, nuts, and gluten-free grains or starches, while carefully checking packaged-food labels for gluten-containing ingredients and potential cross-contact. Oats may be included only when they are specifically labeled gluten-free, since conventional oats can be contaminated during growing or processing. The mother's ability to identify and plan foods within a gluten-restricted diet demonstrates the essential nutritional knowledge needed to manage celiac disease safely at home. The National Institute of Diabetes and Digestive and Kidney Diseases describes a gluten-free diet as the primary treatment for celiac disease, and the Celiac Disease Foundation provides practical information about foods and label reading. See NIDDK: Treatment for Celiac Disease and Celiac Disease Foundation: What Is Gluten?.

QUESTION NO: 82

Which of the following findings would be abnormal in a postpartal woman?

A. Chills shortly after delivery

B. Pulse rate of 60 bpm in morning on first postdelivery day

C. Urinary output of 3000 mL on the second day after delivery

D. An oral temperature of 101F (38.3C) on the third day after delivery

ANSWER: D

Explanation:

An oral temperature of 101F (38.3C) on the third day after delivery is abnormal because a postpartum fever at this level and timing warrants assessment for infection. Although a mild, transient temperature elevation can occur during the first 24 hours after birth because of labor-related exertion or dehydration, a temperature of 100.4°F (38°C) or greater after the initial 24 hours is clinically significant. On the third postpartum day, this finding should prompt nursing assessment for associated symptoms and timely communication with the obstetric clinician. Potential sources include uterine infection, urinary tract infection, breast infection, wound infection, or another systemic infectious process. The nurse should obtain and trend vital signs, assess uterine tenderness and lochia, evaluate the breasts, inspect any incision or laceration repair as applicable, assess urinary symptoms, and follow orders for diagnostic testing or treatment. Early identification is important because postpartum infections can progress rapidly and may lead to serious maternal complications if not addressed. The Merck Manual identifies a temperature of 38°C or higher after the first 24 postpartum hours as a finding that requires evaluation for postpartum infection. The American College of Obstetricians and Gynecologists also emphasizes prompt recognition and treatment of maternal infection and sepsis warning signs. See Merck Manual: Postpartum Endometritis and ACOG: Recognizing and Responding to Maternal Sepsis.

QUESTION NO: 83

A client has been diagnosed as being preeclamptic. The physician orders magnesium sulfate. Magnesium sulfate (MgSO4) is used in the management of preeclampsia for:

A. Prevention of seizures

B. Prevention of uterine contractions

C. Sedation

D. Fetal lung protection

ANSWER: A

Explanation:

Magnesium sulfate is administered to a client with preeclampsia primarily for prevention of seizures. Preeclampsia can progress to eclampsia, which is defined by the development of new-onset generalized seizures in a person with preeclampsia. Magnesium sulfate is the recommended anticonvulsant therapy for seizure prophylaxis in preeclampsia with severe features and for treatment of eclamptic seizures. Its therapeutic effect is neurologic: it decreases neuromuscular excitability and reduces the risk of recurrent seizure activity. Nursing care during the infusion includes frequent assessment for magnesium toxicity, particularly respiratory rate, deep-tendon reflexes, level of consciousness, and urine output, because magnesium is excreted by the kidneys. Calcium gluconate should be readily available as the antidote for clinically significant magnesium toxicity. The medication may be continued during labor and for a prescribed postpartum period because seizure risk does not end immediately after birth. This use is supported by the American College of Obstetricians and Gynecologists guidance on gestational hypertension and preeclampsia and by the World Health Organization recommendations for prevention and treatment of preeclampsia and eclampsia. See ACOG's Practice Bulletin on Gestational Hypertension and Preeclampsia and WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia.

QUESTION NO: 84

Which of the following nursing orders has the highest priority for a child with epiglottitis?

A. Vital signs every shift

B. Tracheostomy set at bedside

C. Intake and output

D. Specific gravity every shift

ANSWER: B

Explanation:

Tracheostomy set at bedside is the highest-priority order because epiglottitis can progress rapidly to critical upper-airway obstruction. Inflammation and edema of the epiglottis and surrounding supraglottic tissues can narrow the airway abruptly, and a child's condition may deteriorate quickly. Nursing priorities therefore follow the airway component of the ABC framework: maintain a calm environment, minimize procedures that could provoke crying or agitation, closely observe for worsening respiratory distress, and ensure that emergency airway equipment is immediately available.

