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Topic Break Down

Topic	No. of Questions
Topic 1, Nursing Care of the Adult	365
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Total	766

QUESTION NO: 1

Entering the client's room, the nurse observes the client to be cyanotic, cool to touch and diaphoretic. Which of the following actions should the nurse carry out first?

A. Use verbal and tactile stimuli

B. Apply oxygen at 10L/min via mask

C. Assess heart and lung sounds

D. Call for help

ANSWER: A

Explanation:

Use verbal and tactile stimuli is the first action because the nurse must immediately establish whether the client is responsive. Cyanosis, cool skin, and diaphoresis are urgent signs that may accompany severe hypoxemia, poor perfusion, shock, or cardiac compromise. A rapid responsiveness check—speaking loudly to the client and gently tapping or stimulating them—takes only seconds and determines the next emergency pathway. If the client responds, the nurse can quickly assess airway, breathing, circulation, and oxygenation while obtaining assistance. If the client does not respond, the nurse should promptly activate the emergency response system, assess breathing and pulse according to facility protocol, and initiate resuscitative measures as indicated. This sequence follows basic life-support principles: first assess the safety of the situation and responsiveness, then summon help and evaluate breathing/circulation. The American Heart Association describes checking responsiveness as an immediate step when an adult is found collapsed or potentially unresponsive. Rapid identification of responsiveness is essential because it distinguishes a critically ill but conscious client from one requiring immediate cardiopulmonary resuscitation. See the American Heart Association CPR and ECC Guidelines and the Merck Manual approach to the critically ill patient.

QUESTION NO: 2

A pregnant woman who is at term cannot get to the hospital in time for delivery of her infant and calls a neighbor, who is a nurse. After the infant's head is delivered, the nurse should take which of these actions?

A. Facilitate delivery of the anterior shoulder

B. Cleanse the infant's face

C. Stimulate the infant to cry

D. Check for a nuchal cord

ANSWER: D

Explanation:

“Check for a nuchal cord” is correct because, immediately after the fetal head is born, the attendant should assess whether the umbilical cord is wrapped around the infant’s neck. A nuchal cord is relatively common and may be loose enough to gently slip over the infant’s head. If it is tight and prevents delivery, it may need to be clamped in two places and cut so the body can be delivered safely. This assessment is performed before proceeding with birth of the shoulders because a cord around the neck can restrict descent or compromise circulation if it is tightly stretched during delivery. The nurse should support the newborn’s head as it emerges, avoid pulling on the head or cord, and allow the normal external rotation of the head that aligns the shoulders for birth. Once cord status has been addressed, the attendant can continue to support an uncomplicated delivery and provide immediate newborn care. Guidance for emergency or unplanned delivery similarly emphasizes checking for and managing a cord around the neck after delivery of the head. See the Merck Manual’s management of normal delivery and the American Academy of Family Physicians review of out-of-hospital birth.

QUESTION NO: 3

A client complains of eye pain and is suspected of having glaucoma. Which of the following assessments should the nurse make?

A. "Do your eyes tear a lot?"

B. "Do you see floating spots in front of your eyes."

C. "Does everything look hazy to you?"

D. "Do you see halos around light?"

ANSWER: D

Explanation:

“Do you see halos around light?” is the most appropriate focused assessment because halos around lights are a classic symptom of acute angle-closure glaucoma. In this emergency, obstruction of aqueous humor drainage causes a rapid rise in intraocular pressure. Corneal edema can develop as the pressure rises, producing blurred vision and colored rings or halos around light sources. Eye pain in combination with halos is especially concerning and should prompt urgent ophthalmic evaluation, since sustained elevated pressure can quickly injure the optic nerve and threaten vision. The nurse should also recognize that acute angle closure may be accompanied by headache, nausea, vomiting, a red eye, and a fixed or poorly reactive mid-dilated pupil. Asking specifically about halos helps identify a hallmark visual complaint associated with this acute presentation and supports rapid escalation of care. The American Academy of Ophthalmology describes seeing halos around lights along with severe eye pain and blurred vision as symptoms of angle-closure glaucoma. See the American Academy of Ophthalmology overview of glaucoma and the Merck Manual discussion of angle-closure glaucoma.

QUESTION NO: 4

Which of the following nursing actions would be most important when caring for a patient who has begun treatment with diltiazem hydrochloride (Cardizem)?

A. Auscultating heart sounds

B. Assessing capillary refill

C. Palpating pedal pulses

D. Monitoring blood pressure

ANSWER: D

Explanation:

Monitoring blood pressure is the priority nursing action when a patient begins diltiazem hydrochloride therapy. Diltiazem is a nondihydropyridine calcium channel blocker that relaxes vascular smooth muscle and reduces cardiac workload. Its therapeutic effects can lower systemic blood pressure, but this also creates a clinically important risk for hypotension, particularly when treatment is initiated, when the dose is increased, or when the patient also receives other antihypertensive medications. Regular blood-pressure assessment allows the nurse to identify an excessive response promptly and to evaluate whether treatment is achieving the intended effect safely.

Blood-pressure trends should be interpreted with the patient’s symptoms and baseline measurements. Findings such as dizziness, light-headedness, weakness, syncope, or an unusually low reading may indicate clinically significant hypotension and require timely nursing intervention, including patient safety measures and notification of the prescribing clinician as appropriate. Diltiazem can also reduce heart rate and slow atrioventricular conduction, so pulse and rhythm assessment are important in practice; however, monitoring blood pressure is the best answer because hypotension is a central hemodynamic adverse effect requiring close assessment after treatment begins. The FDA prescribing information specifically warns of symptomatic hypotension and recommends appropriate clinical monitoring. See the FDA Cardizem prescribing information and NCBI StatPearls review of diltiazem.

QUESTION NO: 5

A client who has ulcerative colitis does not respond to the prescribed therapy and is admitted to the hospital for a total colectomy and ileostomy. Which of these measures should be given priority in the client's preoperative care plan?

A. Promoting the client's acceptance of an ileostomy

B. Monitoring the client's emotional state

C. Preventing the client from developing a decubitus

D. Correcting the client's fluid imbalance

ANSWER: D

Explanation:

Correcting the client's fluid imbalance is the priority because active ulcerative colitis can cause frequent, high-volume diarrhea with substantial losses of water and electrolytes. Poor oral intake, intestinal bleeding, fever, and prescribed bowel preparation can further worsen dehydration before surgery. Restoring circulating volume and correcting clinically significant electrolyte abnormalities support renal perfusion, tissue oxygenation, cardiovascular stability, and a safer response to anesthesia and the physiologic stress of a total colectomy. Preoperative nursing care should therefore include careful assessment of intake and output, vital signs, daily weight, urine output, and ordered laboratory results, along with administration of prescribed intravenous fluids and electrolyte replacement. The care team should promptly report findings that suggest worsening hypovolemia or electrolyte disturbance so these can be addressed before the procedure. This focus is especially important because an ileostomy may initially produce substantial liquid output after surgery, making a stable baseline fluid and electrolyte status valuable for recovery. Guidance on ulcerative colitis recognizes diarrhea, dehydration, and electrolyte disturbances as clinically important complications, and perioperative fluid optimization is a central element of safe surgical preparation. See the NCBI StatPearls review of ulcerative colitis and the NCBI StatPearls overview of perioperative fluid management.

QUESTION NO: 6

A patient who has terminal cancer has an order for morphine sulfate (MS Contin) tablets every 8 to 12 hrs prn. for moderate pain or morphine sulfate injections of 10 to 12 mg every four hours prn. intramuscularly for severe pain. The patient has been receiving MS Contin po. every 12 hours but is experiencing breakthrough pain after about 10 hours. Which of the following nursing actions is most appropriate?

A. Administer injectable morphine sulfate, 12 mg, IM, prn.

B. Administer the MS Contin, po, every 12 hours

C. Administer the MS Contin, po, every 10 hours

D. Withhold the pain medications and notify the physician

ANSWER: C

Explanation:

Administer the MS Contin, po, every 10 hours is correct because the prescribed oral dosing interval is every 8 to 12 hours as needed for moderate pain. The patient’s pain returning at approximately 10 hours indicates that the current 12-hour interval is not maintaining adequate analgesia for the full interval. Giving the next ordered oral dose at 10 hours is within the authorized interval and addresses the patient’s reported breakthrough pain while following the existing prescription.

For a patient with terminal cancer, timely, individualized opioid administration is essential to maintaining comfort and function. Before administration, the nurse should assess the pain’s intensity, location, quality, previous response to analgesia, sedation level, respiratory status, and other opioid-related adverse effects. The patient should also be reassessed after the dose to determine whether pain relief is achieved and whether the regimen continues to meet the patient’s needs. Sustained-release morphine is used for ongoing pain control, and the prescribed interval may be adjusted within the ordered range according to the patient’s pain pattern. Information on morphine administration and safety is available from MedlinePlus and cancer-pain management principles are described by the World Health Organization.

QUESTION NO: 7

A client who had a myocardial infarction has an order for digoxin (Lanoxin) 0.25 mg po daily and furosemide (Lasix) 40 mg intravenously, stat. Because the client is receiving these medications, the client should be assessed for which of the following manifestations?

A. Oliguria

B. Hypertension

C. Tachycardia

D. Hypokalemia

ANSWER: D

Explanation:

Hypokalemia is the key manifestation to assess for because intravenous furosemide is a loop diuretic that can produce substantial urinary potassium loss, particularly when it causes brisk diuresis. Potassium has an important effect on the heart and on the clinical response to digoxin. When serum potassium is low, digoxin binds more readily to the sodium-potassium ATPase pump in cardiac tissue, increasing the drug's effects and raising the risk of digoxin toxicity and potentially serious dysrhythmias. This is especially important after myocardial infarction, when close observation of cardiac status is already essential.

The nurse should monitor serum potassium and other electrolytes, renal function, fluid balance, heart rate and rhythm, and clinical findings that may suggest digoxin toxicity. Assessment and prompt reporting of low potassium are important so that potassium replacement, adjustment of diuretic therapy, or other treatment can be considered as ordered. The prescribing information for furosemide specifically identifies electrolyte depletion, including hypokalemia, as a concern requiring observation, while digoxin labeling notes that low potassium increases susceptibility to toxicity. See the FDA furosemide prescribing information and the FDA digoxin prescribing information.

QUESTION NO: 8

A nurse enters a client's room and finds the client having a generalized tonic-clonic seizure. The nurse should first

A. Protect the client from injury.

B. Insert an oral airway into the client's mouth.

C. Restrain the client's arms and legs.

D. Offer the client water after the seizure begins.

ANSWER: A

Explanation:

Protect the client from injury is the first priority during an active generalized tonic-clonic seizure. The nurse should remain with the client, ease the client to the floor or bed if possible, remove nearby objects that could cause injury, protect the head with a soft object, and loosen restrictive clothing around the neck. The client should not be restrained, and nothing should be placed in the mouth because these actions can cause injury. After the seizure activity ends, the nurse should position the client on the side to promote drainage of oral secretions, assess airway and breathing, obtain vital signs, and document the duration and characteristics of the seizure. The Centers for Disease Control and Prevention provides seizure first-aid guidance.

QUESTION NO: 9

Which of the following interventions should be added to the nursing care plan for a client who has difficulty swallowing after a stroke?

A. Avoid salty foods

B. Thicken liquids before feeding

C. Elevate head of bed 360 degrees

D. Place food in center of mouth

ANSWER: B

Explanation:

“Thicken liquids before feeding” is an appropriate intervention for a client with post-stroke dysphagia because thin liquids move rapidly through the mouth and pharynx and can be difficult to control when swallowing muscles or reflexes are impaired. Thickened liquids flow more slowly, giving the client additional time to coordinate oral control and airway closure during swallowing. This can reduce the likelihood of material entering the airway and causing aspiration. The prescribed thickness should be individualized following a swallowing assessment, ideally by a speech-language pathologist, because swallowing impairments and the safest food/liquid consistency differ among clients. Nursing care also includes following the ordered texture-modified diet, maintaining an upright position during meals, observing for coughing, wet vocal quality, or respiratory distress, and providing oral care. Dysphagia after stroke is a significant aspiration-pneumonia risk; therefore, safe swallowing strategies and diet modifications should be implemented promptly and reevaluated as the client’s neurologic status changes. Guidance on post-stroke dysphagia screening and management is available from the American Stroke Association and the American Speech-Language-Hearing Association.

QUESTION NO: 10

A new mother asks the postpartum nurse how she will know when she should breastfeed her newborn. The best response by the nurse would be

A. "Mothers should rely on their instincts, which are usually correct."

B. "Babies should be fed when it is most convenient for mother and infant."

C. "The newborn requires feeding when he gets irritable and makes kicking movements."

D. "Early feeding clues are infant hand to mouth movements."

ANSWER: D

Explanation:

“Early feeding clues are infant hand to mouth movements.” is correct because responsive, cue-based feeding is recommended for healthy newborns. Early hunger cues commonly include stirring, increased alertness, rooting, opening the mouth, and bringing the hands to the mouth. These behaviors indicate that the infant is ready to begin feeding, allowing the parent to offer the breast before the infant becomes distressed. Feeding in response to early cues supports establishment of breastfeeding, promotes effective milk transfer, and helps the newborn feed frequently enough to meet nutritional needs. Crying, marked irritability, and vigorous body movements are generally later hunger cues; by that stage, an infant may be more difficult to latch and may first need soothing. In the early postpartum period, nurses should teach parents to observe their individual infant’s cues and offer feeds on demand, rather than relying solely on a fixed schedule. The American Academy of Pediatrics advises feeding newborns whenever they show signs of hunger, which is commonly eight to twelve times in 24 hours for breastfed infants. The Centers for Disease Control and Prevention likewise identifies hand-to-mouth activity and rooting as early signs of hunger. See the CDC breastfeeding guidance and the American Academy of Pediatrics guidance on infant feeding frequency.

