- **Prometric Questionnaire**

- **The nurse administered a dose of morphine sulfate as prescribed to a patient who is in the post anesthesia care unit (PACU). The patient appears to be resting comfortably, the respiratory rate is 8 and the O2saturation is 21 oxygen via cannula is 86%. The nurse should IMMEDIATELY administer:**

- **Flumazenil (Romazicon)**
- **Medazolum (versed)**
- **Naloxone (Narcan)**

- **Ondansetron (Zofran)**

- **Answer : C**

- **A patient schedule for a major surgery in one hour is very nervous and upset. Which of the following order medications would the nurse administer torelax this patient?**

- **Meperidine Hydrochloride(Demerol)**
- **Scopolamine (Transderm-Scop)**
- **Pentobarbital sodium(Nembutal sodium)**
- **Trazodone hydrochloride(Trazadone)**

- **Answer : A**

- **A patient with poor wound healing and poor appetite has an order to begin total parentalnutrition (TPN). Waiting for the TPN solution to arrivefrom the pharmacy, the nurse shouldobtain:**

- **A pair of sterile gloves**
- **An infusion pump**
- **IV tubing with a micro-dripchamber**
- **Povidine-iodine (Beta dine)swabs**

- **Answer : B**

- **A nurse is caring for a patientreceivingtotal parenteral nutrition(TPN). The patient reportsthesudden onset of feeling short ofbreath and anxious. The nursehears crackles inbilateral lowerlobes of the lungs and the patient's O2 saturation is 90%on room air.The nurse must IMMEDIATELY:**
  - **Turn off the TPN**
  - **Notify the physician**
  - **Asses the patient's capillary blood glucose level**
  - **Attempt to suction the patient's airway**

- **Answer : A**

- **A nurse has just started totalparenteral nutrition (TPN) asprescribed for a patientwithsevere dysphagia lowprealbumin levels.In one totwo hours, the nurse shouldanticipate assessing thepatient's:**

- **Blood glucose level**
- **Weight**
- **Liver**
- **Spo 2**

- **Answer : D**

- **The nurse is planning care for several children who were admitted during the shift. Daily weights should be the plan of care for the child who is receiving:**

- **Total parenteral nutrition(TPN)**
- **Supplement oxygen**

- **Intravenous anti-ineffective**
- **Chest physiotherapy**

- **Answer : A**

- **The nurse is caring for a 4-year-old patient with adiagnosis of cystic fibrosis andpneumonia. The child isfeeling better on the 3rd day ofthe hospitalization and "wantsto play." What would be thebest choice of entertainment?**

- **Blowing bubbles**
- **Looking at picture books**
- **Watching videos**
- **Riding in a wagon**

- **Answer : A**

- **A nurse is caring for an 8-year-old male with cystic fibrosis. Based on the nurse's understanding of the disease.What nursing intervention should the nurse expect to perform?**

- **Restrict sodium and fluidintake**
- **Give antidiarrhealmedications**
- **Discourage coughing afterpostural drainage**
- **Administer pancreatic enzymes with each meal**

- **Answer: D**

- **A nurse is caring for a childwith a diagnosis of cysticfibrosis and pneumonia. Theplan of care includes nebulizer treatment and chestphysiotherapy. The nurseshouldperform chest physiotherapy:**

- **Continuously during thenebulizer treatment**
- **Prior to the nebulizer treatment**
- **After the nebulizer treatment**
- **Intermittently during the nebulizer treatment**

- **Answer: C**

- **When conducting discharge teaching for the parent of achild newly diagnosed with cystic fibrosis. Which of the following statement by the parent indicates the need for further teaching?**

- **Weekly weights help evaluate effectiveness ofnutritional interventions**
- **Weekly weights help thedoctor know if may child isabsorbing nutrients**
- **Weekly weights reassure mychild that recovery isprogressing**

- **Weekly weights help the doctor know if my child needs additional enzymes**

- **Answer : D**

- **While caring for a patientwith an ileostomy, the nursewould expect the ostomy tobe located In Which Quadrant of the abdomen?**

- **Right lower**
- **Left lower**

- **Left upper**
- **Right upper**

- **Answer : A**

- **A patient has been assessedand found to have severe dysphagia and will need longterm nutritional support,which one of the following types of feeding would MOST likely to be beneficial for this patient?**

- **Gastrostomy**
- **Patenteral**
- **Nasogastric**
- **Nasoduodenal**

- **Answer : C**

- **A surgeon instructs a nurse to serve as a witness to anelderly patient's informedconsent for surgery. Duringthe explanations to the patient,it becomes clear that the patient is confused and does not understand the procedure,but reluctantly sign theconsent form. The nurseshould:**

- **Sign the form as a witness,making a nation that the patient did not appear tounderstand**
- **Not sign the form as a witness and notify the nurse supervisor**
- **Not sign the form and answerthe patient's questions afterthe surgeonleaves he room**
- **Sign the form and tellsurgeon that the patientdoesn't understand theprocedure**

- **Answer : B**

- **The nurse is evaluating the patient with end stage chronic obstructive pulmonary disease (COPD).The patient has not achieved any of the goals in the plan of care.The spouse reports concerns about the patient's mood and increased dependency .What action should the nurse take FIRST?**

- **Continue the care plan for 1more month**
- **Refer the patient to psychiatric services**
- **Collaborate with the patient and spouse to revise the care plan**

- **Revise the care plan based on the spouse's input**

  - **Answer : C**

- **A home care patient withchronic obstructivepulmonary disease (COPD)reports anupset stomach. Thepatient is taking theophylline(Theo -Dur) and triamcinoloneacetonide (Azmacort) Thenurse should instruct thepatient to take:**

- **Theo-dur an emptystomach**
- **Theo-dur and azmacortat the same time**
- **Theo-dur and azmacort12 hours apart**
- **Theo-dur milk or crackers**

- **Answer : B**

- **When giving post operative discharge instructs a patient who had abdominal surgery,all of the following regarding wound healing are true EXCEPT:**

- **Bathing to soak abdomen ispreferred**
- **Avoid tight belts and clothswith seams that may rub thewound**
- **Pain medication may effectability to drive.**
- **Irregular bowel habits can beexpected**

- **Answer: A**

- **A nurse giving post operative discharge instructs a patient who had abdominal surgery, when teaching the patient about wound healing all of the following are the true EXCEPT:**

- **Wound may feel tightly oritchy as healing occurs**

- **Scabs promote infection ofthe new skin underneaththem**
- **Numbness or a slight pulling sensation is normal**
- **Wound should not have anydrainage**

- **Answer : C**

- **A 12-year-old child who hasbeen diagnosed with insulin dependant mellitus (IDDM)since age3.Comes to the clinicfor a routine visit. The**

patienthas begun to self managecarewith parental supervision. Thepatient injects 28 units of NPHinsulin everymorning and 8units at bedtime. The patientchecks blood sugar 4 timesevery day.The patient' sweightis stable and diet isunchanged. However, thepatient reports severalhypoglycemicreactions everyweek. The nurse knows theMOST likely cause is that:

- **The patient is not eating the adequate number of calories reported**
- **The dosages of insulin may need to be decreased as the patient continues to grow**
- **There may be changes in exercise or stress levels or the beginning of a growth Spurt**

- **The patient may not becompetent in techniques ofdrawing up and injectinginsulin**

  - **Answer : C**

- **A nurse visits a patient at home who does not understand how to take anewlyprescribed medication.The prescription reads: 5 ml PO TID p.c. meals. The nurseexplains to the patient that thecorrect way to take themedication is:**
- **1 teaspoon by mouth, 3times a day, before meals**
- **1 teaspoon by mouth, 3times a day, after meals**

- **1 tablespoon by mouth, 3times a day, before meals**
- **1 tablespoon by mouth, 3times a day, after meals**

- **Answer : B**

- **The nurse is caring for a patient who had major abdominal surgery under general anesthetic 4 hours ago. An appropriate goal for the patient includes:**

- **Having minimal fine cracklesin the base of the lungs**

- **Using the incentivespirometry every 4 hours**
- **Expectorating minimalamount of secretions**
- **Performing Coughing Exercises every hour whileawake**

- **Answer : D**

- **While caring for a child with aventriculoperitoneal shuntrevision, the nurse find the patient lying with the head and feet flexed back. The nurse should call for help and prepare for a(n):**

- **Spinal tap**
- **Shunt culture**

- **Electrocardiogram**
- **Ventricular tap**

  - **Answer : D**

- **A patient under goingtreatment for cancer with bone metastasis is experiencing Severe pain.Which of the following treatment would the nurse MOST likely expect to improve the patient's pain control?**

- **Adjuvant radiation therapy**
-
- **Curative radiation therapy**
- **Radiosurgery (stereotactic)**

  - **Answer : B**

- **During surgery requiring general anesthesia, the patient heart's stops and acarotid pulse is not palpated.How**

many compressionsper minute should beadministered?

- **50**
- **60**
- **80**
- **100**

- **Answer :D**

- **When teaching a community class on cerebro vascular accidents (stroke), which of the following should participants of the class know at the completion of the class?**

- **Muscle and ligament damageis not reversible**
- **Expressive aphasia isresolved by voice rest**

- **There is a risk for mood disorders such as depression**
- **Liquids should be consumed at the same times as solids food**

- **Answer : D**

- **A community health carenurse visits a patient who hada cerebrovascular accident.The patient is at risk fordeficient volume due tovoluntary reductionintakefluid intake to avoid the useof the bathroom. The nurseeducates thepatient on theimportance of drinking fluidsand maintaining hydration.Whichof the**

followingindicates the efficacy of thenursing intervention?

- Amber color urine
- Respiration of 35
- Tachycardia
- Moist mucous membrane

- Answer : A

- A home health nurse isvisiting a patient following acerebrovascular accident(CVA). The patient is having trouble sleeping and is feeling sad. The patient's spouse tells the nurse that the patient is not eating much and often

cries when nooneis watching. Which of thefollowing would be thenurse's MOST likelyintervention?