Keeping a tracheostomy set at the bedside supports rapid preparation for a definitive emergency airway if obstruction becomes severe and less-invasive airway management is unsuccessful or cannot be safely performed. Airway intervention for suspected epiglottitis should be undertaken by experienced clinicians in a controlled setting whenever possible, but bedside readiness is essential because complete obstruction is a recognized emergency risk. This order directly addresses the most immediate life-threatening complication of the condition and is therefore the priority nursing action. See the Merck Manual Professional overview of epiglottitis and the NCBI Bookshelf review of epiglottitis.

QUESTION NO: 85

A 7-year-old child is brought to the ER at midnight by his mother after symptoms appeared abruptly. The nurse's initial assessment reveals a temperature of 104.5◦F (40.3◦C), difficulty swallowing, drooling, absence of a spontaneous cough, and agitation. These symptoms are indicative of which one of the following?

A. Acute tracheitis

B. Acute spasmodic croup

C. Acute epiglottitis

D. Acute laryngotracheobronchitis

ANSWER: C

Explanation:

Acute epiglottitis is the correct diagnosis. This presentation reflects acute, potentially life-threatening inflammation and swelling of the epiglottis and adjacent supraglottic tissues. The abrupt onset of a very high fever, dysphagia, prominent drooling, agitation, and absence of a cough are particularly significant because they suggest that the child cannot comfortably swallow secretions and may have progressive upper-airway obstruction. Children can deteriorate rapidly as swelling narrows the airway, so the immediate nursing priority is to maintain a calm environment, avoid procedures that could agitate the child or provoke airway closure, and prepare for expert airway management. The child should be allowed to remain in a position of comfort, often sitting upright, while anesthesia and otolaryngology support are urgently obtained. Examination of the throat with a tongue blade or attempts to obtain an oropharyngeal specimen should not be performed before the airway is secured. Current clinical references emphasize that suspected epiglottitis requires prompt airway-focused assessment and controlled management because complete obstruction can occur unexpectedly. See Merck Manual: Epiglottitis and StatPearls: Epiglottitis.

QUESTION NO: 86

Goal setting for a client with Meniere's disease should include which of the following?

A. Frequent ambulation

B. Prevention of a fall injury

C. Consumption of three meals per day

D. Prevention of infection

ANSWER: B

Explanation:

Prevention of a fall injury is an appropriate priority goal for a client with Ménière's disease because recurrent, episodic vertigo is a core manifestation of the disorder. During an attack, altered vestibular input can produce an intense sensation of spinning or movement, disequilibrium, nausea, and difficulty walking safely. These symptoms can begin abruptly and may substantially impair balance, coordination, and the ability to perform usual activities without assistance. Therefore, nursing goals should emphasize maintaining physical safety and preventing injury during periods of dizziness or vertigo.

Interventions that support this goal include assessing the client's gait and fall risk, assisting with ambulation when symptomatic, encouraging the client to sit or lie down promptly at the onset of vertigo, keeping needed items within reach, and maintaining an uncluttered environment with adequate lighting. Teaching the client and family to recognize the onset of an episode and to seek assistance before walking also supports a realistic, measurable safety outcome. The National Institute on Deafness and Other Communication Disorders identifies vertigo and balance problems among the characteristic symptoms of Ménière's disease. Additional clinical information is available from the National Institute on Deafness and Other Communication Disorders and the Merck Manual Professional Edition.

QUESTION NO: 87

The physician decides to prescribe both a short-acting insulin and an intermediate-acting insulin for a newly diagnosed 8-year-old diabetic client. An example of a short-acting insulin is:

A. Novolin Regular

B. Humulin NPH

C. Lente Beef

D. Protamine zinc insulin

ANSWER: A

Explanation:

Novolin Regular is correct because it is human regular insulin, which is classified as a short-acting insulin. Regular insulin is administered subcutaneously and has a comparatively rapid onset for a non-analog insulin, generally beginning to lower blood glucose within about 30 minutes. Its glucose-lowering effect peaks several hours after administration and lasts for several hours, so meal timing and blood-glucose monitoring are essential to reduce the risk of hypoglycemia. In a child who is beginning insulin therapy, a prescribed short-acting insulin may be used to provide prandial coverage and/or be combined with an intermediate-acting insulin as part of an individualized regimen intended to approximate basal and meal-related insulin needs. The exact dose, timing, food plan, and monitoring schedule must be directed by the child's diabetes care team and adjusted for growth, activity, illness, and glucose results. The FDA-approved Novolin R prescribing information identifies the product as human insulin injection (recombinant DNA origin) and provides its pharmacologic timing information. The American Diabetes Association also describes insulin therapy as individualized and notes the importance of matching insulin action to meals and glucose-management needs. See the Novolin R prescribing information and the American Diabetes Association insulin overview.