QUESTION NO: 11

Which of the following findings, if identified in a patient who is being treated for hypovolemic shock, should indicate to a nurse that the treatment is having the desired effect?

A. Central venous pressure of 4 mm Hg

B. Pulse oximeter reading of 98%

C. Urine output of 50 ml/hr

D. Temperature of 98.6°F (37°C)

ANSWER: C

Explanation:

Urine output of 50 ml/hr indicates that treatment for hypovolemic shock is producing the desired restoration of circulating volume and organ perfusion. In hypovolemic shock, reduced intravascular volume lowers cardiac output and renal blood flow. Because the kidneys are highly sensitive to inadequate perfusion, declining urine output is an important clinical sign of persistent shock. As fluid replacement and any necessary blood-product therapy restore effective circulating volume, renal perfusion improves and the patient should produce an adequate amount of urine.

For adults, a commonly used resuscitation target is urine output of at least 0.5 mL/kg/hr; this is often approximately 30 mL/hr or more for an average-sized adult. A measured output of 50 mL/hr exceeds that general minimum and supports that the kidneys are receiving sufficient blood flow. Urine output should be assessed along with other perfusion indicators, such as mental status, skin perfusion, blood pressure trends, heart rate, and serum lactate, but it is a practical and clinically meaningful endpoint during ongoing shock management. The Merck Manual identifies urine output as a useful marker of end-organ perfusion in shock, and StatPearls includes maintaining urine output at or above 0.5 mL/kg/hr among resuscitation goals. See Merck Manual: Shock and StatPearls: Hypovolemic Shock.

QUESTION NO: 12

A six-month-old infant is suspected of having intussusception. A nurse should expect the child to undergo which of the following procedures?

A. Colonoscopy

B. Rectal biopsy

C. Barium enema

D. Cholangiography

ANSWER: C

Explanation:

Barium enema is correct because a contrast enema has traditionally been used to confirm and, in many clinically stable children, nonsurgically reduce an intussusception. Intussusception occurs when one segment of bowel telescopes into the adjacent bowel, most often near the ileocecal region in infants and young children. Introducing contrast into the rectum under fluoroscopic guidance creates pressure that may gently push the telescoped bowel back into its normal position. The study also helps demonstrate the location and extent of the obstruction.

In current pediatric practice, an air enema is often preferred because it can be highly effective and uses less radiation exposure than a barium contrast study. However, “barium enema” remains the best answer among the listed procedures because it identifies the classic contrast-enema approach used for both diagnosis and nonoperative reduction. The child is monitored closely during and after the procedure, since recurrence can occur and signs of perforation or peritonitis require urgent surgical evaluation rather than enema reduction. The Merck Manual Professional describes contrast or air enema as diagnostic and often therapeutic. The RadiologyInfo.org also explains enema reduction for pediatric intussusception.

QUESTION NO: 13

To which of the following assessment data should the nurse give highest priority for a client admitted to the emergency room in a hepatic coma?

A. Neurological status

B. Airway adequacy

C. Ammonia levels

D. Gastrointestinal bleeding

ANSWER: B

Explanation:

Airway adequacy is the highest-priority assessment because a client in hepatic coma has markedly impaired consciousness and may be unable to maintain a patent airway or protect it from aspirated saliva, gastric contents, blood, or vomitus. Emergency assessment follows the airway, breathing, and circulation approach: airway patency and protection must be established immediately because hypoxemia or aspiration can rapidly become life-threatening. The nurse should assess respiratory effort, airway obstruction, oxygen saturation, gag and cough reflexes, ability to handle secretions, and signs of aspiration. Positioning, suction availability, supplemental oxygen, and prompt preparation for advanced airway support may be needed depending on the client's level of consciousness and clinical status.

Hepatic encephalopathy can progress from cognitive changes to stupor and coma as liver dysfunction and portosystemic shunting impair cerebral function. In severe encephalopathy, airway protection is a central component of supportive care, while further neurologic assessment and evaluation of precipitating factors proceed after immediate stabilization. This priority is consistent with emergency care principles and the risk of reduced airway reflexes in coma. See the Merck Manual discussion of hepatic encephalopathy and the NCBI StatPearls overview of airway management.

QUESTION NO: 14

An elderly client 2 days post-operative for a total hip replacement is noted to be restless and irritable. Respirations are 22/min, pulse 104 beats/min and pulse oximetry 90%. The nurse should suspect which of the following complications?

A. Post-operative hemorrhage

B. Pulmonary embolism

C. Acute infection

D. Drug reaction

ANSWER: B

Explanation:

Pulmonary embolism is the most likely complication because this client has several classic early findings of impaired pulmonary perfusion: new restlessness and irritability, tachypnea (22/min), tachycardia (104 beats/min), and decreased oxygen saturation (90%). Acute hypoxemia can initially present as anxiety, agitation, or an unexplained change in mental status, particularly in an older adult. Total hip replacement also creates substantial venous thromboembolism risk because major orthopedic surgery can injure vessels, activate coagulation, and substantially reduce mobility. A thrombus forming in the deep veins of the leg or pelvis can embolize to the pulmonary circulation, producing ventilation-perfusion mismatch and hypoxemia. The onset on postoperative day 2 is clinically compatible with this potentially life-threatening complication. Prompt nursing action includes assessing the client's respiratory and hemodynamic status, administering oxygen as ordered, maintaining close monitoring, and immediately notifying the surgical or rapid-response team so diagnostic evaluation and treatment can proceed without delay. The American Academy of Orthopaedic Surgeons recognizes hip replacement as a setting in which blood clots can occur, including pulmonary embolism, and the Merck Manual identifies dyspnea, tachypnea, tachycardia, and hypoxemia among common pulmonary embolism findings. See AAOS: Blood Clots and Orthopaedic Surgery and Merck Manual: Pulmonary Embolism.

QUESTION NO: 15

Lithium carbonate (Eskalith), 300 mg, qid, po has been ordered for a client who has bipolar disorder, manic type. After three weeks of therapy, the client's blood lithium level is 2.2 mEq per liter.

Which of these nursing actions would be appropriate?

A. Ask the physician to increase the dosage.

B. Give the medication as ordered.

C. Assess the client for symptoms of toxicity.

D. Obtain an order for sedation.

ANSWER: C

Explanation:

“Assess the client for symptoms of toxicity.” is appropriate because a serum lithium concentration of 2.2 mEq/L is markedly elevated and places the client at significant risk for lithium toxicity. Although target concentrations vary according to the phase of treatment and the timing of the blood draw, maintenance concentrations are commonly about 0.6–1.0 mEq/L, and concentrations above 1.5 mEq/L are generally associated with toxicity. A concentration of 2.2 mEq/L warrants prompt clinical assessment and escalation to the prescribing clinician according to facility policy. The nurse should specifically evaluate neurologic and gastrointestinal manifestations, including worsening tremor, muscle weakness, lack of coordination or ataxia, slurred speech, confusion, drowsiness, nausea, vomiting, and diarrhea. Cardiac status, hydration, renal function, and recent factors that can increase lithium concentrations—such as dehydration, sodium loss, or interacting medicines—also require attention. Early recognition is essential because severe toxicity can progress to seizures, coma, dysrhythmias, and kidney injury. Lithium has a narrow therapeutic index, so serum-level monitoring must always be interpreted alongside the client’s clinical condition. See the NCBI StatPearls review of lithium toxicity and the FDA-approved lithium labeling.

QUESTION NO: 16

A client is taking atenolol (Tenormin) 50 mg daily. The nurse should instruct the client to notify the physician in which of the following situations?

A. Temperature less than 98.6єF (37єC)

B. Pulse rate less than 50 beats/min

C. Blood pressure less than 120/70 mm Hg

D. Respirations greater than 18/min

ANSWER: B

Explanation:

The client should notify the physician if the pulse rate is less than 50 beats/min. Atenolol is a selective $beta_1$-adrenergic blocker that lowers heart rate, slows atrioventricular-node conduction, and reduces cardiac workload. Although a reduced pulse may be an expected pharmacologic effect, marked bradycardia can indicate excessive beta blockade and may reduce cardiac output. Clients should be taught to check their pulse as instructed and to report a substantially slow heart rate, particularly if it is accompanied by dizziness, fainting, unusual fatigue, weakness, shortness of breath, or chest discomfort. The U.S. prescribing information for atenolol identifies bradycardia as an important adverse effect and contraindicates its use in sinus bradycardia. A pulse below 50 beats/min is therefore an appropriate threshold for contacting the prescriber promptly so the client can be assessed and the medication regimen adjusted if necessary. The client should not independently change or stop atenolol unless directed, because abrupt discontinuation can worsen angina or precipitate other cardiac complications. See the DailyMed atenolol prescribing information and StatPearls: Atenolol.

QUESTION NO: 17

A teenager with acne says to the nurse in the physician's office, "Look at my face! No matter how often I clean my face, I still get pimples." The nurse should explain to the teenager that a contributing cause of acne in adolescents is

A. eating a large amount of foods high in fat.

B. eating foods that are high in complex carbohydrates.

C. an increase in secretions of the sebaceous glands.

D. an increase in secretions of the adrenal glands.

ANSWER: C

Explanation:

An increase in secretions of the sebaceous glands is correct. During adolescence, rising androgen activity stimulates sebaceous glands in the skin to enlarge and produce more sebum, an oily substance that normally helps lubricate the skin and hair. When excess sebum combines with shed keratinized skin cells, it can obstruct the hair follicle opening and form a comedone. The plugged follicle can then support proliferation of *Cutibacterium acnes* and trigger local inflammation, leading to papules, pustules, or other acne lesions. This physiologic increase in sebum production explains why acne commonly begins or worsens during puberty and why frequent washing alone does not prevent all pimples. Appropriate cleansing can remove surface oil and cosmetics, but it does not stop hormonally stimulated sebum production within the glands. Nursing teaching should therefore normalize acne as a common pubertal condition, encourage gentle skin care, and support use of clinician-recommended topical therapies when needed. The American Academy of Dermatology describes excess oil production and clogged pores as central features of acne, and the National Institute of Arthritis and Musculoskeletal and Skin Diseases identifies hormonal changes during puberty as an important contributor. See American Academy of Dermatology: What causes acne? and NIAMS: Acne.

QUESTION NO: 18

During the nursing history, a client states, "I have anemia". The nursing care plan should include measures to

A. promote hydration.

B. prevent infection.

C. alleviate fatigue.

D. protect skin integrity.

ANSWER: C

Explanation:

Alleviating fatigue is an appropriate priority for a client who reports anemia because reduced hemoglobin or red blood cell availability decreases the blood's oxygen-carrying capacity. When tissues receive less oxygen, clients commonly experience tiredness, weakness, decreased exercise tolerance, shortness of breath with activity, dizziness, and palpitations. Nursing care should therefore focus on assessing the severity and pattern of fatigue, monitoring tolerance of activity and physiologic responses such as heart rate and dyspnea, and helping the client balance activity with rest. Practical measures include clustering nursing care to avoid unnecessary exertion, assisting with activities of daily living as needed, encouraging the client to sit during self-care tasks, scheduling demanding activities during periods of greatest energy, and gradually increasing activity only as tolerated. Teaching energy-conservation techniques helps the client maintain safety and participation in essential daily activities while the underlying anemia is evaluated and treated. The National Heart, Lung, and Blood Institute identifies fatigue, weakness, and shortness of breath as common manifestations of anemia: NHLBI: Anemia Symptoms. Additional clinical information on anemia and its effects on oxygen delivery is available from Merck Manual: Overview of Anemia.

QUESTION NO: 19

When monitoring a patient who has respiratory acidosis, a nurse would expect which of the following arterial blood gas levels?

A. pH, 7.50; pCO2, 30 mm Hg; pO2, 80 mm Hg

B. pH, 7.30; pCO2, 56 mm Hg; pO2, 68 mm Hg

C. pH, 7.38; pCO2, 42 mm Hg; pO2, 88 mm Hg

D. pH, 7.26; pCO2, 37 mm Hg; pO2, 75 mm Hg

ANSWER: B

Explanation:

The expected arterial blood gas values are **pH, 7.30; pCO2, 56 mm Hg; pO2, 68 mm Hg**. Respiratory acidosis is a primary acid-base disorder caused by inadequate removal of carbon dioxide through ventilation. Carbon dioxide combines with water to form carbonic acid; therefore, retaining carbon dioxide increases acidity and lowers blood pH. The defining ABG pattern is an acidemic pH below 7.35 together with an elevated arterial carbon dioxide pressure above the usual reference range of about 35–45 mm Hg. Here, the pH of 7.30 demonstrates acidemia and the pCO2 of 56 mm Hg demonstrates carbon dioxide retention, which identifies the disorder as respiratory acidosis. The pO2 of 68 mm Hg also indicates mild hypoxemia, which may accompany hypoventilation or impaired gas exchange and is clinically consistent with conditions that can produce respiratory acidosis. Nurses should assess the patient's respiratory effort, airway patency, oxygenation, mental status, and potential causes of hypoventilation while monitoring ABG trends. The Merck Manual overview of acid-base disorders describes respiratory acidosis as reduced ventilation leading to increased arterial carbon dioxide and decreased pH. Normal ABG reference concepts are also summarized by StatPearls: Arterial Blood Gas.