- **Assess for changes in cognitive abilities**
- **Complete a depression index**
- **Strengthen family coping methods**
- **Screen for pain**

- **Answer : B**

- **A home health nurse is visiting a patient who recently suffered a Cerebro vascular accident(CVA). The nurse would MOST likely implement which of the following interventions to prevent muscle and ligament deformities?**

- **Daily moist heat and isometric exercises**
- **Daily balance training and routine medications for pain**
- **Instruct patient to use non-affected side to perform activities of daily living**
- **Daily range of motion exercises.**

- **Answer : C**

- **A nurse is assigned to do a home visit for an 81-year-old patient. The patientlives at home with an adult caretaker and is completely bed-bound following a Cerebrovascular accident (CVA) 2 weeks ago. In planning caregiver education, The nurse should be prepared to instruct the caretaker in:**

- **How to select a nursing home for the patient**
- **Performing passive range of motion exercises**
- **The importance of avoiding viscous drinks**

- **Forming a local chapter of a care giver support group**

  - **Answer : D**
- **A home care nurse makes a follow-up visit to a patient who recently suffered acerebrovascular accident. The patient is mobile and able to perform activities ofdaily living. However, the patient has not sleeping and has lost weight due tolack of appetite. The patient also feels overwhelmed with sadness. Which of thefollowing is the most appropriate evaluation?**

- **Patient's progress is as expected and no furtherintervention is necessary**
- **Patient needs referral to anutritionist**
- **Patient needs intervention fordepression**
- **Patient needs sleeping medication**

- **Answer : C**

- **A patient admitted with a cerebrovascular accident (CVA), is unable to chew orswallowed. The patient is a risk for aspiration. The nurse would anticipate receivingwhich of the following orders for this patient?**

- **Give no food by mouth andstart intravenous hydration**
- **Start a pureed diet withthickened liquids**
- **Refer the patient to apsychiatrist for depressionrelated to the CVA**

- **Refer the patient to physicaltherapy for musclestrengthening**

- **Answer : A**

- **While the nurse is administering a large volume enema, the patient complains ofcramping. The nurse should:**

- **Increase the flow rate**
- **Lower the fluid container**
- **Elevate the head of the bed**
- **Gently massage the abdomen**

- **Answer : B**

- **A home health nurse has entered a home to complete an admission assessment on apatient who has a methicillin-resistant Staphylococcus aureus (MRSA) urinary tractinfection. The patient will receive intravenous anti-infective via a peripherallyinserted central catheter (PICC) for 3 weeks. Which of the following actions shouldthe nurse take FIRST?**

- **Shake the patient's hand**
- **Place the nursing supply bagon a clean, dry surface**
- **Obtain the patient's writtenconsent for home health care**
- **Perform hand hygiene perthe agency protocol**

- **Answer : D**

- **A home health nurse is teaching a family member about the care of patient'speripherally inserted central catheter (PICC). Which of the following statementswould be appropriate for the nurse to make?**

- **Place the used intravenoustubing in a leak proofcontainer and then place thissealed container inside asecond leak proof container.**"
- **"You will need to put on adisposable face mask beforeyou connect theintravenoustubing to the port of thePICC."" The port of the PICcatheter will need to becleansed with povidone-**

iodine(BETADINE) afterthe infusion is completed.”

- **“The empty medicationcontainer can be placed inthe same container as yourHousehold refuses.”**

  - **Answer : A**

- **A patient had a craniotomy with resection of a nonmalignant neoplasm for the temporal lobe. The patient’s vital signs are within the base line normal range. The nurse observes that the patient has developed bilateral periorbital edema. Which of the following actions would be appropriate for the nurse to take?**

- **Apply cold compresses to the patient's eyes**
- **Apply warm compresses to the patient's eyes**
- **Elevate the head of the patient's bed to 60 degrees**
- **Elevate the head of the patient's bed to 45 degrees**

- **Answer :D**

- **To decrease the incidence of aspiration of gastric contents in a child hospitalization with severe burns, the nurse should position the head:**

- **Flat except during meals**
- **Elevates 30-45 degrees during meals**
- **Elevated 15-30 degrees for12-hours after meals**
- **Elevated 45 degrees at all times**

- **Answer : B**

- **A home health nurse visits a patient with diabetes and primary open-angle glaucoma.The patient takes metformin (Glucophage) 500 mg once a day for diabetes and timolol ophthalmic solution twice a day in each eye for glaucoma. Which of thefollowing evaluations indicates that the patient is noncompliant with glaucomamanagement?**

- **Patient has not been taking glucophage**
- **Patient has tearing of the eye**
- **Patient has not refilled prescription for timolol in 3 months**
- **Patient has yellow discharge from the eyes**

- **Answer : C**

- **A patient is having difficulty with cognitive abilities after a stroke. What part of the brain was MOST likely affected?**

- **Midbrain**
- **Cerebrum**
- **Medulla oblongata**
- **Cerebellum**

- **Answer : B**

- **A 16-years old patient present to the clinic requesting birth control. With the diagnosis of health seeking behaviors, the BEST goals have the patient:**

- **Verbalizing understanding of safe sex practices and following safe sexual practices in all encounters**
- **Not engaging in sexual encounters until she is over18 years old and maintaining a healthy life style**
- **Recognizing the sign of pregnancy and the symptoms of sexually transmitted diseases**
- **Understanding safe sexual practices and use a condomto prevent pregnancy andsexually transmitted diseases**

- **Answer : D**

- **A nurse plans to teach a group of 20to25-year-old women about oral contraceptives.The nurse should instruct that oral contraceptives may:**

- **Increase the risk of pelvic inflammatory disease**
- **Cause acne to worsen**
- **Decrease the risk of breastand cervical cancer**
- **Decrease the risk of endometriosis**

  - **Answer : A**

- **Following lumbar surgery a patient has a 4 millimeter (mm) surgical incision. The incision is clean and the edges are well appropriate. This type of tissue**

healing is classified as which of the following?

- **Primary intention**
- **Secondary intention**
- **Tertiary intention**
- **Superficial epidermal**

  - **Answer : A**

- **Shrinkage device is applied after surgery for amputation of the leg. The goal of the shrinkage device is to from the residual limb into what shape?**

- **Cone**
- **Oval**
- **Mushroom**
- **Cylinder with blunt end**

  - **Answer : D**

- **A patient with a pulmonary embolus and a nursing diagnosis of impaired gas exchange has an order to obtain arterial blood gases. The FIRST intervention by the nurse is to:**

- **Perform an Allens test**
- **Explain the procedure**
- **Gather the equipment**
- **Document the procedure**

- **Answer : A**

- **.A patient is diagnosed with pulmonary hypertension. Which of the following nursing diagnoses should be the PRIORITY?**

- **Impaired gas exchanged related to altered blood flow secondary to pulmonarycapillary constriction**
- **Fatigue related to hypoxia**
- **Anxiety related to illness and loss of control**
- **Activity intolerance related to imbalance between oxygen supply and demand due to right and left ventricular failure**

- **Answer : D**

- **A patient who had abdominal surgery is in the post anesthesia care unit (PACU).Which of the following nursing diagnosis takes PRIORITY?**

- **Disturbed sleep pattern**
- **Acute pain**

- **Risk for infection**
- **Ineffective airway clearance**

- **Answer : D**

- **While caring for a patient in the post-anesthesia care unit (PACU), a nurse observes the onset of rapid breathing cyanosis, and narrowing blood pressure. The nurse should plan to:**

- **Administer bolus glucose**
- **Suction the airway**
- **Turn the patient to the right side**
- **Administer intra venous fluids**

- **Answer : B**

- **While caring for a patient in the post-**

anesthesia care unit (PACU) Who has developed Hypovolemic shock, a nurse should position the patient:

- **Flat with legs elevated**
- **In Trendelenburg position**
- **With the head of the bed elevated 45 degrees**
- **Completely flat**

- **Answer : B**

- **A patient had a vitrectomy and is about to be transported to the post anesthesia care unit (PACU). The patient should be placed in which of the following positions before transport to the PACU?**

- **Semi-fowler's**
- **Prone**

- **Dorsal recumbent**
- **Sim's**

- **Answer : B**

- **While caring for a patient in the post-anesthesia care unit (PACU), a nurse plans toKeep the patient warm. What is the MUST important reason for this action?**

- **To preserve nutritional stores**
- **To prevent cutaneous vessel dilation**
- **To decrease patient anxiety**
- **To lower risk of infection resulting from chill**

- **Answer : C**

- **A patient had a total abdominal hysterectomy 2days-ago and has not been out of the bed yet. The patient is complaining left leg pain and swelling. What should the nurse do FIRST?**

- **Gently massage the patient'sleg**
- **Assess the patient's pain level**
- **Assess the patient for Homan's sign**
- **Instruct the patient to reflex the left knee and hip**

- **Answer : C**

- **To minimize a toddler from scratching and picking at a healing skin graft site, the nurse should utilize?**

- **Hand mittens**

- **Mild sedatives**
- **Punishment for picking**
- **Distraction**

- **Answer : D**

- **The nurse is teaching the mother of a 3 -months-old infant about bottle feeding.Which statement indicates the mother understands of appropriate procedure?**

- **“I should hold my baby in aslightly reclined position,close to my body”**
- **“It is OK to prop the bottle on a pillow ”.**
- **“It can feed my baby wholemilk”**
- **“I should warm the bottlesin the microwave if theycome out of**

theRefrigerator".