QUESTION NO: 88

A 10-year-old client with a pin in the right femur is immobilized in traction. He is exhibiting behavioral changes including restlessness, difficulty with problem solving, inability to concentrate on activities, and monotony. Which of the following nursing implementations would be most effective in helping him cope with immobility?

A. Providing him with books, challenging puzzles, and games as diversionary activities

B. Allowing him to do as much for himself as he is able, including learning to do pin-site care under supervision

C. Having a volunteer come in to sit with the client and to read him stories

D. Stimulating rest and relaxation by gentle rubbing with lotion and changing the clientâ€™s position frequently

ANSWER: B

Explanation:

Allowing him to do as much for himself as he is able, including learning to do pin-site care under supervision, is the most effective intervention because it preserves autonomy and gives a school-age child meaningful control during a period of enforced immobility. At age 10, children are developing industry: they benefit from completing achievable tasks, learning practical skills, and seeing that their actions contribute to their own care. Traction and hospitalization can disrupt normal routines, independence, peer interaction, and participation in age-appropriate activities. Supervised self-care helps counter the loss of control that commonly accompanies immobility and can build competence, confidence, and active coping. Pin-site care is also a concrete, developmentally appropriate task when the child is physically able and willing to participate. The nurse should provide simple teaching, demonstrate the skill, supervise performance, reinforce success, and adjust the level of assistance to the child's condition and institutional policy. This approach supports psychosocial adaptation while maintaining safety and infection-prevention practices. The NCLEX-RN test plan emphasizes individualized nursing interventions that promote client participation, self-care, and psychosocial integrity. See the NCSBN NCLEX-RN Test Plan and NCBI StatPearls: Erikson's Stages of Psychosocial Development.

QUESTION NO: 89

The health team needs to realize that the compulsive concern with cleanliness that a client with severe anxiety exhibits is most likely an attempt to:

A. Reduce his anxiety

B. Avoid going to psychotherapy

C. Manipulate the health team members

D. Increase his self-image by showing higher standards than the fellow clients

ANSWER: A

Explanation:

"Reduce his anxiety" is correct because compulsive cleaning behaviors function as efforts to manage intense, distressing anxiety. In obsessive-compulsive presentations, intrusive fears or thoughts—such as contamination concerns—produce substantial discomfort. Repetitive behaviors such as washing, cleaning, checking, or arranging are then performed to obtain a sense of relief, safety, or control. The relief is generally temporary, but it reinforces the behavior: when anxiety decreases immediately after the ritual, the person becomes more likely to repeat it when distress returns. This is an important therapeutic concept for the health team because it supports a nonjudgmental approach. Nurses should recognize that the behavior is driven by anxiety and perceived threat, not simply by a preference for cleanliness. Care should promote safety, therapeutic communication, and gradual evidence-based treatment rather than shaming or abruptly demanding that the client stop rituals. The National Institute of Mental Health describes compulsions as repetitive behaviors a person feels driven to perform in response to obsessions, often to reduce anxiety or prevent a feared event. The American Psychiatric Association likewise identifies exposure and response prevention as a core treatment approach that addresses this anxiety-compulsion cycle. See NIMH: Obsessive-Compulsive Disorder and American Psychiatric Association: What Is OCD?.