QUESTION NO: 20

Which of the following parameters should be given priority when caring for a patient with hypoadrenalism (Addison's disease)?

A. Evaluating pulmonary function

B. Monitoring blood sugar

C. Measuring blood pressure

D. Assessing neurological status

ANSWER: C

Explanation:

Measuring blood pressure should be prioritized for a patient with hypoadrenalism (Addison's disease) because inadequate adrenal hormone production can impair circulatory volume and vascular tone. Deficient aldosterone promotes renal sodium and water loss, reducing intravascular volume; deficient cortisol also decreases the body's ability to maintain an appropriate vascular response to stress. Consequently, hypotension, including orthostatic hypotension, is a characteristic and clinically important manifestation of adrenal insufficiency.

Frequent blood-pressure assessment helps the nurse identify worsening volume depletion and potential progression to adrenal crisis, a life-threatening emergency that may cause profound hypotension and shock. A declining pressure, dizziness on standing, weakness, or signs of poor perfusion require prompt clinical escalation and treatment directed by the care team, commonly including intravenous isotonic fluids and stress-dose glucocorticoid replacement in suspected crisis. Monitoring this parameter also provides an immediate, objective indication of the patient's hemodynamic response to fluid therapy and corticosteroid/mineralocorticoid replacement. The Merck Manual describes hypotension and dehydration as key findings in primary adrenal insufficiency, while the Endocrine Society guideline emphasizes urgent treatment of severe adrenal insufficiency presenting with hypotension. See the Merck Manual overview of primary adrenal insufficiency and the Endocrine Society clinical practice guideline.

QUESTION NO: 21

A 31/2 -year-old is prescribed digoxin (Lanoxin) po. In view of the child's age, which of these approaches by the nurse would be most effective in getting the child to take his medication?

A. "If you take your medicine, you'll get to go home sooner."

B. "I know that you are a good boy and will take your medicine for me."

C. "Here is your medicine. Do you want to take it with water or juice?"

D. "Are you ready to take your medicine now, or do you want me to come back in ten minutes?"

ANSWER: C

Explanation:

“Here is your medicine. Do you want to take it with water or juice?” is the most effective approach because a 3½-year-old is in the preschool developmental stage and benefits from simple, concrete communication and limited choices. Offering two acceptable choices gives the child an appropriate sense of control and independence while maintaining the essential boundary that the medication must be taken. This technique helps reduce resistance without making medication administration a negotiation about whether it will occur. The nurse should present the choice calmly and matter-of-factly, allow the child a brief opportunity to choose, and then administer the prescribed dose using safe pediatric medication practices. In particular, digoxin requires precise dosing, and the nurse should verify the ordered dose and assess the apical pulse according to facility policy and the prescriber’s parameters before administration. Developmentally appropriate care supports the child’s emerging autonomy while preserving safety and adherence. The American Academy of Pediatrics describes preschool-aged children as developing initiative and increasing independence, making limited, guided choices a useful communication strategy. Medication safety guidance for digoxin is available in the FDA prescribing information. See the American Academy of Pediatrics developmental milestones resource and the FDA Lanoxin prescribing information.

QUESTION NO: 22

A client who has an acute asthmatic attack is being treated with epinephrine hydrochloride (Adrenalin). The client should be observed for side effects of Adrenalin, which include

A. epistaxis.

B. bradycardia.

C. tremors.

D. tearing.

ANSWER: C

Explanation:

Tremors are a common adverse effect of epinephrine hydrochloride (Adrenalin). Epinephrine is a sympathomimetic catecholamine that stimulates alpha- and beta-adrenergic receptors. In acute bronchospasm, beta-2 receptor stimulation relaxes bronchial smooth muscle, producing bronchodilation and helping relieve airway obstruction. However, adrenergic stimulation also activates skeletal-muscle beta receptors and the central nervous system, which can produce fine tremors, nervousness, restlessness, anxiety, headache, and dizziness. These effects may be especially noticeable after parenteral administration or in clients who are sensitive to sympathomimetic medications. Nursing observation should include assessment for tremor as well as monitoring of heart rate, blood pressure, respiratory status, and the client’s subjective symptoms during treatment. The medication’s prescribing information specifically lists tremor among nervous-system adverse reactions and notes that common systemic effects may arise from its adrenergic activity. Recognizing tremors promptly supports safe monitoring while the desired bronchodilator effect is achieved. See the DailyMed epinephrine injection prescribing information and StatPearls: Epinephrine.

QUESTION NO: 23

A nurse should assess a client with an enlarged prostate for which of these symptoms?

A. Suprapubic pain

B. Flank discomfort

C. Polyuria

D. Urinary frequency

ANSWER: D

Explanation:

Urinary frequency is correct because enlargement of the prostate can narrow the urethra and impede normal bladder emptying. As urine flow becomes obstructed, the bladder must work harder and may become irritable, producing lower urinary tract symptoms such as frequent voiding, urgency, nocturia, hesitancy, a weak stream, straining, and a sensation of incomplete emptying. Nursing assessment should clarify the frequency and timing of voiding, including nighttime awakenings; assess fluid intake, medication use, and the degree to which symptoms affect sleep and daily activities; and determine whether the client has difficulty initiating or maintaining urine flow. The nurse should also assess for warning signs of acute urinary retention, such as inability to void with bladder distention and discomfort, because this requires prompt evaluation. Frequency is therefore a common, clinically relevant symptom to identify in a client with prostatic enlargement. The National Institute of Diabetes and Digestive and Kidney Diseases describes frequent urination and nocturia among the characteristic lower urinary tract symptoms associated with prostate enlargement. The American Urological Association similarly identifies urinary frequency as a symptom used in evaluating lower urinary tract symptoms attributable to prostatic enlargement. See NIDDK: Enlarged Prostate and American Urological Association Guideline.

QUESTION NO: 24

A client is taking the atypical antipsychotic medication, olanzapine (Zyprexa). Which of the following client statements indicates that the nurse's teaching about the side effects of the medication has been successful?

A. "I will stand up slowly when getting out of bed."

B. "I will take the medicine on an empty stomach."

C. "I will decrease my fluid intake."

D. "I may have one drink of wine before bed."

ANSWER: A

Explanation:

"I will stand up slowly when getting out of bed." demonstrates successful teaching because olanzapine can cause orthostatic hypotension, particularly during initial dose titration. Orthostatic hypotension is a drop in blood pressure that occurs when changing position, such as moving from lying down to sitting or standing. It may produce dizziness, light-headedness, weakness, blurred vision, or fainting and can increase the risk of falls and injury. Rising slowly gives the cardiovascular system time to adjust to the positional change and is an important practical safety measure for a client taking olanzapine. The client should also be encouraged to sit at the bedside briefly before standing and to seek assistance if dizziness occurs. The U.S. prescribing information specifically warns that olanzapine may induce orthostatic hypotension and advises caution in people at risk for hypotension. This teaching directly addresses a clinically important adverse effect and helps the client prevent harm while taking the medication. See the FDA Zyprexa prescribing information and MedlinePlus olanzapine drug information.

QUESTION NO: 25

A nurse observes a nurse's aide taking all of the following measures when caring for a patient who has had a right modified radical mastectomy. Which measure requires immediate intervention by the nurse?

A. Encouraging the patient to brush her hair with her right hand

B. Applying a blood pressure cuff to the patient's right arm

C. Elevating the patient's right arm on two pillows

D. Giving the patient a rubber ball to squeeze in her right hand

ANSWER: B

Explanation:

Applying a blood pressure cuff to the patient's right arm requires immediate intervention. A modified radical mastectomy generally includes removal of breast tissue and axillary lymph nodes. Disruption of axillary lymphatic drainage can leave the affected arm vulnerable to lymphedema, an abnormal accumulation of lymph fluid that may cause swelling, discomfort, heaviness, reduced mobility, skin changes, and infection risk. Inflating a blood pressure cuff creates circumferential pressure on the arm and is traditionally avoided on the operative side to reduce potentially avoidable trauma or compression of lymphatic structures. The nurse should stop the procedure and obtain the blood pressure from the unaffected arm when possible; if that is not feasible, the care team should determine an appropriate alternative site or method based on the patient's clinical condition and institutional policy. Protecting the arm after axillary-node surgery is a core postoperative teaching and safety priority, alongside monitoring for swelling and promptly reporting concerning symptoms. The American Cancer Society discusses lymphedema risk after lymph-node surgery at American Cancer Society: Lymphedema. Additional guidance on risk reduction is available from the National Cancer Institute.

QUESTION NO: 26

Which of the following findings, if identified in a patient in the immediate postoperative period following coronary artery bypass grafting (CABG), would indicate the need for immediate follow- up by the nurse?

A. Chest tube drainage of 75 ml/hr

B. Urinary output of 100 ml/hr

C. Blood pressure of 124/60 mm Hg

D. Oxygen saturation of 92%

ANSWER: D

Explanation:

Oxygen saturation of 92% warrants immediate nursing follow-up in the immediate period after CABG because it may signal impaired oxygenation at a time when cardiopulmonary complications can deteriorate quickly. Following cardiac surgery, patients are vulnerable to atelectasis, retained secretions, pulmonary edema, hypoventilation from anesthetic or opioid effects, and impaired gas exchange. A saturation of 92% is below the usual target range for most acutely ill adults without chronic hypercapnic respiratory failure, generally 94% to 98%. The nurse should promptly assess respiratory rate and work of breathing, lung sounds, airway patency, mental status, hemodynamic status, oxygen-delivery equipment, and trends in pulse oximetry. Immediate interventions may include positioning, encouraging pulmonary hygiene when appropriate, administering or titrating oxygen according to orders and protocol, and promptly notifying the surgical or critical-care team if the low reading persists or is accompanied by respiratory distress or instability. Early recognition and correction of hypoxemia is especially important after CABG because adequate arterial oxygenation supports myocardial oxygen delivery and recovery. The British Thoracic Society guideline recommends a target saturation of 94%–98% for most acutely ill adults: British Thoracic Society oxygen guideline. Postoperative pulmonary complications and their importance after cardiac surgery are also reviewed by StatPearls: Postoperative Pulmonary Complications.

QUESTION NO: 27

A client is admitted with diabetic ketoacidosis. Which of the following prescriptions should the nurse implement first?

A. Begin an infusion of 0.9% sodium chloride solution.

B. Administer sodium bicarbonate intravenously.

C. Give a long-acting insulin injection.

D. Offer a meal high in carbohydrates.

ANSWER: A

Explanation:

Begin an infusion of 0.9% sodium chloride solution is the priority prescription because clients with diabetic ketoacidosis commonly have severe fluid-volume depletion from osmotic diuresis. Initial isotonic fluid replacement supports circulating volume, tissue perfusion, renal function, and correction of hyperglycemia. Insulin therapy is essential, but it is typically started after initial fluid resuscitation and assessment of serum potassium because insulin shifts potassium into cells and may worsen hypokalemia. The nurse should monitor blood glucose, electrolyte levels, urine output, cardiac rhythm, vital signs, neurologic status, and the client's response to treatment. The American Diabetes Association provides information about diabetic ketoacidosis.

QUESTION NO: 28

The nurse should include which of these measures in a client's care plan to detect possible laryngeal nerve damage following a thyroidectomy?

A. Asking the client to speak

B. Stimulating the client's gag reflex

C. Determining the client's ability to swallow

D. Telling the client to extend the tongue

ANSWER: A

Explanation:

Asking the client to speak is the appropriate measure for detecting possible laryngeal nerve damage after thyroidectomy. The recurrent laryngeal nerves course close to the thyroid gland and are at risk of stretching, contusion, or injury during surgery. These nerves supply most intrinsic muscles of the larynx, which control vocal-cord movement. Damage may impair vocal-cord function and produce hoarseness, a weak or breathy voice, changes in pitch, vocal fatigue, or—in more serious bilateral injury—airway compromise.

Accordingly, the nurse should assess the client's voice soon after surgery and regularly thereafter, asking the client to speak clearly, state their name, or say a short phrase. Any new hoarseness or notable voice change should be documented and promptly reported to the surgical team, particularly when accompanied by stridor, dyspnea, or increased work of breathing. Voice assessment is a direct, practical bedside screen for postoperative laryngeal nerve dysfunction and supports timely escalation for airway evaluation if needed. The American Thyroid Association identifies voice change as an important potential complication of thyroid surgery, and clinical postoperative guidance likewise emphasizes assessment for hoarseness and airway symptoms. See the American Thyroid Association's thyroid surgery information and StatPearls: Thyroidectomy.