- **Answer : C**
- **A 9-month-old child who has had four ear infections in the past 6 months is being discharged. Which statement by the parent indicates the need for further discharge teaching?**

- **I should never put my baby to bed with bottle**
- **My child should not use a pacifier after age 6 months**
- **My child should drink his bottle while laying flat in my lap**
- **My child should not be around people who smoke**

- **Answer : B**

- **A Patient complains of severe menstrual cramping. Bleeding is not un usually heavy and the patient has no uterine disorders. Which of the following interventions should the nurse anticipate the doctor will order promote comfort?**

  - **Acetaminophen (Tylenol)**
  - **Strict bed rest**
  - **Heating pad to the back of neck**
  - **Ibuprofen (Motrin)**

- **Answer : D**

- **During Pre operative preparation of a patient for amputation of the left leg.**

The nurse has primary responsibility for:

- **Witnessing the patient signature on the consent form**
- **Explaining the procedure to the patient**
- **Explaining the risks of the surgery to the patient**
- **Making appropriate incision lines on the leg.**

- **Answer : A**

- **A 52-years-old is admitted to the nursing unit from the physician's office with a diagnosis of acute cholecystitis. Physician orders on admission include: monitor vital sign**

every 4 hours; IV of ringer's lactate 125ml per hour; 1500 calorie, low-fat liquid diet, morphine sulfate 2mg IV every 2 hours as needed for pain, notify physician for sudden increase in frequency or intensity of pain, promethazine12.5 mg IV every 4 hours as needed for nausea or vomiting. Which of the following should the nurse plan to do FIRST?

- **Remove any high-foods from the patient's room**
- **Notify the dietitian of the diet order**
- **Obtain venous access and start Ringer's lactate infusion**
- **Obtain an emesis basin and clean linens for the be side**

- **Answer : C**

- **A parent brings a 10-month-old infant into the department saying, "my baby put a button in her mouth and now she is not breathing!" After the nurse determines the infant is not breathing. What should the nurse do NEXT?**
  - **Perform the Heimlichmaneuver**
  - **Initiate cardio pulmonary resuscitation (CPR)**
  - **Administer 4 back blows**
  - **Administer 4 thrusts midline on the patient back**

- **Answer : D**

- **An infant arrives in the emergency department not breathing and does have a pulse. When starting cardio pulmonary resuscitation (CPR), where is the correctplace to assess for a pulse in this patient?**

- **Carotid**
- **Radial**
- **Brachial**
- **Temporal**

- **Answer : C**

- **A 5 years old patient who under went abdominal surgery suffers from deficient fluid volume related to nothing by mouth (NPO) status; intravenous fluid therapy is given for hydration. Which of the following indicates that thetreatment is effective?**

- **Urinary output of 15ml/ hr**
- **Respiration rate, 35**
- **Heart rate 100**
- **Good skin turgor**

- **Answer : D**

- **A 7-years-old child is brought to the physician office due to sudden onset of bright redness on the cheeks. The nurse observes that the child has a temperature of 38^0 C (100.4^0 F) With chills the nurse suspects that the MOST like diagnosis would be:**

- **Fifth disease**
- **Rotavirus**
- **Roseolainfantum**

- **Answer : A**

- **A nurse instructs a community education class on breast health. Which statement BEST described understanding of the appropriate age to start screening mammograms is a woman of average risk?**

  - **At menopause**
  - **At 65-years-old**
  - **At the cessation of breastfeeding**
  - **At 40-years-old**

- **Answer : A**

- **A patient is taught how to perform a breast self-exam by a nurse. Whichstatement is BEST described as understanding of the proper procedure fordoing a breast self-exam?**

  - **Use of the palm of the hand to feel for lumps**
  - **Apply three differentlevels of pressure to feelbreast tissue**
  - **Stand when performingbreast self-exam**
  - **Perform self-examannually**

- **Answer : A**

- **While caring for a child with in effective airway clearance related to increased mucus production, the nurse should encourage fluids to:**
  - **Maintain nutrition**
  - **Prevent boredom**
  - **Stimulate coughing**
  - **Thin secretions**

- **Answer : D**

- **A 59-years old patient with lung cancer and metastases to the bone is in the**

hospital for pain management. The patient rates the pain 10 on a scale of 0(no pain) to 10 (severe pain). The BEST goal for the nurse diagnosis of alteration is comfort is that the patient will:

- **Show no objective signs of pain**
- **Not complain of pain**
- **State pain is at a tolerable level**
- **State that all pain is relieved**

- **Answer : D**

- **A patient with advanced lung cancer is exhibiting cyanosis and edema of the head and upper extremities. Which of the following intervention would MOST likely provide an immediate benefit for this patient?**
  - **Place in Trendelenburg position**
  - **Position on the right side**

- **Elevate the head of the bed**
- **Elevate extremities**

- **Answer : C**

- **If a patient develops a complication during a blood transfusion, the nurse first should be to:**

  - **Stop the transfusion**
  - **Notify the practitioner**
  - **Administer anantihistamine**
  - **Administer an anti- inflammatory medication**

- **Answer : A**

- **Which of the following types of health care services is an example of the**

primary level of care?

- **Diagnosis**
- **Acute care**
- **Restoration**
- **Immunization**

- **Answer : D**

- **In planning for the care of a patient with Crohn's disease, the nurse and patient discuss the interventions. Which of the following treatment modalities would MOST likely be considered a primary intervention for this disease?**

  - **Surgery**
  - **Medications**
  - **High-residue diet**

- **Blood replacement**

- **Answer : B**

- **A patient with acute crohn's disease has been prescribed an elemental diet. The MOST likely rationale for this is to:**

- **Reset the bowel**
- **Improve nutrition**
- **Improve medication absorption**
- **Prepare for surgery**

- **Answer : C**

- **A patient has a6-year history of inflammatory bowel disease that is**

resistant to medical therapy. The patient can BEST decreased the like hood of the disease progressing to

- **Consuming only elemental foods**
- **Stopping smoking**
- **Using effective birth control**
- **Avoiding over heating**

- **Answer : A**

- **A home health nurse is setting up a medication administration schedule for an elderly patient. The patient is talking Oscal (calcium corbonate), Feosol (ferroussulfate), and Orazinc (Zinc sulfate). The patient eat meals at 8:00 AM, 12 noon, and6:00 PM. Which of the following medication administration times would the**

nurseMOST likely implement for this patient?

- **Oscal, Orazinc, and foesal at 8:00AM**
- **Oscal at 6:00AM, Orzinc at 12:00 noon, Foesal At 4:00PM**
- **Oscal and Foesal at 12:00 noon and Orazinc at 6:00PM**
- **Orazinc at 6:00 AM, Oscal at 12:00 noon, and Foesal at 6:00PM**

- **Answer : C**

- **A Community Health nurse is administering tuberculin skin tests purified protein derivative (PPD), which of the following time frames should the nurse tell the patient to return to the clinic for the test to be read?**

- **In 12-24 hours**
- **In 24-36 hours**
- **In 36-48 hours**
- **In 48-72 hours**

- **Answer : D**

- **A patient who is scheduled for a tonsillectomy is in pre operative unit. The nurse notes an order for pre anesthetic medication to be given "on call to operation room".The nurse should give this medication:**

- **Immediately upon being notified to prepare the patient for transport**
- **When the operation room staff arrive to transport the patient**
- **Only if clearly needed after assessment**
- **Upon the patient's arrival in the operation room**

- **Answer : A**

- **A patient recently under went coronary artery bypass graft surgery (CABG). The Nursing diagnosis includes sleep deprivation related to intensive care environment. The goal for this diagnosis would be that the patient:**
  - **Gets 4 hours of uninterrupted sleep during the right**
  - **Takes naps during the day**
  - **Is free of pain in the first hour post surgery**
  - **Ambulates 3 hours post surgery**

- **Answer : B**

- **The nurse is assisting a patient to ambulate in the hall. The patient a history of coronary artery disease(CAD), and had coronary artery bypass graft surgery(CABG) 3 days ago, the patient reports chest pain rated 3 on a scale of 0 (no pain)to 10 (severe pain) the nurse should FIRST:**

- **Determine how long it has since the patient's last dose of aspirin**
- **Obtain a chair for the patient so sit down**
- **Assess the patient's radial pulse**
- **Ask the patient to take several slow, deep breaths**

- **Answer : A**

- **A 35-years-old female has an inherited gene mutation for achondroplasia, anautosomal dominate genetic disorder. Her husband does not have genemutation. In planning genetic counseling for this patient, the nurse would beMOST correct in including which of the following statements regarding the risk of their children inherited the genetic mutation?**

- **Each child has a 50% chance of inheriting the gene mutation**
- **Female children have 50% chance of inheriting the gene mutation**
- **Male children will not inherited the gene mutation**
- **All female children will inherit the gene mutation.**

- **Answer : A**

- **A patient is one day post operative repair of a large umbilical hernia. The patient complains of abdominal pain and described feeling the sutures give way. Upon assessment of the abdomen the nurse observes an evisceration. The nurse's IMMEDIATE response should be to:**

- **Medicate the patient for pain**
- **Instruct the patient to cough hard**
- **Have the patient perform the valsalvas maneuver**
- **Cover the abdomen with asterile soaked dressing**

- **Answer : D**

- **A 3-years old child is seen at the pediatrician's office. The parents the child has had vomiting and diarrhea for the past 15 hours. The child's is lethargic with the following vital signs: temperature 37.2^0 C (99.^{0} F), heart rate 145,respiration rate 25, and blood pressure level 95/ 55 mmHg. Which of the vital sign is abnormal?**

- **37.2^0 C (99.0^0 F)**
- **Heart rate 145**
- **Respiration rate 25**
- **Blood pressure level 95/ 55**

- **Answer : B**

- **A home health nurse is teaching a family member about the care of a patient's peripherally inserted central catheter (PICC). Which of the following would be appropriate for the nurse to make?**
- **"Place the used intravenous tubing in a leak proof container and then this in sealed container inside a second leak proof container".**
- **"You will need to put on adisposable face maskbefore you connect thethe port of the PICC."**
- **"The port of the PICCcatheter will need to becleansed with providence-iodine Betadine) after theinsulin is**

completed.”

- **“The empty medicationcontainer can be placed inthe same container as your house hold refuses.”**

  - **Answer : A**

- **While Obtaining the pre operative history of a patient schedules for cosmetic surgery, the most valuable skill at the nurse disposal is:**

- **knowledge of the procedure**
- **Time management skills**
- **Listening skills**
- **Empathy**

- **Answer : D**

- **A community health nurse screens a group of high risk adults for tuberculosis. Which gauage needle should the nurse use for an intradermal injection on theventral surface of the forearm?**

- **16 gauge needle**
- **20 gauge needle**
- **22 gauge needle**
- **26 gauge needle**

- **Answer : D**

- **A patient hospitalized with tuberculosis (TB) has a productive cough and hemoptysis. Which of the following types of isolation room would be the best choice for the**

patient?