QUESTION NO: 90

The primary reason for sending a burn client home with a pressure garment, such as a Jobst garment, is that the garment:

A. Decreases hypertrophic scar formation

B. Assists with ambulation

C. Covers burn scars and decreases the psychological impact during recovery

D. Increases venous return and cardiac output by normalizing fluid status

ANSWER: A

Explanation:

Decreases hypertrophic scar formation is correct. Following a significant burn injury, especially one with delayed healing or skin grafting, the healing scar can produce excess collagen and become raised, thickened, red, pruritic, and restrictive. A properly fitted pressure garment provides consistent, circumferential compression over the healed burn area. This external pressure is used during scar maturation to help limit the development and severity of hypertrophic scarring and to promote a flatter, softer, more pliable scar. Improved scar pliability is clinically important because it can support comfort, movement, and function while the client recovers. Pressure therapy is generally initiated only after the wound has healed sufficiently, and the garment must be fitted and monitored by the burn-rehabilitation team to maintain appropriate pressure as edema resolves and body contours change. Clients commonly wear these garments for prolonged periods during the active scar-maturation phase, with adherence and skin assessment emphasized in discharge teaching. The American Burn Association identifies scar management, including pressure garments when indicated, as a component of burn rehabilitation and outpatient recovery. Further information is available from the American Burn Association and the Model Systems Knowledge Translation Center's scar-management guidance.

QUESTION NO: 91

Proper positioning for the child who is in Bryant's traction is:

A. Both hips flexed at a 90-degree angle with the knees extended and the buttocks elevated off the bed

B. Both legs extended, and the hips are not flexed

C. The affected leg extended with slight hip flexion

D. Both hips and knees maintained at a 90-degree flexion angle, and the back flat on the bed

ANSWER: A

Explanation:

Both hips flexed at a 90-degree angle with the knees extended and the buttocks elevated off the bed is the correct position for Bryant's traction. This traction is generally used for small children with certain femoral fractures. Skin traction is applied to both lower extremities, which are suspended vertically so that the hips are flexed to approximately 90 degrees and the knees remain extended. The child's buttocks should be just clear of the mattress. This slight elevation is essential because the child's body weight provides the countertraction that balances the upward pull on the legs.

Safe nursing assessment includes verifying that the child remains properly aligned, that the buttocks stay slightly elevated rather than resting fully on the bed, and that the traction weights hang freely without touching the bed or floor. The nurse should also perform frequent neurovascular checks of both legs, assess skin under the traction materials, maintain prescribed traction continuously, and provide comfort and age-appropriate distraction. Correct positioning preserves the intended line of pull and helps maintain fracture alignment while minimizing complications associated with skin traction. See the NCBI Bookshelf resources on Bryant traction and the MSD Manual overview of fracture care.

QUESTION NO: 92

A 3-month-old infant has had a unilateral cleft lip repair. He has resumed feedings of oral formula. The nurse should feed the infant with:

A. Gavage tube

B. Nipple and bottle

C. A straw and cup

D. Syringe

ANSWER: D

Explanation:

Syringe is the appropriate feeding method immediately after a cleft lip repair because it permits controlled placement of small amounts of formula along the side and toward the back of the infant's mouth. This approach limits the need for vigorous sucking and helps avoid direct pressure, friction, or tension at the newly repaired lip and suture line. The nurse or caregiver should deliver the formula slowly, pause frequently for swallowing and breathing, and keep the infant in an upright position to promote safe swallowing and reduce aspiration risk. Feeding should follow the cleft team or surgeon's specific postoperative instructions, since techniques and restrictions can vary by surgical procedure and institution. Maintaining adequate nutrition and hydration is important for healing, and a syringe allows oral intake while protecting the surgical repair during the early postoperative period. Cleft-care guidance emphasizes individualized feeding support and coordination with the surgical team after repair. See the American Cleft Palate-Craniofacial Association Parameters of Care and Boston Children's Hospital cleft lip and palate repair information.

QUESTION NO: 93

The nurse notes scattered crackles in both lungs and 1+ pitting edema when assessing a cardiac client. The physician is notified and orders furosemide (Lasix) 80 mg IV push stat. Which of the following diagnostic studies is monitored to assess for a major complication of this therapy?