QUESTION NO: 29

The physician orders interferon alfa-2b for a client with hepatitis

C. The nurse should assess the client for which of these side effects of the medication?

A. Constipation

B. Bradycardia

C. Insomnia

D. Fatigue

ANSWER: D

Explanation:

Fatigue is a common and clinically important adverse effect of interferon alfa-2b. Interferon therapy frequently produces a systemic, flu-like reaction, particularly early in treatment, that can include fatigue, malaise, fever, chills, myalgias, and headache. Fatigue may be substantial and can affect the client's ability to perform usual activities, maintain nutrition and hydration, work, or safely manage tasks that require alertness. Therefore, the nurse should assess the severity, timing, functional impact, and associated symptoms of fatigue throughout therapy.

Nursing assessment should also include whether the client is obtaining adequate rest, has symptoms that could intensify fatigue such as fever or poor oral intake, and needs support with activity pacing. Teaching may include planning rest periods, balancing activity with energy conservation, and promptly reporting severe or persistent fatigue, especially when accompanied by concerning symptoms. The prescribing information for interferon alfa-2b identifies fatigue among commonly reported adverse reactions, supporting ongoing assessment for this effect in a client receiving the medication for hepatitis. See the FDA prescribing information for INTRON A (interferon alfa-2b) and MedlinePlus drug information for interferon alfa-2b.

QUESTION NO: 30

A nurse in the antepartal clinic discusses health practices during pregnancy with a woman who is six weeks pregnant. Which of these comments by the woman indicates that further discussion is necessary?

A. "I plan to continue my jogging for at least the next 3 to 4 months."

B. "I'm hoping to continue working as a secretary until two weeks before my due date."

C. "My husband and I are going to drive about 500 miles to visit my parents, but we'll stop to exercise periodically."

D. "My husband and I enjoy wine every day with our dinner."

ANSWER: D

Explanation:

"My husband and I enjoy wine every day with our dinner." indicates a need for further discussion because alcohol use is not considered safe at any point in pregnancy. Alcohol crosses the placenta, and fetal exposure can interfere with development of the brain and other organs. Prenatal alcohol exposure is associated with fetal alcohol spectrum disorders, which can cause lifelong problems involving growth, behavior, learning, attention, and physical development. Risk cannot be eliminated by choosing wine instead of other alcoholic drinks, by limiting intake to mealtimes, or by stopping only after pregnancy is more advanced. At six weeks of pregnancy, prompt counseling is especially important: the nurse should clearly recommend complete abstinence from alcohol for the remainder of pregnancy, provide nonjudgmental support, assess for barriers to stopping, and help connect the patient with appropriate treatment resources if needed. The patient can also be reassured that stopping alcohol use now is beneficial, regardless of any prior exposure. The Centers for Disease Control and Prevention states that there is no known safe amount, safe type, or safe time to drink alcohol during pregnancy. See the CDC guidance on alcohol use during pregnancy and ACOG's patient guidance on alcohol and pregnancy.

QUESTION NO: 31

A multiparous woman delivered a 30 weeks' gestation stillborn infant. Which of the following actions would a nurse take initially to foster the mental health of the woman?

A. Encourage the woman to seek genetic counseling

B. Have a picture of the woman's other child brought to the hospital

C. Offer the woman an opportunity to see and hold the infant

D. Make arrangements for a member of the clergy to visit with the woman

ANSWER: C

Explanation:

“Offer the woman an opportunity to see and hold the infant” is the appropriate initial nursing action because it supports individualized grieving and acknowledges the infant as an important member of the family. Following a stillbirth, many parents benefit from being offered—not pressured into—time with their baby. Seeing and holding the infant can help make the loss real, promote attachment and memory-making, and allow parents to begin processing their grief. The nurse should use sensitive, nonjudgmental language, prepare the woman for what she may see if needed, respect her cultural and personal preferences, and allow her to decline or change her mind. Creating a calm, private environment and allowing adequate time are important components of compassionate bereavement care. This approach fosters emotional well-being by giving the woman control and an opportunity for meaningful contact during an acutely distressing event. Professional guidance on stillbirth care emphasizes offering parents opportunities for contact with their baby and for creating memories, while tailoring care to their wishes. See the American College of Obstetricians and Gynecologists guidance on management of stillbirth and the NICE guideline on care after stillbirth.

QUESTION NO: 32

When providing anticipatory guidance to the parents of a six-month-old infant, a nurse would give priority to which of the following issues?

A. Engaging the infant in interactive play

B. Placing potted plants out of the infant's reach

C. Adding multivitamin supplements to the infant's diet

D. Providing the infant with a cool-water-filled teething ring

ANSWER: B

Explanation:

Placing potted plants out of the infant's reach is the priority because around 6 months of age infants increasingly grasp objects, bring them to their mouths, and may begin moving independently by rolling, scooting, or crawling. Anticipatory guidance should prepare parents for hazards that emerge as mobility and oral exploration increase. Soil, fertilizer, plant leaves, berries, and bulbs can be ingested; some common household plants can cause irritation, gastrointestinal symptoms, or more serious toxic effects. Moving plants and related gardening products out of reach reduces an avoidable poisoning risk before the infant can access them. This guidance also supports a broader home-safety approach: caregivers should regularly assess the environment from the infant’s level and secure potential toxins as developmental abilities change. The American Academy of Pediatrics recommends keeping medicines, chemicals, and potentially poisonous household items secured and inaccessible to children, and Poison Control advises checking the toxicity of household plants and preventing children from chewing or ingesting them. See the American Academy of Pediatrics poison-prevention guidance and Poison Control information on household plants.

QUESTION NO: 33

Which of the following manifestations, in a woman who delivered a newborn 36 hours ago, would lead a nurse to suspect the woman may be experiencing postpartum depression?

A. Expressing concern about taking the infant home

B. Delaying her morning shower

C. Exhibiting prolonged periods of fatigue

D. Asking repeated questions about infant care

ANSWER: C

Explanation:

“Exhibiting prolonged periods of fatigue” is the finding that should prompt concern for postpartum depression. Although tiredness is common immediately after birth, fatigue that is prolonged, substantial, or disproportionate to expected postpartum sleep disruption can reflect the low energy and impaired functioning associated with perinatal depression. In clinical assessment, the nurse should explore the severity and duration of the fatigue, its effect on self-care and infant care, sleep quality when the patient has an opportunity to rest, mood, interest or pleasure, appetite, concentration, feelings of guilt or hopelessness, and any thoughts of self-harm or harm to the infant. Early recognition is important because postpartum depression can interfere with recovery, maternal-infant bonding, and safe functioning, and it is treatable with timely support and referral. The American College of Obstetricians and Gynecologists recommends screening for depression and anxiety during the perinatal period using validated tools and ensuring systems for assessment, treatment, and follow-up. See ACOG’s guidance on perinatal mental-health screening and the NICHD overview of postpartum depression symptoms.

QUESTION NO: 34

A client who has had a transurethral prostatectomy is receiving intravenous fluids and has an indwelling urethral (Foley) catheter attached to gravity drainage. One hour earlier, there was drainage from the Foley catheter, but now the nurse notes that there is no drainage. Because of this finding, which of these actions should be taken by the nurse?

A. Increase the flow rate of the client's intravenous fluids.

B. Percuss the client's abdomen for bladder distention.

C. Irrigate the client's catheter.

D. Change the client's catheter.

ANSWER: C

Explanation:

Irrigate the client's catheter. is the appropriate action because a sudden cessation of urinary drainage shortly after a transurethral prostatectomy commonly indicates that the catheter lumen or drainage openings may be obstructed by blood clots or prostatic tissue debris. Bleeding is expected to some degree after this procedure, and retained clots can prevent urine from draining freely. Promptly restoring catheter patency is important to prevent bladder overdistention, discomfort, increased bleeding, and impaired urinary drainage.

The nurse should perform catheter irrigation using sterile technique and the facility’s postoperative protocol or the prescriber’s order. Irrigation is typically done with the prescribed sterile solution, using gentle pressure, while observing for return of urine, clots, and the character of the drainage. The amount instilled and returned should be measured accurately so urine output is interpreted correctly. Ongoing assessment includes monitoring drainage color, amount, and flow after patency is restored, as well as reporting persistent obstruction or inability to irrigate. The CDC specifically recognizes closed continuous irrigation as appropriate when obstruction from bleeding is anticipated after prostatic surgery. See the CDC CAUTI prevention recommendations and the NCBI StatPearls review of transurethral resection of the prostate.

QUESTION NO: 35

Shortly after a transfusion is started, the client complains of lower back pain. Which of these actions should the nurse take first?

A. Notify the physician

B. Reposition the client

C. Discontinue the transfusion

D. Check the client's temperature

ANSWER: C

Explanation:

“Discontinue the transfusion” is the priority first action. New-onset lower back or flank pain shortly after blood administration begins can indicate an acute hemolytic transfusion reaction, a potentially life-threatening event in which transfused red cells are rapidly destroyed. The nurse must immediately stop exposure to the suspected blood product to limit any further infusion of incompatible or harmful blood. The IV line should then be kept open with normal saline using new tubing, while the nurse assesses the client, verifies identification and blood-product information according to policy, notifies the appropriate clinician and blood bank, and prepares to send required specimens and the blood bag/tubing for investigation. Prompt recognition and immediate cessation of the transfusion are essential because acute hemolysis may quickly progress to hypotension, disseminated intravascular coagulation, acute kidney injury, or shock. This response follows standard transfusion-reaction management guidance from the AABB and clinical guidance summarized in the NCBI StatPearls review of transfusion reactions.

QUESTION NO: 36

Which of the following conditions, if reported in a patient's history, should a nurse recognize as a contributing factor to the development of metabolic alkalosis?

A. Chronic obstructive pulmonary disease(COPD)

B. Type 1 diabetes mellitus

C. Cushing's syndrome

D. Raynaud's disease

ANSWER: C

Explanation:

Cushing's syndrome is a contributing factor to metabolic alkalosis because excess cortisol can produce mineralocorticoid-like effects, particularly when cortisol concentrations are markedly elevated. This promotes renal sodium reabsorption while increasing potassium and hydrogen-ion secretion in the distal nephron. Loss of hydrogen ions raises serum bicarbonate relative to acid, producing metabolic alkalosis; concurrent potassium loss commonly results in hypokalemia. In nursing assessment, a history or clinical features suggestive of cortisol excess—such as central weight gain, muscle weakness, hypertension, hyperglycemia, and easy bruising—should therefore prompt attention to electrolyte values and acid-base status. The metabolic alkalosis associated with cortisol excess is often described as a hypokalemic, hypertensive alkalosis because the renal effects resemble those of excessive aldosterone activity. Recognizing this association supports timely evaluation of serum potassium, bicarbonate, blood pressure, and the underlying endocrine disorder. The Merck Manual overview of Cushing syndrome describes the mineralocorticoid effects that may occur with cortisol excess. The Merck Manual discussion of metabolic alkalosis also identifies increased renal hydrogen-ion loss and mineralocorticoid activity as important mechanisms.

QUESTION NO: 37

An infant born at 34 weeks gestation is at risk for respiratory synctial virus (RSV). When teaching the family about health care promotion, what primary recommendation should the nurse make to the parents?

A. "Avoid group settings of other children if at all possible."

B. "Limit visitation of the infant by anyone who has a cold."

C. "Use good handwashing techniques."

D. "Keep the baby out of drafts."

ANSWER: C

Explanation:

“Use good handwashing techniques.” is the primary recommendation because careful hand hygiene is the most effective routine measure families can use to reduce an infant’s exposure to RSV and many other respiratory viruses. RSV spreads

through respiratory droplets and through contact with contaminated hands or surfaces; the virus can then enter the body when a person touches the eyes, nose, or mouth. A preterm infant born at 34 weeks has increased vulnerability to severe lower-respiratory illness because pulmonary and immune-system development are less mature than in a full-term infant. Parents, siblings, and all caregivers should wash hands with soap and water before touching the infant, especially after coughing, sneezing, blowing the nose, using the bathroom, or returning home from public places. If soap and water are unavailable, an alcohol-based hand sanitizer may be used when hands are not visibly soiled. Teaching this practice gives the family an effective, practical prevention behavior they can apply consistently in every setting and with every caregiver. The Centers for Disease Control and Prevention specifically identifies handwashing and cleaning frequently touched surfaces as measures that help prevent RSV transmission. See the CDC RSV overview and CDC handwashing guidance.

QUESTION NO: 38

Which of these assessment findings in a client on long-term corticosteroid therapy would indicate a complication of this regimen?

A. Reduction in height

B. Plantar flexion

C. Hypertension

D. Joint tophi or crystal deposits

ANSWER: A

Explanation:

Reduction in height is a significant finding because prolonged systemic corticosteroid therapy can accelerate bone loss and cause glucocorticoid-induced osteoporosis. Corticosteroids decrease bone formation, impair calcium balance, and can increase bone resorption. Over time, the vertebrae may become fragile and sustain compression fractures, sometimes without an acute traumatic event. Vertebral compression causes loss of vertebral body height and may present clinically as a measurable decrease in the client's height, kyphosis, or persistent back pain.