- **Reverse isolation**
- **Standard isolation**
- **Positive-pressure**
- **Negative-pressure**

- **Answer : D**
- **A patient diagnosed with tuberculosis is prescribed isoniazid (Isoniazid), Rifampin (Rifadin), pyrazinamide (Rifamate), ethambutol HCL (Myambuton), one month later the patient comes to the physician office with hepatitis. Which drug is the MOST likely cause?**

  - **Ethambutol(Myambuton),**
  - **Acetaminophen,**
  - **Izoniazid (Izoniazid),**

- **Pyrazinamide (Rifamate).**

- **Answer : C**

- **A Patient with tuberculosis can transmit the disease to another individualThrough:**

  - **Air droplets**
  - **Physical contact**
  - **Hand to mouth exchange**
  - **Blood and body fluids**

- **Answer : A**

- **A patient recently under went joint replacement surgery, which of the following nursing diagnosis takes PRIORITY?**

    - **Risk for peripheral neurovascular dysfunction**
    - **Deficient knowledge on appropriate activity precaution**
    - **Impaired physical mobility**
    - **Sexual dysfunction related to pain**

- **Answer : C**

- **The parents are anxious after the doctor tells that their child needs**

surgery.The assess parents' ability to cope with this anxiety, which of the following questions should the nurse ask

- **"Did you know that feeling anxious about your child's surgery is normal?"**
- **"Can you wait until after surgery to begin to cope with being anxious?"**
- **"How do you think feeling of anxiety will affect your child?"**
- **"What has helped you when you felt anxious in the past?"**

- **Answer : A**

- **A 4-year-old child brought to the community health clinic for scheduled immunizations. The child should receive:**

    - **Varicella, rotavirus,pneumococcal and hepatitis B**
    - **Measles, mumps, rubella and varicella**
    - **Rotavirus and inactivatedpolio virus**
    - **Varicella andhaemophilus influenza**

- **Answer : B**

- **The nurse is conducted a community-based educational program about Diabetes mellitus. Which of the following statements by a participant would indicate correct understanding of the teaching?**

    - **Lantus insulin can be mixed with other insulin**
    - **It is necessary to wipe off the top the insulin vial with alcohol to prevent infection**
    - **Insulin will changedcolor after opening**
    - **Needles can be placedin a hard plasticcontainer with atightly secure lid**

- **Answer : B**

- **A child is treated for superficial (first-degree) thermal burns to the thigh. The child is in great discomfort and does not eat. Which of the following diagnosis should receive PRIORITY?**

    - **Altered nutrition**
    - **Impaired skin integrity**
    - **Risk for infection**
    - **Acute pain**

- **Answer : D**

- **The nurse calls together an inter disciplinary team with members from medicine, social services, the clergy, and nutritional services to care for a**

patient with aterminal illness. Which of the following types of care would the team MOST likely is providing?

- **Palliative**
- **Curative**
- **Respite**
- **Preventive**

- **Answer : A**

- **A nurse makes a home visit to a patient recently diagnosed with chronic obstructive pulmonary disease (COPD), which of the following should**

the nurse teach the patient about managing COPD?

- **Recognizing signs of impending respiratory infection**
- **Limiting fluids intake minimize bronchial secretions**
- **Correct technique to auscultate the lung fields**
- **Importance of starting antibiotic therapy**

- **Answer : A**

- **A patient with chronic obstructive pulmonary disease (COPD) experiencing frequent dyspnoea which of the following exercise would teach**

the patient how to BETTER control breathing?

- **Lower side rib**
- **Segmental**
- **Pursed-lip**
- **Diaphragmatic**

  - **Answer : C**

- **In evaluating the appropriateness of various exercises enjoyed by a patient with osteoporosis, the nurse would recommend:**

- **Walking**
- **Bowling**
- **Sit-ups**
- **Golf**

- **Answer : A**

- **A patient present to the clinic with“ pins and needles” sensations of the left foot and complains that objects appear “ Shimmering”.The patient is diagnosed with opticneuritis and referred for further testing. The patient is MOST likely to be tested for:**

- **Glaucoma**
- **Multiple sclerosis**
- **Lesion of brain stem**
- **Psychosis**

- **Answer : B**

- **A 3-years-old has returned to the clinic 4 days after being diagnosed with gastroenteritis and dehydration. A**

parent reports that the vomiting has stopped, and the child is tolerating liquids, rice, apple sauce, and bananas. The diarrhea persists,but seems to be decreasing in volume. When evaluating for signs of dehydration,the nurse will assess the patient's skin turgor by:

- **Grasping the skin over the abdomen with two fingers raising the skin with twofingers**
- **Grasping the skin over the forehead with two fingers and raising the skin withtwo fingers**
- **Holding the patient's mouth open and assessing the tongue for deep creases orFurrows**
- **Drawing two tubes of blood and running blood urea nitrogen (BUN) andCreatinine (Cr).**

- **Answer : A**

- **When administering albuterol to a child with asthma, the nurse should observe for sign of what major side effect to this medication?**

- **Tachycardia**
- **Renal failure**
- **Apnea Blurred vision**

- **Answer : A**

- **A child with asthma is experiencing thick respiratory secretions resulting in increased work of breathing. The best nursing intervention is to:**

- **Encourage fluids**
- **Eliminate dairy products**
- **Decrease relative humidity of the room**

- **Have the child lay on the left side.**

  - **Answer : C**

- **What would be the long-term goal for a child with asthma?**

- **Quickly reverse airflow obstruction**
- **Correct hypoxemia**
- **Deliver humidified oxygen via nasal cannula**
- **Develop a home and school management plan**

- **Answer : D**

- **A nurse administers an albuterol nebulizer on a child with asthma exacerbation. Which of following**

indicates effectiveness of the treatment?

- **Adventitious breath sound with cough**
- **O2 saturation 94%**
- **Nasal flaring**
- **Respiration rate 28**

- **Answer : B**

- **A Child is diagnosed with asthma exacerbation. Which of the following nursing diagnoses should be the FIRST priority?**

- **In effective airway clearance related to broncho spasm and mucosal edema**
- **Fatigue related to hypoxia**
- **Anxiety related to illness andloss of control**

- **Deficient knowledge relatedto potential side effect of themedication**

  - **Answer : A**

- **An asthmatic patient presents with wheezing and coughing. Oxygen saturation is 88% on room air. Which of the following nursing diagnosis would take priority?**

  - **Imbalanced nutrition related to decreased food intake**
  - **Activity intolerance related to inefficient breathing**
  - **Anxiety-related dyspnea and concern of illness**
  - **Ineffective gas exchange related to broncho spasm**

- **Answer : D**

- **The nurse is visiting the asthmatic patient at home to reinforce the importance of eliminating environmental allergens and to assess the patient's response to the environmental changes. This type of implementation is called:**

- **Supervision and coordination**
- **Discharge planning**
- **Monitoring and surveillance**

Ans c

- **A patient finds their 2-weeks-old infant unresponsive. The infant is limp, cyanotic and pale. There is no respiration, while the skin is cold to the touch. The parent begins resuscitation, and the infant is transferred to the hospital where the infant expires. The MOST likely diagnosis is:**

- **Sudden infant death syndrome**
- **Apparent life-threatening event**
- **Apnea of infancy**
- **Apnea of unknown origin**

- **Answer : A**

- **A neonatal nurse performs Apgar assessment at 1 minute of birth to evaluate the physical condition of the newborn and immediate need for resuscitation. At 1 minute, Apgar score is 7. At 5 minutes Apgar score is to the progression of scores suggests:**

- **A healthy newborn**
- **The need for supplement oxygen**
- **A genetic defect**
- **The infant is becoming stable**

  - **Answer : A**

- **The nurse is caring for full-term**

newborn who was delivered vaginally 5minutes ago. The infant's APGAR Score was 8 at one minute and 10 at 5minutes. Which of the following has the highest priority?

- **Maintaining the infant in the supine position**
- **Assessing the infant's red reflex**
- **Preventing heat loss from the infant**
- **Administering humidified oxygen to the infant**

- **Answer : A**

- **Which of the following can be use to determine if a prescribed pain management therapy is effective for a**

non verbal patient?

- **Papanicolaoutest**
- **Faces rating scale**
- **Braden's scale**
- **Apgar assessment tool**

- **Answer : B**

- **While caring for a neonate with a meningocele, the nurse should AVOID positioning the child on the:**

- **Abdomen**
- **Left side**
- **Right side**
- **Back**

- **Answer : D**

- **A patient with exacerbation of congestive heart failure has a nursing diagnosis of excess fluid volume. The nurse monitors fluids intake and output and administers furosemide, as ordered. Which of the following indicates the efficacy of the intervention?**

- **The patient has pitting edema**
- **The patient has shortness of breath**
- **The patient has a decrease in weight**
- **The patient has jugular vein distention**

- **Answer : C**

- **A 62-year-old patient has been treated for congestive heart failure and aNursing diagnosis of fluid volume excess. After diuretic therapy and dietary Interventions, the patient has met all short-term goals. The nurse should:**

- **Revise the care plan with a diagnosis of risk for alteration in fluid balance**
- **Add a new diagnosed of risk of fluid volume deficit**
- **Discontinue the care plan as the diagnosis is resolved**
- **Continue the care plan as written**

  - **Answer : D**

- **A patient with congestive heart failure**

and severe peripheral edema has a nursing diagnosis of fluid volume excess. What are the two MOST important interventions for the nurse to initiate?