A. Serum electrolytes

B. Arterial blood gases

C. Complete blood count

D. 12-Lead ECG

ANSWER: A

Explanation:

Serum electrolytes are monitored because intravenous furosemide produces prompt, potent loop diuresis and can cause clinically significant electrolyte depletion, particularly hypokalemia. Furosemide inhibits sodium and chloride reabsorption in the ascending loop of Henle, increasing urinary loss of sodium and water; potassium loss commonly accompanies this diuresis. With a high stat IV dose, the client may experience rapid fluid and electrolyte shifts, making timely measurement of serum potassium especially important. Monitoring electrolytes also assesses for associated sodium, magnesium, chloride, and bicarbonate abnormalities that can develop with aggressive diuresis. Hypokalemia is a major safety concern in a cardiac client because potassium is necessary for normal cardiac electrical conduction and myocardial function; early laboratory detection permits potassium replacement or adjustment of therapy before severe manifestations occur. The FDA prescribing information for furosemide directs clinicians to observe patients for signs of fluid or electrolyte imbalance and to determine serum electrolytes periodically. This is particularly relevant when substantial diuresis is expected. See the DailyMed furosemide prescribing information and the NCBI StatPearls review of furosemide.

QUESTION NO: 94

Which of the following should the nurse anticipate receiving as an as-needed order for a postoperative carotid endarterectomy client?

A. Nifedipine 10 mg SL for B/P 140/90

B. Furosemide 20 mg/PO for decreased urine output

C. Magnesium salicylate to decrease inflammation

D. Nitroglycerin gr 1/150 for chest pain

E. Labetalol IV as needed for postoperative hypertension

ANSWER: E

Explanation:

Labetalol IV as needed for postoperative hypertension is an appropriate anticipated as-needed order after carotid endarterectomy because close blood-pressure control is essential during the immediate postoperative period. Removal of a carotid plaque can alter baroreceptor responsiveness, and postoperative hypertension is common. Marked hypertension can stress the arterial repair and is associated with serious complications, including neck hematoma and cerebral hyperperfusion syndrome; the latter can progress to severe headache, seizures, intracranial hemorrhage, or neurologic deterioration. An intravenous, titratable antihypertensive such as labetalol permits prompt reduction of elevated blood pressure while allowing frequent reassessment of the client's neurologic status and hemodynamic response. The specific blood-pressure threshold and target should follow the surgeon's or facility's protocol and account for the client's baseline pressure and cerebral perfusion needs. Postoperative carotid endarterectomy care therefore includes frequent blood-pressure measurement and rapid treatment of clinically significant hypertension. The clinical importance of managing post-carotid-endarterectomy hypertension and hyperperfusion risk is reviewed in StatPearls: Carotid Endarterectomy and in the European Society for Vascular Surgery carotid guidelines.

QUESTION NO: 95

A 55-year-old client is admitted with a diagnosis of renal calculi. He presented with severe right flank pain, nausea, and vomiting. The most important nursing action for him at this time is:

A. Intake and output measurement

B. Daily weights

C. Straining of all urine

D. Administration of O2 therapy

ANSWER: C

Explanation:

Straining of all urine is the most important action because it allows the nurse to collect any stone or stone fragments that the client passes. The recovered calculus can be sent for laboratory analysis to identify its composition, such as calcium oxalate, uric acid, cystine, or struvite. Knowing the stone composition helps guide subsequent prevention strategies, including individualized fluid, dietary, and medication recommendations. Consistently straining every void is necessary because calculi may be small, may pass unexpectedly, and may otherwise be discarded unnoticed. In a client with acute flank pain, nausea, and vomiting from suspected renal calculi, capturing the stone also provides clinically useful evidence that the calculus has progressed through and exited the urinary tract. The nurse should use the prescribed strainer for all urine, inspect it for sediment or stones, retain any specimen according to facility policy, and document passage and relevant characteristics. This intervention directly supports diagnosis and ongoing management while the client receives assessment and treatment for symptoms. The National Institute of Diabetes and Digestive and Kidney Diseases notes that a health care professional may ask a person to catch a kidney stone so it can be tested to determine its type. See NIDDK: Diagnosis of Kidney Stones and NIDDK: Kidney Stones.

QUESTION NO: 96

After instructing a female client on circumcision care, the nursery nurse asks her to restate some of the key points covered. Which statement shows that the client will properly care for her son's circumcision?