This complication is especially important to identify early because fracture risk rises with both corticosteroid dose and duration of treatment. Nursing assessment should include periodic height measurement, evaluation for new back pain or changes in posture, review of fall risk, and reinforcement of prescribed bone-protective measures. Clients receiving long-term corticosteroids may require assessment of bone mineral density and interventions such as adequate calcium and vitamin D intake, weight-bearing activity when appropriate, and pharmacologic osteoporosis prevention or treatment based on individual risk. The American College of Rheumatology provides guidance on prevention and treatment of glucocorticoid-induced osteoporosis: ACR Glucocorticoid-Induced Osteoporosis Guideline. Additional clinical information is available from StatPearls: Corticosteroid Adverse Effects.

QUESTION NO: 39

Which of the following arterial blood gas levels would a nurse expect to observe when monitoring a patient who has metabolic alkalosis?

A. pH, 7.50; pCO2, 38 mm Hg; HCO3, 30 mEq

B. pH, 7.30; pCO2, 56 mm Hg; HCO3, 24 mEq

C. pH, 7.38; pCO2, 42 mm Hg; HCO3, 25 mEq

D. pH, 7.26; pCO2, 37 mm Hg; HCO3, 18 mEq

ANSWER: A

Explanation:

Metabolic alkalosis is correctly represented by **pH, 7.50; pCO2, 38 mm Hg; HCO3, 30 mEq**. The defining primary disturbance is an increase in serum bicarbonate (HCO3−), which raises blood pH. A pH of 7.50 is above the usual arterial range of 7.35–7.45, demonstrating alkalemia, and a bicarbonate value of 30 mEq/L is elevated above the typical range of approximately 22–26 mEq/L. Together, these findings identify a primary metabolic cause of the alkalemia. The pCO2 of 38 mm Hg remains within the usual reference range of about 35–45 mm Hg. Although the body commonly compensates for metabolic alkalosis through hypoventilation and CO2 retention, compensation may be absent, incomplete, or not yet evident, particularly in an acute state. Therefore, a normal pCO2 does not change the primary interpretation when the pH is alkaline and bicarbonate is elevated. In clinical practice, metabolic alkalosis may occur with loss of gastric acid from prolonged vomiting or gastric suction, diuretic-related volume and chloride loss, or excess alkali administration. ABG interpretation starts by identifying the pH direction and then determining whether PaCO2 or bicarbonate changes match that direction. See the Merck Manual overview of metabolic alkalosis and StatPearls: Alkalosis.

QUESTION NO: 40

A male client who is on the psychiatric unit asks a female nurse to go out to dinner with him when he gets out of the hospital. Which of these actions by the nurse would be therapeutic?

A. Accept the invitation and comment on the therapeutic purpose of accepting.

B. Refuse the invitation and explain that it is inappropriate to meet clients outside of the hospital.

C. Decline the invitation and make up a reason for refusing.

D. Acknowledge the compliment implied by the invitation and clarify the respective roles of the nurse and the client.

ANSWER: D

Explanation:

Acknowledge the compliment implied by the invitation and clarify the respective roles of the nurse and the client is therapeutic because it responds honestly and respectfully while preserving the professional boundary essential to psychiatric nursing. A client's invitation may reflect a wish for connection, gratitude, transference, testing of limits, or a need to understand the nature of the therapeutic relationship. The nurse can acknowledge the client's positive intent without encouraging a personal or social relationship. She should then clearly state that her role is to provide professional care within the treatment relationship, rather than engage in a relationship outside of it.

Clear, consistent boundaries promote safety, trust, and effective treatment. This approach also models appropriate interpersonal limits without shaming or rejecting the client. In mental health care, exploring the feelings or needs underlying the request can be appropriate when clinically indicated, but the nurse must maintain the therapeutic frame and avoid dual relationships. The American Nurses Association explains that nurses maintain professional boundaries and do not exploit a patient relationship for personal benefit. Guidance on maintaining professional boundaries is available from the American Nurses Association and the National Council of State Boards of Nursing.

QUESTION NO: 41

Which of the following findings would lead a nurse to suspect that the ventriculoperitoneal shunt of a seven-year-old child is obstructed?

A. Frequent complaints of tinnitus

B. Falling asleep daily in school for the past five days

C. Occasional complaints of abdominal pain

D. The presence of fever for the past three days

ANSWER: B

Explanation:

“Falling asleep daily in school for the past five days” is a concerning indication of increasing lethargy and decreased level of consciousness, which can occur when a ventriculoperitoneal shunt becomes obstructed. A shunt normally diverts cerebrospinal fluid from the cerebral ventricles to the peritoneal cavity. When flow is blocked, cerebrospinal fluid can accumulate, causing recurrent hydrocephalus and increased intracranial pressure. In a school-age child, a change from usual alertness or functioning—such as new, persistent daytime sleepiness at school—is clinically significant and should prompt prompt assessment for shunt malfunction.

The nurse should assess for associated manifestations of increased intracranial pressure, including headache, nausea or vomiting, behavior or personality changes, visual disturbances, and declining neurologic status. Comparing the child’s current level of consciousness and school functioning with the established baseline is particularly important, because subtle lethargy may be an early manifestation before more severe neurologic deterioration develops. Suspected shunt obstruction requires urgent communication with the child’s neurosurgical or health care team for further evaluation. The Hydrocephalus Association identifies sleepiness and difficulty waking as potential signs of shunt malfunction: Hydrocephalus Association—Complications of Shunt Systems. Additional clinical information is available from Merck Manual—Hydrocephalus.

QUESTION NO: 42

An elderly widow who has dementia of the Alzheimer type says to the nurse who offers her breakfast, "Oh no, honey. I have to wait until my husband gets here." The nurse should say to the woman,

A. "Your husband died six years ago. Let me put milk on your cereal for you."

B. "I've told you several times that your husband is dead. It's time to eat now."

C. "You're going to have to wait a long time. Your food will get cold."

D. "Why do you think he's alive? Why can't you just eat your breakfast?"

ANSWER: A

Explanation:

"Your husband died six years ago. Let me put milk on your cereal for you." is the best answer because it combines a brief, calm statement of reality with immediate redirection to a simple, concrete activity. In the reality-orientation approach tested by this question, the nurse should not reinforce an inaccurate belief about the husband’s arrival. The response gives factual orientation without arguing, then promptly shifts attention to breakfast and offers practical assistance. This reduces the need for the patient to reason through a complex discussion and supports nutrition and daily functioning. The warm wording, including “Let me put milk on your cereal for you,” helps preserve a supportive nurse-patient interaction while guiding the woman toward the present task. Communication with people who have Alzheimer dementia should be calm, respectful, simple, and focused on one idea or activity at a time. The Alzheimer’s Association recommends using a reassuring tone and simplifying communication during dementia care: Alzheimer’s Association: Communication and Alzheimer’s. Guidance on person-centered dementia communication is also available from the Alzheimer’s Society: Alzheimer’s Society: Communication and dementia.

QUESTION NO: 43

The purpose of ordering treatment with an angiotensin-converting enzyme (ACE) inhibitor for a patient who has heart failure is to

A. diminish the stroke volume of the leftventricle.

B. reduce peripheral vascular resistance.

C. improve cardiac electrical conduction.

D. enhance venous return to the right atrium.

ANSWER: B

Explanation:

ACE inhibitor therapy in heart failure is used to reduce peripheral vascular resistance. By inhibiting conversion of angiotensin I to angiotensin II, these drugs decrease angiotensin II-mediated arteriolar vasoconstriction. This produces systemic vasodilation and lowers systemic vascular resistance, which reduces left ventricular afterload. With less resistance against which to pump, the failing left ventricle can eject blood more effectively, supporting forward cardiac output and reducing cardiac workload.

ACE inhibitors also reduce aldosterone secretion, which can lessen sodium and water retention and thereby help limit congestion over time. In patients with heart failure with reduced ejection fraction, guideline-directed renin-angiotensin system inhibition improves symptoms and clinical outcomes when clinically appropriate. Clinicians monitor blood pressure, kidney function, and serum potassium because the intended hemodynamic and hormonal effects can alter these values. The central therapeutic purpose tested here is the reduction in peripheral vascular resistance and afterload. See the American Heart Association overview of heart-failure medications and the NCBI StatPearls review of ACE inhibitors.

QUESTION NO: 44

If steroid therapy is achieving its desired effect for a child who has nephrosis, which of these outcomes should the nurse expect?

A. Urine specific gravity is increased.

B. Blood glucose levels are increased.

C. Urine proteins are decreased.

D. Serum sodium concentration is decreased.

ANSWER: C

Explanation:

Urine proteins are decreased. In childhood nephrosis, most commonly nephrotic syndrome caused by minimal change disease, increased glomerular permeability permits substantial amounts of protein—especially albumin—to be lost in the urine. This proteinuria is a defining manifestation of the condition and contributes to hypoalbuminemia, edema, and related fluid shifts. Corticosteroids such as prednisone are used to induce remission by reducing the disease process responsible for glomerular protein leakage. Therefore, a falling urine protein level or a negative/trace urine protein result is a direct, clinically meaningful indication that steroid therapy is producing the intended response. Nurses monitor urine protein regularly, often with dipstick testing, along with daily weights, edema, urine output, and laboratory measures of kidney status. Improvement in proteinuria may precede or accompany resolution of edema and normalization of serum albumin. The National Institute of Diabetes and Digestive and Kidney Diseases notes that corticosteroids are the standard initial treatment for childhood nephrotic syndrome, and remission is assessed by resolution of proteinuria. See the NIDDK overview of nephrotic syndrome in children and the National Kidney Foundation nephrotic syndrome resource.

QUESTION NO: 45

A client receiving warfarin asks the nurse which laboratory test will be used to monitor the medication's therapeutic effect. The nurse should respond that the client will need regular monitoring of the

A. activated partial thromboplastin time.

B. international normalized ratio.

C. platelet count.

D. bleeding time.

ANSWER: B

Explanation:

International normalized ratio (INR) is used to monitor the anticoagulant effect of warfarin. Warfarin decreases production of vitamin K-dependent clotting factors and prolongs the prothrombin time; the INR standardizes this measurement. The nurse should monitor for bleeding, teach the client to maintain a consistent dietary intake of vitamin K, and reinforce the need for scheduled INR testing. The MedlinePlus PT/INR test information explains the role of INR monitoring in clients taking warfarin.

QUESTION NO: 46

The nurse is triaging clients in the emergency department. Which of the following clients should be evaluated first?

A. A 65 year old with abdominal pain

B. A 15 year old with a lacerated leg

C. A 2 year old with a 2-day history of diarrhea

D. A 30 year old with shortness of breath

ANSWER: D

Explanation:

A 30 year old with shortness of breath should be evaluated first because breathing difficulty can indicate an immediate threat to oxygenation and ventilation. Emergency triage prioritizes potentially life-threatening problems using the airway, breathing, and circulation framework. Shortness of breath may reflect conditions such as acute asthma, pulmonary embolism, pneumonia with respiratory compromise, heart failure, anaphylaxis, or other cardiopulmonary emergencies. Even when the client's vital signs and full history are not yet known, the symptom requires prompt assessment because respiratory status can deteriorate rapidly.

The nurse should immediately assess airway patency, respiratory rate and effort, oxygen saturation, breath sounds, mental status, skin color, and circulation, while initiating appropriate emergency interventions and escalation as indicated. Rapid identification and treatment of hypoxemia or respiratory failure can prevent cardiac arrest and other severe complications. The Emergency Severity Index identifies patients needing immediate life-saving intervention as the highest-acuity group, and respiratory distress is a key presentation requiring urgent clinical attention. The American Heart Association likewise emphasizes rapid assessment and support of airway and breathing in emergency care. See the Agency for Healthcare Research and Quality Emergency Severity Index resources and the American Heart Association CPR and ECC Guidelines.

QUESTION NO: 47

The nurse is caring for a gravely ill young woman in the intensive care unit who has requested that the "pyramid" brought in by her family be placed under her bed. The best action by the nurse would be to

A. comply with the client's wishes.

B. ask the family to take it home because it will be in the way.

C. put it on the window ledge because of the equipment needed in the room.

D. hang it from an intravenous pole to keep it away from medical equipment.

ANSWER: A

Explanation:

Comply with the client's wishes is the best action because the pyramid may have personal, cultural, or spiritual significance for this gravely ill client. Respect for patient autonomy includes supporting an informed client's preferences and values, including meaningful practices that may provide comfort, hope, and a sense of control during critical illness. Person-centered nursing care requires the nurse to avoid dismissing a request merely because its meaning is unfamiliar to the healthcare team.

Nothing in the scenario indicates that placing the item under the bed would compromise treatment, infection-control precautions, access to emergency equipment, or staff safety. Therefore, the nurse should honor the request while using routine clinical judgment to ensure the item does not obstruct equipment, cleaning, or urgent care. Supporting such a request can strengthen therapeutic trust and address spiritual well-being, an important dimension of holistic nursing care. The American Nurses Association's ethical guidance emphasizes respect for each person's inherent dignity and their values and beliefs. Cultural humility likewise calls for eliciting and accommodating patient preferences whenever feasible. See the American Nurses Association Code of Ethics and this NCBI overview of culturally competent nursing care.

QUESTION NO: 48

During a discharge planning discussion with a postpartum client who has several children, the woman makes all of the following comments. Which comment indicates a need for further discussion?