- **Diuretic therapy and intake and output**
- **Nutritional education and low-sodium diet**
- **C. Daily weights and intake output**
- **D.Low-sodium diet and elevate legs when in bed**

- **Answer : A**

- **A patient has exacerbation of**

congestive heart failure, with one of the nursing diagnosis being excess fluid (lasix). The nurse closely monitors fluid intake and output and administers furesemide (lasix). Which of the following indicates theefficacy of the nursing intervention?

- **The patient has leg edema**
- **The patient has shortness of breath**
- **The patient has decreased in weight**
- **The patient has jugular vein distention**

- **Answer : C**

- **When caring for a patient with an ostomy, the nurse knows that extra**

skin protection for the peristomal skin is MOST important for those with a(n):

- **Ileostomy**
- **Ascending colostomy**
- **Transverse colostomy**
- **Sigmoid colostomy**

- **Answer : B**

- **While evaluating the nutritional intake of a bedridden patient with multiple pressuresores, the nurse should make sure the patient INCREASES the intake of:**

  - **Protein-rich foods**
  - **Water**

- **Foods rich in vitamin A**
- **Fiber rich foods**

- **Answer : A**

- **In what position should a dyspneic patient be placed?**

  - **Prone**
  - **Recumbent**
  - **Semi-fowler's**
  - **Trendelenburg**

- **Answer : C**
- **. A patient presents to the clinic for a routine visit and has the following vital signs: temperature 37.0^{0}C (98.6^{0}F), heart rate 82, respiration rate 18 and blood pressure level of 130/ 94 mmHg. Which vital sign is abnormal?**

- **Temperature**
- **Pulse**
- **Respiration**
- **Blood pressure**

- **Answer : D**

- **. A female patient admitted for abdominal pain complains of generalized pain, nausea vomiting and constipation. Nursing assessment finds: temperature,38.6^{0}C (101.5^{0}F), heart rate-92; respiration rate-18; blood pressure level, 130/ 68mmHg. The patient has rebound tenderness and abdominal rigidity. In the past hour, her pain has localized on the right side. The nurse suspects:**

- **Intestinal obstruction**
- **Influenza**

- **Appendicitis**
- **Pyloric Stenosis**

- **Answer : C**

- **. A community health nurse is implementing an adult immunization program in the neighborhood. Which of the following would MOST likely be a universally recommended adult vaccination and dose frequency general population?**

- **Tetanus-diphtheria toxoid every 20 years**
- **Pneumococcal vaccination every 2 years**
- **Influenza vaccination every year**
- **One time typhoid vaccine followed by**

boosters every5 years

- **Answer : C**

- **. A 6-year-old patient has been diagnosed with acute rheumatic fever. Then nurse knows that the antibiotic of choice for this illness is:**

- **Bezathgine penicillin(Megacillin)**
- **Amoxicillin (Amoxil)**
- **Erythromycin (Eryhrocin)**
- **Vancomycin (Vancocin)**

- **Answer : A**

    - **. A child is admitted to the hospital with congenital heart disease. Which of the following nursing diagnoses should receive PRIORITY?**

- **Decreased cardiac output related to decreased myocardial function**
- **Activity intolerance related to cachexia**
- **Impaired gas exchanged related to altered pulmonary blood flow**
- **Imbalanced nutrition: less than body requirements related to excessive energy demands**

- **Answer : A**

- **. Prior to initiating therapy with unfractionated heparin for a patient hospitalized with a deep vein thrombosis, the nurse should plan to:**

- **Weigh the patient**
- **Administer aspirin**
- **Limit fluid intake**
- **Undress the patient**

- **Answer : B**

- **. Prior to initiating therapy with unfractionated heparin for a patient hospitalized with a deep vein thrombosis, this treatment requires:**

- **Bed rest**
- **Aspirin therapy**

- **Fluid restrictions**
- **A high protein diet**

- **Answer : B**

- **. A patient with chronic liver disease secondary to hepatitis C has been admitted with malnutrition. With a nursing diagnosis of alteration in nutrition, less than body requirements, the BEST long-term goal is the patient will:**
- **Gain atleast 10% of bodyweight**
- **Attain and maintain ideal weight**
- **Verbalize understandingnutritional needs**
- **Include high quality protein in diet**
- **Answer : B**
- **. The nurse is assessing a patient with a history of a seizure disorder. While**

checking the patient's vital signs, the patient develops rhythmic, jerking movements of the arms and legs. The nurse should IMMEDIATELY place the patient in which of the following positions?

- **Prone**
- **Supine**
- **Semi-fowler's**
- **Lateral**

- **Answer : D**

- **. A nurse is assessing to care for a child with a seizure disorder. The nurse observes the child becomes stiff and lose consciousness, following by**

jerking movements for 1 minute after which the child becomes very sleepy, which of the following types of seizures occurred?

- **Absence (petit mal)**
- **Generalized (tonic-clonic)**
- **Partial Psychomotor(temporal lobe)**
- **Status epilepticus**

- **Answer : B**

- **. A patient is scheduled for an abdominal aneurysm repair. This is what type of surgical intervention?**

- **Diagnostic**
- **Transplant**
- **Curative**
- **Palliative**

- **Answer : C**

- **. A Community health nurse is teaching a health class about infectious disease processes. The nurse instructs the class that rabies would be considered which of the following types of infection?**

- **Viral**
- **Protozoan**
- **Fungal**
- **Bacterial**

- **Answer : A,**

- **. A patient receiving chemotherapy developed some raised; red edematous wheals on the skin, which of the following care plan alter natives MOST likely need to occur before the treatment?**

- **Rein forced relaxation techniques**
- **Continue chemotherapy without change**
- **Continue with radiation therapy only**
- **Pre-medicate the patient with an antihistamine**

  - **Answer : D**

- **A 6-year-old patient has presented to the clinic with fever, malaise and anorexia.The patient was treated 2 weeks ago for a streptococcal infection**

of the throat. The nurse should expect the physician to order what test?

- **Electrocardiogram**
- **Jones test**
- **Spinal tap**
- **Heart biopsy**

- **Answer : B**

- **. A community is experiencing an out break of staphylococcal infections. The nurse instructs residents that the MOST common mode of transmission is by:**

- **Respiratory droplets**
- **Contaminated foods**
- **Hands**
- **Soil**

- **Answer :D**

- **. A hospitalized patient has fallen from bed. The nurse notes shortening of the left leg.Pain upon movement of the left leg, and rapid, swallow respirations. What action should the nurse take FIRST?**

- **Call for help**
- **Immobilize the left leg**
- **Obtain blood pressure**
- **Evaluate lung sounds**

- **Answer : B**

- **. A community health nurse visits a patient who has suffered a stroke. The patient's spouse explains to the nurse that the patient chokes on foods at times. Which of the following referral ordered would the nurse anticipate needing for this patient?**

- **Speech therapist**
- **Dietician**
- **Physician therapist**
- **Neurologist**

- **Answer : A**

- **. A 59-year-old patient arrives in the emergency department diaphoretic and complains of chest pain and shortness of breath. The patient's**

sibling states that this has happened before and it is just anxiety. Upon evaluation the physician diagnosis unstable angina and prescribes anti-anginal medications. What is the expected results of this drug therapy

- **Balanced between oxygen supply and demand**
- **Increase in blood flow to the heart**
- **Reduction in oxygen demand and consumption**
- **Vessel relaxation**

- **Answer : B**

- **. A patient with end-stage cardiomyopathy and angina pectoris to the office complaining of frequent chest pain and severe dyspnea. With a nursing diagnosed of alteration in comfort, what is the BEST long term**

goal for this patients?

- **Perform all activities of daily living without complaints of chest pain or shortness of breath**
- **Verbalize and employ strategies to decrease pain and increase coronary blood flow**
- **Take pain medications around the check and use supplement oxygen at all times**
- **Understand the disease process and accept the limitation that it places on his lifestyle**

- **Answer : A**

- **. A patient has an order for a pneumatic compression device. Which**

of the following is an appropriate goal?

- **Reduce the risk deep vein thrombosis**
- **Reduce lower extremity edema**
- **Reduce lower extremity pain**
- **Reduce the risk of phlebitis**

- **Answer : A**

- **. A patient with severe diverticulitis had surgery for placement of colostomy. The patient is upset, crying and will not look at the colostomy. Which of the following would be the HIGHEST priority nursing diagnosis at this time?**

- **Knowledge deficit,colostomy care**
- **Distorted body image**
- **Self-care deficit, toileting**
- **Alteration in comfort**

- **Answer : B**

- **. A patient presents to the emergency department with complaints of head ache,dizziness and confusion. Clinical symptoms include tachypnoea and dyspnea with the use of accessory muscles to facilitate breathing. Which of the following orders would the nurse MOST likely implement to reduce the patient's confusion and disorientation?**

- **Oxygen therapy**
- **Chest physical therapy**
- **Bronchodilators**
- **Hydration fluids**

- **Answer : A**

- **138. A 6-month-old boy is admitted with a diagnosis of failure to thrive. According to the growth chart at 3 months of age the infant's weight is in which percentile?**

- **25th**
- **5th**
- **10th**
- **Below the 5th**

- **Answer : B**

- **. A patient is 2-days post operative hernia repair and has an order for a dressing change patients has been diagnosed with auto immune deficiency disease syndrome(AIDS). While performing the dressing change the nurse should take which of the**

following actions?

- **Put the patient in a private room**
- **Wear gloves during the dressing change**
- **Wear gloves gown, and mask during dressing change**
- **Put the patient in reverse isolation**

- **Answer : C**

- **. When administering an enema to adult patient, how far should the nurse insert the tubing into the rectum?**

- **2.2 to 4.4cm (1 to 2 inches)**
- **4.4 to 6.6cm (1 to 3 inches)**
- **6.6 to 8.8cm (3 to 4 inches)**
- **8.8 to 11cm (4 to 5 inches)**

- **Answer : C**

- **. A nurse is implementing nursing interventions to monitor a patient following kidney surgery. Which of the following complications would be the MOST likely post operative risk after renal surgery?**
- **Deep vein thrombosis**
- **Hemorrhage**
- **Nausea**
- **Hemiparesis**

- **Answer : B**

- **. As per of a neurological assessment, which of the following is associated with the higher score on the Glasgow**

coma scale?