A. "I'll make sure I soak the gauze with warm water first, before I take it off each time."

B. "I'll make sure that I report any drainage around where they operated."

C. "I'll apply alcohol to the area daily to clean it and prevent any infection."

D. "I'll keep a close watch on it for a day or two."

ANSWER: A

Explanation:

“I’ll make sure I soak the gauze with warm water first, before I take it off each time.” demonstrates appropriate post-circumcision care. A petrolatum-impregnated gauze dressing may be placed over the penis after a newborn circumcision to protect the incision from friction and from adhering to the diaper. If this dressing sticks to the healing surface, wetting or soaking it with warm water before removal helps loosen it gently. This minimizes pulling on newly healing tissue, reduces discomfort, and helps prevent bleeding or disruption of the surgical site. The parent should use gentle handling during diaper changes and follow the clinician’s instructions about applying petroleum jelly or changing any dressing. Normal healing commonly includes local redness, swelling, and a yellowish film or crust on the glans as the tissue repairs. Teaching should support safe, atraumatic cleansing and dressing removal while the site heals, typically over about 7 to 10 days. Guidance from the Stanford Newborn Nursery describes routine care with petroleum jelly and notes the expected appearance during healing: Stanford Medicine Newborn Nursery. Additional parent-focused aftercare information is available from MedlinePlus.

QUESTION NO: 97

A client is diagnosed with Mycobacterium tuberculosis. He is placed in respiratory isolation, intubated, and receives mechanical ventilation. When performing suctioning, the nurse should:

A. Suction for a maximum of 20 seconds

B. Hyperoxygenate before and after suctioning

C. Suction for a maximum of 30 seconds

D. Maintain clean technique during suctioning

ANSWER: B

Explanation:

Hyperoxygenate before and after suctioning is correct because endotracheal suctioning temporarily interrupts ventilatory support and removes air, oxygen, and secretions from the artificial airway. This can rapidly lower oxygen saturation, particularly in a mechanically ventilated client who may already have impaired pulmonary gas exchange from tuberculosis. Providing supplemental oxygen before suctioning builds an oxygen reserve to better tolerate the brief procedure. Re-establishing or increasing oxygen delivery after the suction pass supports recovery of oxygenation and helps reduce procedure-related hypoxemia.

The nurse should use the ventilator’s oxygenation feature or provide the prescribed increased fraction of inspired oxygen as appropriate to the client’s condition and institutional protocol, while monitoring oxygen saturation, heart rate, respiratory status, and ventilator response. Suctioning should be performed only when clinically indicated, using a brief, efficient technique to minimize interruption of ventilation. Because *Mycobacterium tuberculosis* is transmitted through airborne particles, suctioning also requires continued adherence to airborne-infection-isolation practices and appropriate respiratory protection; however, the immediate suctioning intervention identified here is oxygenation before and after the procedure. Guidance on airway suctioning and prevention of hypoxemia is available from StatPearls: Surgical Airway Suctioning and the CDC’s tuberculosis infection-control guidance.

QUESTION NO: 98

A diagnosis of hepatitis C is confirmed by a male client’s physician. The nurse should be knowledgeable of the differences between hepatitis A, B, and

C. Which of the following are characteristics of hepatitis C?

A. The potential for chronic liver disease is minimal.

B. The onset of symptoms is abrupt.

C. The incubation period is 2–26 weeks.

D. There is an effective vaccine for hepatitis B, but not for hepatitis C.

ANSWER: D

Explanation:

There is an effective vaccine for hepatitis B, but not for hepatitis C. This is the most accurate current characteristic distinguishing hepatitis C from hepatitis B. Hepatitis B vaccination is a well-established preventive measure and is recommended routinely in the United States for all infants and for adults aged 19–59 years, as well as for older adults with risk factors or who want protection. In contrast, no licensed vaccine is available to prevent hepatitis C infection. Prevention of hepatitis C therefore relies on reducing exposure to infected blood, including safe injection practices, screening donated blood, and avoiding shared injection equipment or personal items that could be contaminated with blood. For a client with confirmed hepatitis C, the nurse should support follow-up care, reinforce measures that reduce blood exposure to others, and encourage evaluation for curative direct-acting antiviral therapy. The Centers for Disease Control and Prevention explicitly states that no vaccine exists for hepatitis C, while vaccination is available for hepatitis B. See the CDC hepatitis B vaccination guidance and the CDC hepatitis C overview.

QUESTION NO: 99

A client had a transurethral resection of the prostate yesterday. He is concerned about the small amount of blood that is still in his urine. The nurse explains that the blood in his urine:

A. Should not be there on the second day

B. Will stop when the Foley catheter is removed

C. Is normal for several days after surgery and should be reported if it increases

D. Can be removed by irrigating the bladder

ANSWER: C

Explanation:

“Is normal for several days after surgery and should be reported if it increases” is correct. Following a transurethral resection of the prostate, the resection site in the prostate is healing and may ooze a small amount of blood. Consequently, urine may appear pink or contain a small amount of blood during the early postoperative period. This is an anticipated finding, particularly on the day after surgery, and the nurse should reassure the client while also teaching appropriate monitoring.