A. "My 4 year old is looking forward to helping me change the baby's diapers."

B. "I have several little presents to give my 2 year old if he becomes upset while I'm caring for the baby."

C. "My husband is taking several vacation days so that we can share the care of the children."

D. "I'll make sure to spend time with my other children while the baby is sleeping."

ANSWER: B

Explanation:

"I have several little presents to give my 2 year old if he becomes upset while I'm caring for the baby." indicates a need for further discussion because it makes receiving a reward contingent on becoming upset during the parent's attention to the newborn. This pattern can unintentionally reinforce distress behavior and may make adjustment to the new sibling more difficult. The parent should instead anticipate that a toddler may have strong feelings about a new baby and respond with calm reassurance, consistent routines, affection, and age-appropriate opportunities for positive involvement. Small gifts can be used thoughtfully to celebrate the new baby or recognize helpful, cooperative behavior, but they should not become a predictable response to a child's upset behavior. Teaching the parent to provide individual attention and praise desirable behaviors helps the toddler feel secure and valued while learning to adjust to changes in family routines. The American Academy of Pediatrics recommends preparing siblings for the baby's arrival, maintaining routines when possible, and involving older children in simple, safe ways. See the American Academy of Pediatrics guidance on preparing a child for a new baby and its information about sibling rivalry.

QUESTION NO: 49

A postpartum client delivered two hours ago. During rounds the nurse finds that the client has soaked a number of pads and is lying in a pool of blood. The nurse's first action should be to

A. go to the door and call for help.

B. place the client in reverse trendelenburg position.

C. increase the client's intravenous fluid rate.

D. massage the client's fundus.

ANSWER: D

Explanation:

Massage the client's fundus. Heavy bleeding within the first 24 hours after birth is postpartum hemorrhage until proven otherwise. The most common cause is uterine atony, in which the uterus fails to contract adequately after placental separation. A firm, contracted uterus compresses the blood vessels at the placental implantation site and limits blood loss. Immediate fundal massage promotes uterine contraction and is therefore the priority independent nursing action when severe postpartum bleeding is observed. The nurse should assess whether the fundus is boggy while massaging it and continue to monitor the amount of bleeding and the client's hemodynamic status. If the uterus does not become firm or

bleeding continues, escalation and additional measures, such as uterotonic medication, intravenous fluid support, and evaluation for retained tissue or genital-tract trauma, are needed promptly. Initial fundal massage addresses the likely reversible cause at the bedside without delay, while further interventions can be initiated immediately afterward or concurrently with team support. The American College of Obstetricians and Gynecologists identifies uterine massage as an initial treatment measure for postpartum hemorrhage due to uterine atony. See ACOG's Postpartum Hemorrhage guidance and the Merck Manual overview of postpartum hemorrhage.

QUESTION NO: 50

A staff nurse is giving shift report on a client with a diagnosis of psychophysiologic disorder. Which of these statements by the nurse would be consistent with the client's therapy?

A. "Encourage the client to elaborate on his symptoms."

B. "Assure the client that there is no physical basis for his symptoms."

C. "Tell the client that the symptoms reflect his need for attention."

D. "Direct the client's focus away from his symptoms."

ANSWER: D

Explanation:

“Direct the client's focus away from his symptoms.” is consistent with care for a psychophysiologic disorder. In these disorders, psychological stress and emotional conflict can contribute to, intensify, or perpetuate physical symptoms. Nursing care should acknowledge that the client’s symptoms and distress are real while avoiding repeated reinforcement of symptom monitoring, illness-focused discussion, or dependence on the sick role. Redirecting attention helps the client move toward functional activities, coping skills, relaxation, emotional awareness, and constructive ways of managing stress.

This approach supports therapeutic goals such as improving daily functioning and helping the client recognize connections between stressors, emotions, and physical experiences. During shift report, the nurse can communicate strategies that promote participation in self-care, social interaction, and prescribed behavioral or psychotherapy interventions rather than centering every interaction on the symptom. Consistent, supportive redirection also helps the health care team provide a unified plan without dismissing the client’s experience. The Merck Manual describes management of somatic symptom-related conditions as emphasizing a supportive therapeutic relationship and return to normal functioning: Merck Manual Professional Edition. Additional clinical guidance on assessment and treatment is available from StatPearls: Somatic Symptom Disorder.

QUESTION NO: 51

A client is admitted to the emergency department with an acute myocardial Infarction. Tissue plasminogen activator (t-PA) is ordered. Which of the following signs indicates a complication of this therapy?

A. Shortness of breath

B. Increased blood pressure

C. Vomiting

D. Epistaxis

ANSWER: D

Explanation:

Epistaxis is a sign of bleeding and indicates a potential complication of tissue plasminogen activator (t-PA) therapy. Alteplase, a t-PA thrombolytic, converts plasminogen to plasmin, which breaks down fibrin within thrombi. Although this action may restore coronary blood flow in an eligible client with acute myocardial infarction, it also reduces the body’s ability to maintain stable clots elsewhere. Consequently, bleeding is the major adverse effect and requires careful monitoring. New

nosebleeds, bleeding from venipuncture or IV sites, hematuria, gastrointestinal bleeding, bruising, or neurologic changes that could suggest intracranial hemorrhage must be reported and assessed promptly. Nursing care includes obtaining baseline and ongoing bleeding assessments, limiting invasive procedures and unnecessary injections, avoiding medications that increase bleeding risk unless specifically prescribed, and monitoring vital signs and laboratory results as ordered. A visible nosebleed is clinically important because it can be an early indication of systemic fibrinolysis and increased hemorrhagic risk. The U.S. prescribing information for Activase identifies bleeding, including internal bleeding and bleeding at puncture sites, as the principal risk of alteplase treatment. See the Activase prescribing information and StatPearls: Alteplase.

QUESTION NO: 52

A nurse is planning a community education presentation on domestic violence. Which of the following factors should the nurse include?

A. Instructions on harmonious living with a spouse

B. The telephone number of the local safe house

C. Ways to include the extended family

D. Assertiveness training

ANSWER: B

Explanation:

The telephone number of the local safe house is correct because a community presentation on domestic violence should provide concrete, immediately usable information that connects people experiencing abuse with confidential safety resources. Safe houses and domestic-violence shelters can offer emergency housing, crisis counseling, safety planning, advocacy, and assistance accessing legal, health, and social services. A local telephone number is particularly valuable because it makes the education actionable: an individual, friend, family member, or community professional can use it promptly when safety concerns arise. Nurses should present such resources in a trauma-informed, nonjudgmental manner and emphasize that help is available even when a person is not ready to leave an abusive relationship. Resource information should be offered discreetly, recognizing that an abusive partner may monitor communications or personal belongings. Including local shelter contact details also supports referral pathways after screening, disclosure, or recognition of warning signs. The Centers for Disease Control and Prevention identifies intimate partner violence as a major public-health concern requiring prevention and support strategies, while the National Domestic Violence Hotline provides confidential assistance and links to local services. See the CDC intimate partner violence overview and the National Domestic Violence Hotline.

QUESTION NO: 53

An elderly client has inadvertently taken several extra doses of levothyroxine sodium (Synthroid). The nurse should monitor the client for which of the following side effects?

A. Hypotension

B. Tachycardia

C. Hypothermia

D. Oliguria

ANSWER: B

Explanation:

Tachycardia is the expected adverse effect to monitor after several extra doses of levothyroxine sodium. Levothyroxine is synthetic thyroid hormone (T4), and excessive intake can produce manifestations of thyroid hormone excess, similar to hyperthyroidism. Increased thyroid hormone activity raises metabolic rate and heightens responsiveness to catecholamines, particularly in the cardiovascular system. Consequently, the client may develop a rapid pulse, palpitations, dysrhythmias, chest pain, nervousness, tremor, sweating, heat intolerance, and insomnia. In an elderly client, this is especially significant

because increased heart rate and myocardial oxygen demand can precipitate angina, atrial fibrillation, or heart failure in those with underlying cardiovascular disease. Nursing assessment should include frequent measurement of pulse, blood pressure, cardiac rhythm when indicated, temperature, and symptoms such as palpitations or chest discomfort. The medication prescriber or poison-control resource should be contacted promptly for individualized management after an overdose. The U.S. prescribing information for Synthroid identifies tachycardia and other cardiac manifestations as effects of levothyroxine overdosage. See the FDA Synthroid prescribing information and MedlinePlus information on levothyroxine.

QUESTION NO: 54

A nurse is caring for a client following thyroidectomy. Which of the following findings requires immediate nursing intervention?

A. Stridor

B. Hoarseness when speaking

C. Incisional discomfort when swallowing

D. Small amount of drainage on the dressing

ANSWER: A

Explanation:

Stridor requires immediate nursing intervention because it can indicate airway obstruction from postoperative swelling, bleeding, laryngeal edema, or injury affecting vocal cord function. Airway compromise after thyroid surgery can progress rapidly and is a life-threatening emergency. The nurse should stay with the client, assess oxygenation and respiratory effort, summon immediate assistance, and prepare emergency airway equipment as directed by facility protocol. Other important postoperative assessments include monitoring the neck dressing for bleeding, observing for a sensation of neck tightness, checking the position of the trachea, and assessing for hypocalcemia caused by parathyroid injury or removal. The National Institute of Diabetes and Digestive and Kidney Diseases provides information about thyroid conditions and treatment.

QUESTION NO: 55

Which assessment finding, if identified in a 70 year old client who has a fractured left femur, would require immediate follow-up by the nurse?

A. Urinary output of 50 cc/hr

B. Change in mental status

C. Pain in the left femur

D. Redness at the incision site

ANSWER: B

Explanation:

“Change in mental status” requires immediate follow-up because acute confusion, agitation, drowsiness, or a decreased level of consciousness after a femur fracture can be an early manifestation of fat embolism syndrome or inadequate cerebral oxygenation. Long-bone fractures, especially fractures of the femur, can release marrow fat into the circulation. This may cause pulmonary vascular obstruction and an inflammatory response that impairs gas exchange. Neurologic changes may appear early and can precede or accompany respiratory deterioration, including hypoxemia, tachypnea, and dyspnea. In an older adult, a sudden mental-status change is particularly urgent because reduced physiologic reserve can make hypoxia and other complications progress rapidly. The nurse should promptly assess airway, breathing, circulation, oxygen saturation, respiratory status, and vital signs; provide oxygen as indicated; notify the appropriate clinician or rapid-response team; and prepare for further diagnostic evaluation and supportive care. Early recognition is essential because management of fat embolism syndrome is primarily supportive and focuses on maintaining adequate oxygenation and hemodynamic stability. The Merck Manual’s overview of fat embolism syndrome identifies neurologic abnormalities and respiratory

compromise as important clinical findings after long-bone fractures. Additional clinical details are available from StatPearls: Fat Embolism.

QUESTION NO: 56

A client on the psychiatric unit who has a diagnosis of schizophrenia spends his days sitting alone staring into space. Which of these changes in the client's behavior would indicate his readiness for a rehabilitation program?

A. He seldom hallucinates.

B. He goes to the coffee shop alone more often.

C. He approaches the nurse at frequent intervals.

D. He is able to sleep through the night.

ANSWER: C

Explanation:

“He approaches the nurse at frequent intervals.” is the best indication of readiness for rehabilitation because it represents a meaningful shift from profound social withdrawal toward initiating interpersonal contact. Psychiatric rehabilitation is recovery-oriented and helps people with serious mental illness develop the skills, supports, and confidence needed to function in their communities. A client who begins approaching a nurse is demonstrating emerging interest in connecting with another person, communicating needs, and participating in a therapeutic relationship. These are practical foundations for engaging in structured rehabilitation activities, such as social-skills training, group participation, self-care goals, and community living interventions.

For a person who has spent days isolated and disengaged, even repeated brief contact can signal increased responsiveness to the environment and willingness to relate to others. The nurse can use these encounters to build trust, assess the client’s goals and abilities, and gradually introduce rehabilitation opportunities at an appropriate pace. This aligns with the emphasis on person-centered recovery and functional participation in psychiatric rehabilitation. See the Substance Abuse and Mental Health Services Administration’s recovery resources and the NCBI overview of psychosocial interventions for schizophrenia.

QUESTION NO: 57

A client is suspected of having renal failure. Which of these laboratory values should the nurse anticipate?

A. Blood urea nitrogen (BUN) 10mg/dl

B. Serum creatinine 3.1mg/dl

C. Serum albumin 3.5 g/dl

D. Hemoglobin 15g/dl

ANSWER: B

Explanation:

Serum creatinine 3.1mg/dl is the anticipated finding because creatinine is a waste product produced from normal muscle metabolism and is primarily eliminated by glomerular filtration in the kidneys. When kidney function declines substantially, the glomerular filtration rate falls and creatinine clearance decreases. Creatinine consequently accumulates in the bloodstream, producing an elevated serum creatinine level. In most adults, a typical serum creatinine reference range is approximately 0.6 to 1.3 mg/dL, although the expected range varies with laboratory method, muscle mass, age, and sex. A value of 3.1 mg/dL is markedly elevated and is consistent with impaired renal filtration in suspected renal failure. Creatinine is clinically useful because serial changes can help clinicians recognize worsening or improving kidney function, and it is incorporated into estimated glomerular filtration rate calculations used to assess chronic kidney disease severity. The nurse should recognize an elevated creatinine as a significant indicator of reduced kidney excretory function and anticipate further

assessment of urine output, electrolyte balance, acid-base status, medications, and trends in renal laboratory results. The National Institute of Diabetes and Digestive and Kidney Diseases describes serum creatinine and eGFR testing for evaluation of kidney disease: NIDDK Creatinine Test. Additional kidney-function testing information is available from MedlinePlus.