- **Eye opening to pain, no verbalization**
- **Confused, obey commands**
- **Localized pain, abnormal extension**
- **Eye opening to speech confused**

- **Answer : B**

- **. While caring for a patient prior to surgery to amputate the leg. What is the MOST affective measure to prevent phantom limb sensation after the amputation?**

- **Control pain prior to the surgery**
- **Make sure the patient understands the procedure**
- **Elevate the limb on two pillows**
- **Help the patient grieve for the limb**

- **Answer : D**

- **If a patient develops a complication during a blood transfusion, the nurse's first action should do to:**

- **Stop the transfusion**
- **Notify the practitioner**
- **Administer anantihistamine**
- **Administer an anti-inflammatory medication**

- **Answer : A**

- **. A patient has an elevated prothrombin (PT) time. Which**

medication should the Nurse consider as a possible cause of the elevated PT Time?

- **Rifampin**
- **Vitamin K**
- **Birth control pills**
- **Phenytoin (Dilantin)**

- **Answer : C**

- **. A home care nurse visits a patient with a new-below-the knee amputation. The site of the incision is red, warm and tender with purulent yellow drainage. The patient has a new prescription for cephalexin (Keflex) and oxycodone(oxycontin). What would the nurse instruct the patient to do FIRST?**

- **Take oxycodone as soon as possible**
- **Take cephalexin as soon as possible**
- **Wash the incision site and apply bacitracin cream**
- **Wash the incision site and apply hydrocortisone**

- **Answer : C**

- **. A patient has the following order: cephalexin (keflex) 500 milligrams (mg) by mouth 4 times a day. The pharmacy has the following dose: 250mg per 5milliliters (ml). The nurse should administer:**

- **5ml**
- **10 ml**
- **15 ml**

- **20 ml**

- **Answer : B**

- **A marathon runner experiences a sudden onset of sharp pain in calf immediately after a workout. The nurse in the clinic notes mild swelling of the calf and tenderness to touch. Which of the following would the nurse suspect the patient is experiencing?**

- **Bursitis**
- **Tendonitis**
- **Plantar fascitis**
- **Joint dislocation**

- **Answer : C**

- **. A mastectomy patient has developed lymphedema of the left arm. The nurse should teach the patient that the BEST position for the arm is:**

- **Immobilized across the chest**
- **Dependent**
- **Elevated**
- **In traction**

- **Answer : C**

- **. A patient is seen in the emergency room for a 20cm (7.8 inch) laceration to the right fore arm. The course prepares for which type of anesthesia**

to be administered before the laceration is repaired by the physician?

- **Intravenous**
- **Regional**
- **General**
- **Local**

- **Answer : B**
- **. A nurse in a community health clinic is in charges of immunizations. When patients visits the clinic the nurse knows that immunizations should be reviewed:**

- **At the age they are scheduled to be administered**
- **One month prior to recommended immunization schedule**
- **At every clinic visit**

- **At monthly intervals**

  - **Answer : C**

- **. A child was admitted to the hospital three hours ago with a closed head injury. The child responds appropriately but sluggishly to stimuli, and drift in and out of sleep. Which of the following best describes this patient's level of consciousness?**

- **Lethargic**
- **Obtunded**
- **Semi comatose**
- **Comatose**

  - **Answer :B**

- **. A healthy patient is in doctor's office**

for a pre operative visit before a total replacement. The nurse interviewing the patient charts the following medications: aspirin 81 mg once a day, vitamin E 260 international units once a day, and unknown amount of a herbal supplement once a day, based on the patient's medication list which of the following labs would be important pre operatively?

- **Prostate specific antigen(PSA)**
- **Blood glucose**
- **Creatine phosphokinaseisoenzymes (CPK enzymes)**
- **Prothrombin time**
-
    - **Answer : D**
- **A patient with long-standing diabetes mellitus (type I) is scheduled for surgical amputation of 4 gangrenous toes on the right foot. Which surgical**

intervention would this be classified as?

- **Palliative**
- **Curative**
- **Reconstructive**
- **Diagnostic**

  - **Answer : A**

- **. The nurse is caring for a patient who just had a chest tube inserted due to spontaneous pneumothorax. An appropriate goal is that the patient will:**

- **Be free of pain with in 4hours**
- **Report decreased pain**
- **Rest quietly**
- **Sleep with few movements**

  - **Answer : C**

- **. A patient with the deep vein thrombosis (DVT) is being treated with a low-molecular weight heparin.(LMWH). The patient reports increased pain in the affected extremely. The nurse observe the affected extremity has increased in size by 0.2 cm (0.8 inches) during the past 24 hours. Which of the following actions should the nurse take?**
  - **Administer the next dose of LMWH before the scheduled time.**
  - **Apply dry heal to the site**
  - **Elevate the extremity**
  - **Reinforce the importance of ankle circling exercises**

    - **Answer : C,**

- **. A physician orders Lactated Ringer Solution to infuse at 125 cc/ hour. This is an example of which type of solution?**

- **Hypotonic**
- **Isotonic**
- **Hypertonic**
- **Hyper alimentation**

- **Answer : B**

- **A physician orders an intravenous fluid of D5NS at 100cc/ hr. This is an example of which of the solution?**

- **Hypotonic**
- **Isotonic**
- **Hypertonic**
- **Hyper alimentation**

- **Answer : C**

- **. A patient is in the preoperative area to lumbar surgery. The patient reports anxiety about being intubated and expresses concern about waking up during the surgery. The nurse MUST discuss the patient's concern with the**

- **Anesthesia provider**
- **Surgeon**
- **Scrub nurse**
- **Charge nurse**

- **Answer : B**

- **The nurse is caring for a patient diagnosed with human immune**

deficiency virus. Which of the following nursing diagnoses takes priority?

- **Diarrhea related to medication side effects**
- **Risk for infection related to inadequate immune system**
- **Imbalanced nutrition relate to decreased appetite**
- **Impaired tissue integrity related to cachexia and malnourishment**

- **Answer : B**

- **. A nurse assesses a 3-month-old infant. The patient expresses anxiety and feeling over whelmed. The nurse offer information on available parenting**

support. This level of child abuse prevention is classified as which of the following?

- **Intervention**
- **Primary**
- **Secondary**
- **Tertiary**

- **Answer : B**

- **The nurse is caring for a patient with a coronary thrombosis who is receiving prescribed streptokinase (streptase). The patient reports the onset of a rash as well as feeling hot while experiencing chills. The nurse should**

IMMEDIATELY implemented the plan of care for:

- **A medication side effect**
- **An allergic embolus**
- **A Pulmonary embolus**
- **Peripheral artery occlusion**

- **Answer : B**

- **. The nurse is teaching a patient who was just diagnosed with narcolepsy. The nurse should teach the patient that which of the following typically INCREASES the level of fatigue?**

- **Taking brief naps**
- **Participating in anexercise program**
- **Eating large meals**
- **Working in a coolenvironment**

- **Answer : B**
- **. The physician has prescribed quinidine polygalacturonate (Apo-Quinidine), 8.25 mg/ kg every 4 hours for a patient who weighs 50kgs. The drug is available as a 275 mg tablet. The nurse should administer how many tablets for each dose?**

- **2.5**
- **2**
- **1.5**
- **1**

    - **Answer : C**

- **The nurse is teaching the parent of a**

child with celiac disease.Which of following diets should be reviewed with the parent?

- **Gluten-free**
- **Dairy free**
- **Vegetarian**
- **Sodium-restricted**

- **Answer : A**

- **A patient has peripheral vascular disease.The nursing diagnosis is ineffective tissue perfusion: peripheral.Which of the following is an appropriate goal?**

- **The patient will identify three factors to improve peripheral circulation**
- **The patient will have palpable**

peripheral pulses in1week

- **The patient's feet will be warm to touch**
- **The patient will ambulate the length of the hall way**

- **Answer : B**

- **On the second day of hospitalization for ventriculoperitoneal shunt revision, a child with spina bifida developed hives, itching and wheezing. The nurse should determine if the patient has been exposed to:**

- **Peanuts**
- **Strawberries**
- **Eggs**

- **Latex**

- **Answer : D**

- **A patient with malignant cancer has decided to stop chemotherapy and receive hospice care. What is the PRIORITY nursing diagnosis?**

- **Alteration in comfort**
- **Hopelessness**
- **Powerlessness**
- **Non-compliance**

- **Answer : B**

- **A nurse assessing a 16-month-old child observes bruises scattered over the body that are at different stage of healing. The child also has poor and diaper rash. The goal of treatment for this child is to:**
  - **Ensure the physical and emotional safety of the child**
  - **Remove the child from the parents**
  - **Admonish the parents of the child**
  - **Ensure that the child stays with the biological parents**

- **Answer : A**

- **While visiting a patient who had a left hip replacement surgery one week ago, the Patient complains to the home care nurse of episodic numbness and tingling of the lower left extremities. Assessment of the patient shows that the lower left extremities are slightly cool to touch when compared to the lower right extremities. There is no swelling or redness on assessment. What would be the NEXT nursing intervention?**

- **Reassure the patient that this normal after surgery**
- **Refer the patient to the surgeon immediately**
- **Encourage the patient to decrease**

activities involving the left hip and extremities

- Refer the patient to a physical the rapist immediately

- Answer : C

- . A nurse is evaluating a patient 5 days after a right total hip replacement. Which of the following goals is appropriate for the patient?