The important distinction is that mild, decreasing hematuria is expected, whereas bleeding that becomes heavier, produces large clots, obstructs urine flow, or is accompanied by inability to void requires prompt assessment. Adequate fluid intake, if not contraindicated, supports urine flow and helps reduce clot formation. If continuous bladder irrigation is prescribed, its purpose is to maintain catheter patency and prevent clot retention while the operative area heals. Patient discharge guidance similarly notes that blood in the urine can occur after TURP and identifies increasing bleeding or difficulty urinating as reasons to contact the surgical team. See MedlinePlus: Transurethral resection of the prostate—discharge and Memorial Sloan Kettering: TURP patient education.

QUESTION NO: 100

The nurse is teaching a child’s parents how to protect the child from lead poisoning. The nurse knows that a common source of lead poisoning in children is:

A. Dandelion leaves

B. Pencils

C. Old paint

D. Stuffing from toy animals

ANSWER: C

Explanation:

Old paint is a common and clinically important source of childhood lead exposure. In the United States, homes built before 1978 may contain lead-based paint. As this paint deteriorates, it can create paint chips and lead-contaminated household dust. Young children are particularly vulnerable because of normal hand-to-mouth behavior; they may ingest paint chips directly or swallow lead-containing dust after it settles on their hands, toys, floors, windowsills, and other surfaces. Renovation, repair, or repainting activities in older homes can also disturb lead paint and substantially increase hazardous dust exposure if lead-safe practices are not used.

Teaching should emphasize keeping children away from peeling or chipping paint, wet-cleaning dust from frequently touched surfaces, washing hands and toys often, and using appropriately trained professionals for renovation in older housing. The nurse should also encourage parents to discuss blood lead screening with the child's health care provider when the child has risk factors, such as living in or regularly visiting an older home. The Centers for Disease Control and Prevention identifies lead-based paint and lead-contaminated dust in pre-1978 housing as major childhood exposure sources. See the CDC lead prevention guidance and the EPA information on sources of lead.

QUESTION NO: 101

A 52-year-old client is scheduled for a small-bowel resection in the morning. In conjunction with other preoperative preparation, the nurse is teaching her diaphragmatic breathing exercises. She will teach the client to:

A. Inhale slowly and deeply through the nose until the lungs are fully expanded, hold the breath a couple of seconds, and then exhale slowly through the mouth. Repeat 2–3 more times to complete the series every 1–2 hours while awake

B. Purse the lips and take quick, short breaths approximately 18–20 times/min

C. Take a large gulp of air into the mouth, hold it for 10–15 seconds, and then expel it through the nose. Repeat 4–5 times to complete the series

D. Inhale as deeply as possible and then immediately exhale as deeply as possible at a rate of approximately 20–24 times/min

ANSWER: A

Explanation:

"Inhale slowly and deeply through the nose until the lungs are fully expanded, hold the breath a couple of seconds, and then exhale slowly through the mouth. Repeat 2–3 more times to complete the series every 1–2 hours while awake" is correct because it teaches the essential components of postoperative deep-breathing practice: a slow maximal inspiration, a brief inspiratory hold, and controlled exhalation. Slow deep inhalation promotes diaphragmatic descent and expansion of the lower lung fields, where postoperative clients are particularly prone to reduced ventilation from pain, immobility, and residual anesthetic effects. The short hold helps maintain alveolar expansion and supports gas exchange before exhalation. Repeating a small series at regular intervals while awake provides an achievable routine that helps the client practice the technique before surgery and use it effectively afterward. Preoperative instruction is important because the client can learn the maneuver when comfortable and then apply it despite postoperative fatigue or incisional discomfort. Deep-breathing exercises are part of standard pulmonary hygiene measures intended to support lung expansion and reduce postoperative pulmonary complications. The American College of Surgeons describes deep breathing and coughing as measures that help keep the lungs clear after surgery; see ACS patient guidance. Additional perioperative pulmonary-care guidance is available from AORN.