QUESTION NO: 58

A client has been prescribed furosemide (Lasix) daily. A nursing priority for client education is

A. informing the client that he may experience some dizziness while on the medication.

B. telling the client to stop the medication immediately if he feels joint discomfort.

C. instructing the client on the importance of taking the medication every day, even if he does not feel well.

D. teaching the client to take the medication at bedtime.

ANSWER: A

Explanation:

Informing the client that he may experience some dizziness while on the medication is the priority teaching point because furosemide is a loop diuretic that increases urinary excretion of water and electrolytes. Its diuretic and blood-pressure-lowering effects can reduce circulating fluid volume and contribute to hypotension, particularly orthostatic hypotension. Dizziness may occur when the client stands suddenly, increasing the risk of falls and injury. Education should therefore include recognizing dizziness or light-headedness, changing positions slowly from lying or sitting to standing, maintaining safety when ambulating, and contacting the prescribing clinician if symptoms are persistent, severe, or accompanied by fainting. This teaching helps the client use the medication safely while supporting adherence to the prescribed regimen. Furosemide labeling identifies dizziness and hypotension among clinically important effects, and patient guidance from MedlinePlus also advises individuals taking furosemide to rise slowly to reduce light-headedness. See the MedlinePlus furosemide drug information and the furosemide prescribing information.

QUESTION NO: 59

A 70 year old client, diagnosed with type 2 diabetes, has been taking Glucophage (metformin) 500 mg tid. Which of the following laboratory results should the nurse report?

A. Blood urea nitrogen of 15 mg/dl

B. Serum albumin level of 3.5 g/dl

C. Blood glucose level of 40 mg/dl

D. Serum creatinine level of 0.6 mg/dl

ANSWER: C

Explanation:

Blood glucose level of 40 mg/dl should be reported immediately because it represents clinically significant hypoglycemia. A value this low can deprive the brain of its primary energy source and may quickly progress from adrenergic symptoms, such as sweating, tremor, palpitations, and hunger, to confusion, behavior changes, seizures, loss of consciousness, or coma. Older adults can have less noticeable warning symptoms and are at particular risk for serious consequences, including falls and injury. The nurse should promptly assess the client for symptoms and level of consciousness, confirm the result according to facility protocol when appropriate, and initiate treatment for hypoglycemia without delaying emergency care. For an alert client who can swallow safely, this generally includes rapidly absorbed carbohydrate followed by repeat glucose monitoring; a client who cannot safely take oral treatment requires urgent escalation and protocol-directed rescue therapy. Although metformin alone has a low intrinsic risk of causing hypoglycemia, a glucose value of 40 mg/dl is urgent regardless of the cause and warrants immediate clinical reporting and intervention. The American Diabetes Association identifies

clinically important hypoglycemia at glucose concentrations below 54 mg/dL. See the American Diabetes Association guidance on hypoglycemia and StatPearls: Hypoglycemia.

QUESTION NO: 60

Which of the following comments by a nurse would be most effective in dealing with a patient who has a diagnosis of severe (+3) anxiety?

A. "Call me when you are calm enough to sit down."

B. "Sit in this chair."

C. "Where would you like to sit?"

D. "How would you feel about sitting down?"

ANSWER: B

Explanation:

“Sit in this chair.” is most effective because severe anxiety substantially narrows a patient’s perceptual field and reduces the ability to concentrate, process information, make choices, or participate in extended discussion. At this level, the nurse should communicate in a calm, firm, and simple manner, using short, concrete statements that direct the patient toward an immediate, safe action. A clear direction to sit provides structure and decreases the cognitive demands placed on the patient at a time when decision-making may feel overwhelming. It also helps the nurse establish a quieter, more controlled setting in which the patient can be observed, supported, and gradually assisted with anxiety-reduction measures. Therapeutic communication must be matched to the patient’s current capacity; concise guidance is appropriate until anxiety is reduced enough for the patient to process more information and engage in choices. This approach is consistent with nursing guidance that recommends calm communication, brief instructions, and a low-stimulation environment during acute anxiety or escalating distress. See StatPearls: Anxiety and SAMHSA: Anxiety Disorders.

QUESTION NO: 61

Diphenoxylate hydrochloride with atropine sulfate (Lomotil) is prescribed for a client. The nurse would evaluate the therapeutic effectiveness of Lomotil by assessing the client's

A. weight.

B. number of daily bowel movements.

C. amount of daily food intake.

D. skin turgor.

ANSWER: B

Explanation:

“number of daily bowel movements.” is correct because diphenoxylate hydrochloride with atropine sulfate is an antidiarrheal medication. Diphenoxylate is an opioid derivative that acts primarily in the gastrointestinal tract to decrease intestinal motility and slow the passage of stool through the bowel. This allows more water to be absorbed, reducing the frequency and fluidity of stools. Atropine is included in a small amount mainly to discourage intentional overuse of diphenoxylate because it can produce unpleasant anticholinergic effects at higher doses.

For a client being treated for acute or chronic diarrhea, the most direct therapeutic outcome is a reduction in stool frequency, with progression toward formed stools and relief of diarrhea-related urgency or cramping. Therefore, documenting the number of bowel movements each day provides a measurable, clinically relevant indicator of whether the medication is achieving its intended effect. Nursing assessment should also include the stool’s consistency and monitoring for excessive slowing of bowel function, but daily bowel-movement frequency is the key outcome specified by this question. The FDA prescribing information describes Lomotil as adjunctive therapy for management of diarrhea, and MedlinePlus likewise

identifies its role in controlling diarrhea. See the FDA Lomotil prescribing information and MedlinePlus drug information for diphenoxylate.

QUESTION NO: 62

A nurse is planning a community education presentation about testicular cancer. The target group should be men aged

A. 20 to 39 years.

B. 40 to 49 years.

C. 50 to 64 years.

D. 65 years and older.

ANSWER: A

Explanation:

Testicular cancer education should target men aged 20 to 39 years because this malignancy occurs most often in adolescents and young adult men. Although testicular cancer can develop at other ages, its incidence is highest in the younger adult population, with many cases occurring from the late teens through the thirties. Focusing community teaching on men aged 20 to 39 years directs prevention and early-detection information toward the group most likely to benefit from recognizing a painless testicular lump, swelling, heaviness, or a persistent change in testicular size or consistency.

Teaching should emphasize prompt evaluation of any concerning testicular change by a health care professional. Early diagnosis is important because testicular cancer is highly treatable, including when treatment involves surgery, chemotherapy, radiation therapy, or surveillance based on tumor type and stage. Education for this age group can also reduce delays caused by embarrassment, limited awareness, or the mistaken belief that symptoms are not serious. The American Cancer Society identifies testicular cancer as most common in younger and middle-aged men, and the National Cancer Institute notes that the median age at diagnosis is about 33 years. See the American Cancer Society's testicular cancer statistics and the National Cancer Institute SEER testicular cancer facts.

QUESTION NO: 63

A client arrives in the emergency department complaining of severe headache. On examination the nurse notes a skull depression surrounded by dried blood over the temporal area. The nurse should recognize this finding as

A. blunt force trauma.

B. penetration trauma.

C. primary trauma.

D. acceleration trauma.

ANSWER: A

Explanation:

"blunt force trauma." is correct because a visible, palpable depression of the skull is consistent with a depressed skull fracture, which commonly results when a blunt object strikes the head with concentrated force. The overlying dried blood supports an associated scalp laceration at the impact site. This is a clinically important finding requiring urgent trauma assessment, including neurologic monitoring and prompt imaging—typically noncontrast head CT—to identify fracture characteristics and associated intracranial injury.

The temporal location increases concern because the temporal bone overlies the course of the middle meningeal artery. Head trauma in this region may be associated with an epidural hematoma, and a client can deteriorate rapidly even if initially awake or responsive. Severe headache following a suspected depressed skull fracture warrants immediate escalation, frequent assessment of level of consciousness and pupils, and preparation for emergency medical or neurosurgical management according to facility protocols. The Merck Manual describes depressed skull fractures as injuries in which skull

fragments are displaced inward after impact, and the American College of Radiology identifies CT as the key initial imaging study in acute head trauma. See Merck Manual: Traumatic Brain Injury and American College of Radiology: Head Trauma.

QUESTION NO: 64

All of the following nursing interventions are included in the care plan for a three-month-old infant who has just undergone cleft lip repair. Which of the following interventions would a nurse question?

A. Apply elbow restraints when the infant is unattended

B. Offer a pacifier when the infant is fussing

C. Avoid placing the infant in the prone position

D. Clean the suture line after feeding the infant

ANSWER: B

Explanation:

“Offer a pacifier when the infant is fussing” is the intervention the nurse should question immediately after cleft lip repair. Protecting the newly repaired lip and suture line is the priority during the postoperative healing period. A pacifier requires repetitive sucking and places pressure, friction, and movement directly on the operative area. This mechanical stress can disrupt the approximation of the repaired tissues, increase pain or bleeding, and compromise wound healing. Postoperative feeding and comfort measures should therefore avoid suction or objects that contact and strain the lip repair. Depending on the surgeon’s protocol, the infant may be fed using methods designed to minimize trauma to the incision, such as careful use of a cup, syringe, or other approved technique, while nonnutritive sucking is withheld. Comfort should instead be provided through measures such as holding, swaddling, gentle rocking, or other age-appropriate soothing strategies that do not endanger the surgical site. The American Cleft Palate-Craniofacial Association provides family and care guidance regarding cleft lip and palate treatment at ACPA. Additional postoperative cleft-care education is available from Children’s Hospital of Philadelphia.

QUESTION NO: 65

Which of the following statements made by a client during a teaching session about osteoporosis management indicates the need for further instruction?

A. "I drink about 6 cups of tea a day, so I need to reduce my caffeine intake."

B. "I need to eat more seafood and dried beans."

C. "I will have to limit the amount of walking that I do."

D. I will talk to my doctor about the pros and cons of hormone replacement therapy.

ANSWER: C

Explanation:

“I will have to limit the amount of walking that I do.” indicates a need for further instruction because walking is a weight-bearing exercise that is generally encouraged for people with osteoporosis. During weight-bearing activity, the body works against gravity, helping maintain bone strength and supporting overall mobility, balance, muscle function, and independence. Appropriate regular physical activity is an important nonpharmacologic component of osteoporosis management and fracture prevention.

Teaching should emphasize that the client should not routinely avoid walking simply because osteoporosis is present. Instead, the activity plan should be individualized according to the client’s fracture risk, prior fractures, pain, mobility, and clinician guidance. Safe walking practices may include supportive footwear, a clear walking area, use of prescribed assistive devices, and fall-prevention strategies. Clients with severe osteoporosis or vertebral fractures may need specific instruction about avoiding movements that excessively flex or twist the spine, but this does not mean eliminating safe weight-bearing

exercise. The National Institute of Arthritis and Musculoskeletal and Skin Diseases identifies weight-bearing exercise, including walking, as beneficial for bone health. See NIAMS: Osteoporosis and Bone Health & Osteoporosis Foundation: Exercise and Safe Movement.

QUESTION NO: 66

A client exhibits coughing, sneezing, dyspnea and wheezing. The nurse administers oxygen therapy to the client. Which of the following outcome measures would the nurse expect to see as a result of the oxygen therapy?

A. Improved respiratory rate and rhythm

B. Delayed capillary refill

C. Absence of pain

D. Improved cardiac function

ANSWER: A

Explanation:

Improved respiratory rate and rhythm is the expected outcome because supplemental oxygen increases the amount of oxygen available for gas exchange in the lungs and improves arterial oxygenation in a client experiencing respiratory distress. When hypoxemia is relieved, the compensatory work of breathing commonly decreases. The client may therefore breathe at a more effective rate, demonstrate a more regular respiratory pattern, and report less shortness of breath. Improvement in respiratory status should be assessed alongside objective measures such as pulse-oximetry readings, skin and mucous-membrane color, mental status, lung sounds, and the visible use of accessory muscles. Oxygen is a medication and must be titrated and monitored according to the prescribed target saturation range and the client's clinical condition. In clients at risk for carbon dioxide retention, oxygen should be administered carefully and reassessed frequently rather than given without monitoring. The American Lung Association describes oxygen therapy as treatment used to raise low blood oxygen levels, and MedlinePlus emphasizes that oxygen delivery and response require clinical monitoring. See the American Lung Association's oxygen therapy guidance and MedlinePlus home oxygen therapy instructions.

QUESTION NO: 67

Which of the following observations should be most significant to a nurse when assessing the condition of a six-week-old infant who is suspected of having pyloric stenosis?