- Maintain hip abduction without dislocation
- Rest with legs elevate while sitting
- Tie shoes and put on undergarments without assistive devices
- Perform scissors-like leg exercise daily

- **Answer : A**

- **. Prior to providing care for a hospitalized infant, the nurse MUST:**

- **Introduce self to parent**
- **Perform hand hygiene**
- **Have a witness present**
- **Assess the child'sdevelopmental level**

- **Answer : B**

- **When caring for a patient with new sigmoid colostomy, the nurse knows that the stoma may be expected to decrease in size from up to:**

- **One months**
- **Two months**
- **Six months**
- **One year**

- **Answer : A**

- **A 7-week-old infant boy is admitted with projectile vomiting decreased urine output, decreased bowel movements and weight loss. He has poor turgor and appears hungry. The nurse observes left-to right peristaltic waves after he vomits. The nurse would expect to find which of the following during the physical assessment?**

- **Hepato-spleenomegaly**
- **A palpable pyloric mass**
- **Lymphadenopathy**
- **Bulging fontanelles**

- **Answer : B**

- **A nurse will need to change the dressing on a patient's central venous catheter during the shift. The nurse should plan to:**

- **Limit the patient's activity for an hour dressing change**
- **Position the patient on to the left side before removing the old dressing**
- **Put on sterile gloves after explaining the procedure to the patient**
- **Cleanse the insertion site using a circular motion**

- **Answer : B**

- **During the postoperative period, a nurse is assigned to care for a morbidly obese patient with an abdominal incision. The nurse knows that this patient's weight increases the risk of:**

- **Left-sided heart failure**
- **Pressure sores of the coccyx**
- **Constipation and ileus**
- **Wound dehiscence**

- **Answer : D**

- **Which of the following takes place during the implementation phase of the nursing process?**
- **Development of a goals and a nursing**

care plan

- Identification of actual or potential health problems
- Actualization of the care plan through nursing interventions
- Determination of the patient's responses to the nursing interventions

- Answer : C

- For a patient with a colostomy, which of the following-intervention is appropriate for preventing the risk of the impaired skin related to exposure excretions?

- **Empty pouch when it is completely full**
- **Remove the skin barrier inspect the skin monthly**
- **Recaps Skin barrier opening to size of stoma with each change**
- **Cut an opening in the skin barrier then the circumference of the stoma**
    - **Answer : B**

- **An infant who weighs 9 kg (19.8 lbs) requires 900ml of fluids per day for maintenance fluids. The infant typically consumes 120ml during each feeding. The infant must have how many feedings per day to meet the fluid maintenance needs?**

- **4**

- **8**
- **10**
- **12**

- **Answer : B**

- **A patient has pacemaker implanted. Which of the following interventions is appropriate for the nursing diagnosis of risk for injury?**

- **Have patient avoid exposure to magnetic resonance imaging(MRI)**
- **Observe incision site for redness, purulent drainage,**

- **Offer back rubs to promote relaxation**
- **Instruct patient in dorsiflexion exercises of ankles**

- **Answer : A**

- **A patient undergoing treatment for cancer with bone metastasis is experiencing severe pain. Which of the following treatment would the nurse MOST likely expect to improve the patient's pain control?**

- **Adjuvant radiation therapy**
- **Palliative radiation therapy**
- **Curative radiation therapy**
- **Radio surgery (stereotactic)**

- **Answer : B**

- **A home care nurse visits a patient with diabetes. The patient cast three well balanced meals sweet dessert and exercises 30 minutes a day twice a week. Also, the patient is complaint with taking hypoglycemia medications Blood glucose level ranges from 150-200 mg/ dl. The nurse sets a goal of eliminating sweet desserts and increasing the frequency of exercises to 3 times a week. This week, the patient exercised 3 times for 30 minutes and ate dessert only after dinner. The glucose ranges from 100-150 mg/ dl. The nurse evaluate that:**

- **The goal will not be met**
- **Progression is being made towards the goal**
- **The goal is met**
- **The goal is inappropriate**

- **Answer : B**

- **A nurse is assigned to care for a patient with an ileostomy. The nurse would expect the ostomy discharge to be:**

- **Fluid mushy**
- **Mushy**
- **Liquid**
- **Solid**

- **Answer : C**

- **A nurse educates a patient diagnosed with diabetes, on the importance of exercise and a well-balanced, low-carbohydrate diet. The patient takes metforin(glucophage) 500 mg once a**

day. Which following indicates the patient's plan of Care needs to be re-evaluated?

- **Blood glucose level is 90mg/ dl**
- **HbA1C (glycosylated hemoglobin)level is 9.0%**
- **Total H DL level is 60mg/ dl**
- **Low density Lipoprotien is130 mg/ dl**

- **Answer : B**
- **A nurse schedules a patient for a surgical procedure to take place in 1week. When would the nurse MOST likely implement surgical education?**

- **After admission to the hospital**
- **Start during this visit**
- **Immediately prior to anesthesia**
- **After the operation**

- **Answer : B**

- **The nurse is inserting a nasogastric (NG) tube into a patient as prescribed. The nurse has advanced the tube into patient's posterior pharynx. The nurse should ask the patient to:**

- **Hold the breath**
- **Stare upwards with eyes towards the ceiling**
- **Perform the valsalvas maneuver**
- **Lower the chin towards the chest**

- **Answer : B**

- **A home care nurse visits a diabetic patient who was started on insulin injections. Upon examination, the nurse observes small lumps and dents**

on the right upper arm where the patient has injected insulin. What is the BEST nursing intervention?

- **Refer patient to dermatologist for diabetic cellulites**
- **Instruct the patient to rotate the sites of injection**
- **Refer patient to an endo forbetter control of glucoselevel**
- **Instruct patient to inject inthe muscular area instead ofa endoarea**

- **Answer : A**

- **After cardiac surgery, a patient has been prescribed low-sodium, low cholesterol diet. Which of the following menus is BEST?**

- **Salami, rye bread, sanerkrant**
- **Baked chicken thigh, iceberg lettuce, sliced tomatoes**
- **Pasta with canned tomato sauce, peas, wheat bread**
- ***Bacon, lettuce and tomato sandw*ich with mayonnaise dressing**

- **Answer : C**

- **A home health nurse visits a patient with chronic obstructive pulmonary disease (COPD) using home oxygen at 2 liters per minute. The patient reports periods of shortness of breath and inquires about increasing the oxygen**

to 4 liters/ minute. The nurse explains that increasing the supplemental oxygen will:

- **Increased activity tolerance**
- **Suppress the hypoxic drive**
- **Alleviate the shortness ofbreath**
- **Prevent lung infection**

- **Answer : B**

- **The nurse should avoid the use of the dorsogluteal site for an intramuscular injection in children because of the risk of injury to which of the following nerves?**

- **Vagus**
- **Sciatic**
- **Llioinguinal**
- **Lumbar plexus**

- **Answer : B**

- **Twelve hours after removal of a benign liver tumor, the nurse observed that the patient has decreasing blood pressure, decreasing pulse pressure, increasing heart rate and increasing respiratory rate. The patient's skin is cool and pale after lowering the head of the bed, what should the nurse do next?**

- **Call the physician**
- **Administer pain medication**

- **Position the patient on the left side**
- **Apply cool, wet cloths under the arm**

- **Answer : A**

- **. The nurse is assigned to care for an elderly patient with a low-exudates stage III pressure ulcer, which of the following types of dressings would the nurse MOST likely plan to use?**

- **Hydrogel**
- **Hydrocolloid**
- **Polyurethane**
- **Polyurethane foam**

- **Answer : B**

- **A patient with an unnecessary gait and a history of falls has a care plan intervention that includes keeping the walker in reach and pathway free of obstacle. On evaluation after 1 week, the patient has had no falls, but the gait remains unsteady. The nurse should:**

- **Continue the plan of care as written**
- **Allow the patient to replace the walker with a cane**
- **Allow the patient to ambulate short distance without the walker**
- **Have the patient practice stepping over small objects**

- **Answer : A**

- **The nurse is caring for a patient who had a total proctocolectomy 24 hours**

ago due to a malignant neoplasm in the rectum. The patient continues to receive intravenous fluids and has started a clear liquid diet. The nurse understands that the patient is at INCREASED risk for which of the following postoperative complications?

- **Dissemination intravascular coagulopathy (DIC)**
- **Atelectasis**
- **Syndrome of inappropriate anti-diuretics hormone(SIADH)**
- **Hypokalemia**

- **Answer : D**

- **. When doing community-based teaching for latex allergies, the nurse should plan to teach the patient that :**

- **Food handled by people wearing latex gloves stimulates an allergies response**
- **Food containing nuts may trigger an allergic cross-response in people with latex allergies**
- **The patient should wear a face while in the hospital due to large amount of airborne latex**
- **Hoses used on gases pumps contain latex and should be avoided.**

- **Answer : B**

- **The nurse is assessing 16-month old girl. The nurse observes poor hygiene, diaper rash and bruises over the child's body that is at different stages of healing. Which of the following interventions would reduce fear and**

promotes the trust of the child?

- **Avoid scaring the child by saying "No or setting limits**
- **Challenge the information the parents give regarding the injury**
- **Question the parents of the child regarding the abuse**
- **Assign one nurse to care for the child over the course of hospital stay**

- **Answer : C**

- **A patient is who is prepared for hip surgery has an order for external pneumatic compression devices. The nurse teaches the patient that pneumatic compression can help prevent:**

- **Upper respiratory infection**
- **Decreased breath sounds**
- **Deep vein thrombosis**
- **Bleeding at the surgical site**

- **Answer : C**

- **A patient presents with a productive cough with a moderate amount of while Frothy sputum and dispend. The patient is anxious and the nurse notices on assessment that the patient is using accessory muscle including intercostals spaces to breathe and has jugular vein distention. The patient has a history of hypertension and heart failure. What should the nurse administer FIRST?**

- **Digoxin (lanoxin) toimprovethe abilityof the heart topump effectively**

- **Oxygen therapy to combathypoxemia**
- **Furosemide (lasix) toreduce blood volume andpulmonary congestion**
- **Morphine sulface(Duramorph) to reduceanxiety**

- **Answer : A**

- **A nurse is preparing to meet with an individual whose spouse recently diagnosed with Alzheimer's disease. The nurse should know that the primary goals of treatment are:**

- **Curing the Alzheimer'sdisease**
- **Maximizing the functional ability and improve quality of life**
- **Having the Alzheimer's patient placed in a safe controlled environment**
- **Making all decisions for the patient**

and confirming to home

- **Answer : B**

- **A Community nurse interviews an 87-year-old patient diagnosed with early Alzheimer's disease. Because the patient provides conflicts information, the nurse compares subjective and objectives data to find a possible reason for the conflicting data. This process of assessment is called:**