A. Loose stools

B. Hiccoughs

C. Projectile vomiting

D. Distended abdomen

ANSWER: C

Explanation:

Projectile vomiting is the most significant observation because hypertrophic pyloric stenosis typically develops in early infancy, often between 2 and 8 weeks of age, when thickening of the pyloric muscle progressively obstructs gastric emptying. The classic presentation is forceful, progressively worsening, non-bilious projectile emesis after feeding. Because the obstruction is proximal to the duodenum, bile generally does not appear in the vomitus. Despite vomiting, an affected infant may initially remain eager to feed, sometimes described clinically as a "hungry vomiter." Repeated emesis can rapidly produce dehydration, poor weight gain or weight loss, reduced urine output, and hypochloremic, hypokalemic metabolic alkalosis. Nursing assessment should therefore promptly characterize the timing, force, amount, and bile content of emesis and assess hydration status, intake and output, daily weight, and electrolyte-related concerns. Recognition of projectile vomiting supports urgent medical evaluation, commonly including abdominal ultrasonography, followed by fluid and

electrolyte stabilization and definitive treatment. See the Merck Manual Professional Edition and StatPearls: Pyloric Stenosis for clinical features and management.

QUESTION NO: 68

During the fourth stage of labor, the nurse notes that the client's uterine fundus is boggy and in the midline. Which of these actions should the nurse take first?

A. Massage the client's uterine fundus.

B. Apply downward pressure to the client'suterine fundus while she is voiding.

C. Discuss with the physician the client's needfor an oxytocic medication.

D. Check the characteristics of the client'slochia.

ANSWER: A

Explanation:

“Massage the client's uterine fundus.” is the priority first action. In the immediate postpartum period, a boggy uterus indicates inadequate uterine muscle tone (uterine atony). Normally, contraction of the uterine muscle fibers compresses the blood vessels at the placental implantation site, which limits postpartum blood loss. When the uterus is soft or boggy, those vessels may remain insufficiently compressed and the client can rapidly develop postpartum hemorrhage. A fundus that is midline makes bladder distention less likely as the immediate cause of the altered tone; however, the urgent finding remains the boggy consistency. Firm, controlled fundal massage stimulates uterine contraction and allows the nurse to reassess whether the uterus becomes firm and whether bleeding decreases. This is an immediate independent nursing intervention that directly addresses the potentially life-threatening problem. The nurse should continue to assess bleeding, vital signs, and response to massage, and promptly escalate treatment if uterine tone does not improve or bleeding is excessive. Guidance on postpartum hemorrhage emphasizes prompt assessment of uterine tone and uterine massage as an initial measure when atony is suspected. See the American College of Obstetricians and Gynecologists overview of postpartum hemorrhage and the World Health Organization recommendations for prevention and treatment of postpartum haemorrhage.

QUESTION NO: 69

Shortly after a transfusion is started the patient complains of lower back pain. Which of the following actions should the nurse take first?

A. Notify the physician

B. Check the patient's apical pulse

C. Discontinue the transfusion

D. Monitor the patient's temperature

ANSWER: C

Explanation:

“Discontinue the transfusion” is the priority first action because new lower back or flank pain occurring shortly after blood administration begins can indicate an acute hemolytic transfusion reaction. This potentially life-threatening event may occur when incompatible red blood cells are infused, causing intravascular hemolysis and rapid release of hemoglobin. Immediate cessation prevents additional potentially incompatible blood from entering the patient’s circulation and limits further harm.

After stopping the transfusion, the nurse should maintain intravenous access with normal saline using new tubing, assess the patient and vital signs, verify patient and blood-product identification according to facility policy, promptly notify the provider and blood bank, and preserve the blood bag and tubing for investigation. These follow-up measures support timely treatment and allow the transfusion service to evaluate the suspected reaction. Lower back pain must be treated as a possible serious transfusion reaction even if other manifestations, such as fever, chills, hypotension, hemoglobinuria, or

dyspnea, have not yet appeared. Guidance on immediate management of suspected reactions emphasizes stopping the transfusion as the initial intervention. See Australian Red Cross Lifeblood: Management of suspected transfusion reactions and CDC: Blood Safety.

QUESTION NO: 70

The mother of a 2-month-old says to the nurse in the pediatrician's office, "I plan to start feeding cereal to my baby because she doesn't seem satisfied with her formula. She still wakes up a couple of times a night to be fed." Which of these responses should the nurse make?

A. "How much formula is your baby taking now?"

B. "That sounds like a good idea. Probably you could add some rice cereal to your baby'sbedtime formula."

C. "Have you thought about giving your baby some strained fruit for her first food?"

D. "Do you think your baby doesn't like the taste of the cereal?"

ANSWER: A

Explanation:

"How much formula is your baby taking now?" is the appropriate initial nursing response because it gathers essential assessment data before making feeding recommendations. At 2 months, frequent night waking and feeding can be developmentally normal, and the nurse needs to establish whether the infant's current formula intake, feeding frequency, preparation of formula, growth pattern, and diaper output suggest that nutritional needs are being met. This open-ended, nonjudgmental question also acknowledges the mother's concern and invites a discussion about feeding practices without prematurely endorsing a change in diet.

Breast milk or iron-fortified infant formula is the recommended primary source of nutrition during early infancy. Complementary foods are generally introduced at about 6 months, when the infant shows developmental readiness, rather than solely in response to night waking. An individualized assessment allows the pediatric team to provide safe guidance, confirm adequate intake and growth, and support the parent with realistic expectations about infant sleep and feeding. The American Academy of Pediatrics discusses readiness for complementary foods at HealthyChildren.org, and the CDC provides infant-feeding guidance at CDC: When to Introduce Solid Foods.

QUESTION NO: 71

The best position for the client who is admitted with risk of increased intracranial pressure from a concussion would be

A. Trendelenburg.

B. Semi-fowler's.

C. Sim's lateral.

D. Supine.

ANSWER: B

Explanation:

Semi-fowler's is the best position because elevating the head of the bed, typically to about 30 degrees, promotes cerebral venous drainage and can help limit elevations in intracranial pressure. The client's head and neck should be kept in a neutral, midline alignment to avoid obstructing jugular venous outflow. This positioning supports drainage of venous blood from the brain while preserving cerebral perfusion, an important balance for a client at risk for increased intracranial pressure after a concussion.

Positioning is part of routine neuroprotective care and should be combined with frequent neurologic assessment, monitoring for changes in level of consciousness, pupillary response, headache, vomiting, and other signs of worsening intracranial pressure. The exact head-of-bed elevation may be individualized if hypotension or spinal precautions are present, but semi-

Fowler positioning is the standard best response when no contraindication is stated. The Brain Trauma Foundation describes head elevation as a commonly used measure in intracranial-pressure management, and nursing guidance emphasizes maintaining neutral head positioning to facilitate venous return. See the Brain Trauma Foundation Guidelines for Severe Traumatic Brain Injury and NCBI StatPearls: Increased Intracranial Pressure.

QUESTION NO: 72

Which of the following blood values on the laboratory report should a nurse expect when assessing a patient who has emphysema?

A. pCO2, 52 mm Hg

B. pH, 7.48

C. pO2, 94 mm Hg

D. HCO3, 21 mEq/L

ANSWER: A

Explanation:

pCO2, 52 mm Hg is the expected finding in emphysema because this value is above the usual arterial carbon dioxide range of approximately 35–45 mm Hg and reflects carbon dioxide retention. Emphysema destroys alveolar walls and reduces elastic recoil, which impairs effective ventilation and gas exchange. As alveolar ventilation becomes less effective, carbon dioxide is not eliminated adequately, producing hypercapnia. This is particularly common in advanced or chronic COPD, of which emphysema is a major form.

In long-standing disease, the kidneys may compensate for chronically elevated carbon dioxide by retaining bicarbonate, helping bring blood pH closer to normal. The nurse should therefore recognize an elevated pCO2 as a clinically consistent arterial blood gas finding and assess the patient's respiratory effort, mental status, oxygenation, and trend in blood gas results. A sudden or marked rise in pCO2 can indicate worsening ventilatory failure and requires prompt clinical evaluation. The Merck Manual's COPD overview describes progressive airflow limitation and impaired gas exchange, while the NCBI StatPearls review of emphysema discusses hypercapnia in advanced disease.

QUESTION NO: 73

A pregnant client tells the nurse that she is afraid her baby will have a spinal cord defect because her friend's baby did. Which of the following response by the nurse would be most appropriate?

A. "I'm sure that the doctor would have told you if anything were wrong with your baby."

B. "There is a test to see if you are at high risk."

C. "You are not at risk until late in your pregnancy."

D. "Perhaps you should consider amniocenteses."

ANSWER: B

Explanation:

"There is a test to see if you are at high risk." is the most appropriate response because it acknowledges the client's concern and gives accurate, relevant information without offering false reassurance. Open neural tube defects, including spina bifida, can be assessed during pregnancy through screening. Maternal serum alpha-fetoprotein screening, usually performed in the second trimester, can identify pregnancies with an increased likelihood of an open neural tube defect. Ultrasound is also an important assessment method and is commonly used to evaluate fetal anatomy and detect many neural tube defects. A screening result identifies increased risk rather than making a diagnosis; if findings indicate elevated risk, the client can receive counseling and be offered diagnostic evaluation as clinically appropriate. This response supports informed decision-making, invites further discussion of prenatal screening, and addresses the client's fear in a therapeutic, factual manner. The

nurse should explain that the timing and selection of prenatal tests depend on gestational age, medical history, and the prenatal provider's recommendations. See the American College of Obstetricians and Gynecologists' information on prenatal genetic screening tests and the CDC's overview of neural tube defects.

QUESTION NO: 74

A woman is seen in the physician's office because of nutritional anemia. During a nursing history, the client makes all of the following comments. Which comment would be indicative of nutritional anemia?

A. "I get a headache about twice a week."

B. "I have trouble sleeping at night."

C. "I get pain in my lower back."

D. "I always feel tired and weak."

ANSWER: D

Explanation:

"I always feel tired and weak." is indicative of nutritional anemia. Nutritional anemias, particularly iron-deficiency anemia and deficiencies of folate or vitamin B12, reduce the blood's capacity to carry oxygen effectively. As a result, body tissues receive less oxygen to support normal energy production. Persistent fatigue, generalized weakness, reduced exercise tolerance, and low energy are therefore common and clinically meaningful history findings. These symptoms may develop gradually, so a client may describe feeling continually tired rather than reporting an abrupt change. During assessment, the nurse should further explore the duration and severity of fatigue, dietary intake, menstrual or gastrointestinal blood loss, activity tolerance, and associated symptoms such as shortness of breath, dizziness, palpitations, or pallor. This information helps characterize the functional impact of anemia and supports appropriate diagnostic evaluation, including a complete blood count and nutrient-specific studies when indicated. The National Heart, Lung, and Blood Institute's overview of anemia symptoms identifies tiredness and weakness as common manifestations. The Merck Manual overview of anemia likewise explains that fatigue and weakness result from reduced oxygen delivery to tissues.

QUESTION NO: 75

When caring for a client with a tunneled central venous catheter, which of the following manifestations requires immediate intervention by the nurse?

A. Redness at the catheter site

B. Tenderness along the track of the catheter

C. A loose dressing

D. A small amount of blood in the dressing

ANSWER: B

Explanation:

Tenderness along the track of the catheter requires immediate intervention because it can indicate a tunnel infection involving the subcutaneous path of a tunneled central venous catheter. Unlike a superficial finding confined to the insertion site, pain or tenderness extending along the catheter tunnel raises concern for infection spreading through deeper tissue surrounding the device. This can progress to catheter-related bloodstream infection and systemic illness, particularly in clients who are immunocompromised or receiving long-term intravenous therapy.

The nurse should promptly assess the client for associated findings such as drainage, induration, warmth, fever, chills, or hemodynamic changes; maintain aseptic catheter care; and notify the responsible clinician promptly for further evaluation. Evaluation may include blood cultures and consideration of catheter removal or antimicrobial therapy according to the client's clinical condition and institutional protocol. Early recognition is essential because central-line infections can become severe

quickly. CDC guidance emphasizes careful assessment of central-line sites and prompt action when infection is suspected. See the CDC guidance on intravascular catheter-related infection prevention and the NCBI review of catheter-related bloodstream infections.

QUESTION NO: 76

A 4-year-old admitted with acute lymphocytic leukemia has a low platelet count. Which of these measures should be considered essential to the child's care?

A. Assisting the child with active range of motion exercises.

B. Observing the child's gums for bleeding.

C. Encouraging the child to eat foods high in iron.

D. Restricting the child's interaction with other children on the unit.

ANSWER: B

Explanation:

Observing the child's gums for bleeding is essential because thrombocytopenia, or a reduced platelet count, substantially increases the risk of bleeding. Platelets are needed to form an initial clot after blood-vessel injury. In a child receiving care for acute lymphocytic leukemia, bleeding may occur with minimal trauma and can be subtle at first. The oral mucosa and gums are particularly important sites to assess because they are delicate, highly vascular, and can show petechiae, bruising, oozing, or spontaneous bleeding. Regular assessment allows the nurse to identify bleeding promptly, document changes, notify the clinical team when indicated, and support timely safety interventions.

Bleeding precautions are a core component of nursing care for patients with low platelet counts. Assessment should also include attention to other signs of hemorrhage, such as new bruising, petechiae, epistaxis, hematuria, black or bloody stools, headache, or neurologic changes. Caregivers should be taught to report oral bleeding and to use gentle oral hygiene measures as directed by the care team to limit mucosal injury. The National Cancer Institute discusses bleeding as a possible complication of childhood leukemia and treatment at NCI Childhood Acute Lymphoblastic Leukemia Treatment. Additional guidance on low platelet counts and bleeding precautions is available from the American Cancer Society.