- **Data verification**
- **Analytical interpretation**
- **Mental assessment**
- **Subjective observation**

- **Answer : A**

- **The nurse assesses an elderly patient for health problem. The family reports that the patient has trouble remembering and they are concerned about Alzheimer's. Which of the following are risk factors for Alzheimer's disease?**

- **Genetic history and male gender**
- **Ethnic group and dietary habits**
- **Genetic history and female gender**
- **Dietary habits and male gender**

- **Answer : C**

- **A patient with Alzheimer's disease has a fall, which results to a fracture of the right leg, after repair of the fracture the patient is discharged home with family with instructions of wound care, the family verbalizes that the patient has been doing well ,which of the following instructions would the nurse give to the family?**

- **Instruct the family how to provide skin integrity**
- **Suggest to the family that if the stress is overwhelming ,placement in a skilled nursing facility may be needed**
- **Suggest collecting the patient on a regular schedule and applying**

incontinence brief at all times

- Assess for the cause of incontinence and add an appropriate nursing diagnosis post and interventions

- Answer : A

- . A nurse assists a patient with Alzheimer's disease in teeth brushing. The patient indicates warning to complete the task alone, but is unable to get the toothpaste on the toothbrush. The nurse can MUST effectively help the patient by:

- Providing privacy to complete the task
- Completing task
- Providing hand-over-hand assistance with the task
- Telling the patient to brush the teeth

today

- **Answer : C**

- **A child with iron deficiency complains of feeling tired all the times. The nursing diagnosis of fatigue is related to:**

- **A decreased ability of the blood to transparent oxygen to the tissues**
- **An increased paroxysmal abdominal pain and distension to the stomach**
- **A decreased anxiety level during hospitalization**
- **A decreased nutritional intake with malabsorptionofnutrition**

- **Answer : A**

- **A patient arrives in the emergency room with burns over the upper trunk and arms. The nurse should obtain the patient's pulse at which of the following arterial location?**

- **Radial**
- **Carotid**
- **femoral**
- **Apical**

- **Answer : C**

- **A patient with a spinal cord injury states, "I have no control over my situation, I can't do anything for myself". This patient is exhibiting:**

- **Powerlessness**
- **Delusions**
- **Suicidal ideation**
- **Resignation**

- **Answer : D**

- **A nurse is teaching a prenatal class to a group of the first time mothers, each at different points in their gestation, which of the statement is TRUE regarding the management of fatigue?**

- **Rest flat on back, especially during the third trimester**
- **Exercise programs should focus on their training**
- **Frequent 15 minute to 30minute rest periods are important**
- **Six hours of sleep a night is adequate**

- **Answer : C**

- **A nurse is caring for a postoperative patient who is on subcutaneous, low dose heparin. This medication is used to prevent:**

- **Deep vein thrombosis**
- **Congestive heart failure**
- **Paralytic Ileus**
- **Pneumonia**

- **Answer : A**

- **A Patient is recovering following**

surgery for placement of a colostomy. The nurse goes to the patient's room to instruct the patient how to care for the colostomy. The patient's roommate has visitors and the patient does not want to participate at this time. What should the nurse do?

- **Document the patient's refusal and add non-compliance to the care plan**
- **Tell the patient that this is vital information and may delay discharged**
- **Plan a time convenient to both the patient and the nurse**
- **Pull the curtain around be bed and speak, ensuring privacy**

- **Answer : C**

- **Which of the following actions would be appropriate for the nurse to take when Caring for a patient on contact precautions?**

- **Serve the patient's meals on the disposable with plastic eating utensils**
- **Instruct visitors to talk to the nurse before entering the patient's room**
- **Rinse both hands with water after removing gloves**
- **Place a surgical mask on the patient during transport**

- **Answer : B**

- **. A patient is recently diagnosed with**

Herpes Zoster. The nurse establishing the care plan would MOST likely assign the highest priority to which of the following nursing diagnosis?

- **Anxiety**
- **Social Isolation**
- **Peripheral neurovascular dysfunction**
- **Acute pain**

ANS D

- **In order to reduce the risk of disease transmission from a patient with diphtheria, which of the following standard precautions would be the nurse implemented?**

- **Airborne**
- **Contact**
- **Droplets**

- **Ventilatory**

  - **Answer : C**

- **A patient with measles (rubella) is on airborne precautions, which of the following Precautions techniques would be ESSENTIAL to implement for non-immune person entering the room?**

  - **Gloves**
  - **Gowns**
  - **Face shields**
  - **Masks**

  - **Answer : D**

- **A patient sustained multiple musculoskeletal trauma after a motor vehicle collision and is now in skeletal traction awaiting surgery. The nurse observes that the patient has developed a large area of flat, Pin point purple-colored areas on the thorax. Which of the following actions would be appropriate for the nurse to take?**

- **Discontinue the opioid that is being administered**
- **Place an extra blanket on the patient**
- **Release the weights on the patient's skeletal traction**
- **Administer diphenhydramine(Benadryl) prescribed p.r.n allergic reaction**

  - **Answer : D**

- **A physician has ordered gavage**

feeding every 4 hours for a 12-week-old infantwith failure to thrive. In order to know how far to insert the feeding tube. The nurseshould measure the distance from:

- **The infant's mouth to the xiphoid process of the sternum**
- **The tip of the infant's nose to the ear and then to the umbilicus**
- **C.The infant's mouth to the ear and then to the umbilicus**
- **The tip of the infant's nose to the ear and then to the xiphoid process of the sternum**

- **Answer : D**

- **. A nurse is assessing an infant**

diagnosed with failure to thrive. In addition to accurate anthropometric measurements, complete nutritional history, infant feeding ability, and head-to-toe assessment the nurse should asses which of the following

- **Parent-to-child interaction**
- **Number of sibling in the home**
- **Current sleep patterns**
- **Exposure to second hand smoke**

- **Answer : A**

- **A school nurse refers a child who failed the school vision screening for eye doctor. The child returns with glasses to be worn at all times. The nurse should monitor this child for:**

- **Redness of the eye**
- **Episodes of seizures**
- **Improved vision with glasses**
- **Lazy eye**

  - **Answer : C**

- **A2-years-old child in the emergency department exhibits symptoms of bacterial meningitis. Which of the following tests confirm or rule out this diagnosed?**

- **Magnetic resonanceimaging (MRI)**
- **Magneto encephalogram**
- **Computed tomography scan(CT)**
- **Lumbar puncture (LP)**

  - **Answer : D**

- **A patient exhibits clinical manifestation of a pulmonary embolism. Arterial blood gas (ABG)levels and a chest x-ray are ordered. Which of the following test is used to diagnose this condition?**

- **Computer tomography scan(CT scan)**
- **Magnetic resonanceimaging (MRI)**
- **Pulmonary angiography**
- **Pulmonary function test**

- **Answer : C**

- **A patient is admitted to the emergency department with a sucking, chest**

wound has diminished breath sounds or auscultation. Which of the following interventions would the nurse perform FIRST?

- **Monitor O2 saturation and arterial blood gas (ABG)levels**
- **Apply Petroleum Gauze to wound**
- **Prepare the patient for emergency thoracentesis**
- **Position the patient in anupright position.**

  - **Answer : <u>B</u>**

- **A patient has pulmonary embolism. Which of the following nursing diagnoses has PRORITY?**

- **Anxiety related to pain,dyspnea, and concern of illness**
- **Risk for injury related to altered hemodynamic status**
- **Acute pain related to congestion and possible lung infarction**
- **Ineffective breathing pattern related to acute increase in alveolar dead air space**
    - **Answer : D**

- **Which test should be added to the yearly physical of a patient who has recently turned 50 years old?**

- **Culture and sensitivity**
- **Fecal occult blood**
- **Routine urine analysis test**
- **Angiography studies**

- **Answer : A**

- **The normal range of pH in arterial blood is:**

- **7.15-7.20**
- **7.25-7.30**
- **7.35-7.45**
- **7.50-7.55**

- **Answer : C**

- **To prevent pressure on the feet of a bed-bound patient with decreased tissue perfusion, the BEST intervention the nurse should take is:**

- **Place sheep skin under the heels**
- **Place a foot cradle on the bed**
- **Pad the side rails with foamtubing**
- **Use only natural fiber linens**

- **Answer : D**

- **The nurse assists with a lumbar puncture on a child with suspect bacterial meningitis. If the diagnosis is correct, the cerebrospinalfluid, should have which of the following qualities?**

- **High glucose level**
- **Low protein level**
- **Cloudy or turbid appearance**
- **Pink or blood-tinged appearance**

- **Answer : C**

- **An elderly patient with severe degenerative joint disease comes to the clinic for routine follow up of pain management. The patient reports that over the past month, the pain has begun to increase in severity. The**

patient requests an increase in dosage of the pain medication. The nurse recognize that this is MOST likely due to:

- **Drug addiction**
- **Drug tolerance**
- **An improvement in condition**
- **Lack of efficacy of the current medication**

- **Answer : D**

-
- **A patient has hepatitis B (HBV) and is now a chronic carrier. In planning care, the nurse would explain an HBV carrier would MOST likely be at risk for developing a super infection with which other type of hepatitis?**

- **A**
- **C**
- **E**
- **D**

- **Answer : B**

- **. A preoperative patient has a large volume cleansing enema ordered. In order to facilitate the flow of the solution into the rectum and colon, the nurse should position the patient in the:**

- **Supine position with legs flexed to chest**
- **Right lateral position with left sharply flexed**
- **Supine position with legs spread**
- **Left lateral position with right leg sharply flexed**

- **Answer : D**

- **Respiratory depression is a potentially life-threatening adverse effect of**

- **Opioids**
- **Anticoagulants**
- **Immuno modulators**
- **Non-steriodials (NSAIDS)**

- **Answer : A**

- **A child in the postictal state of a seizure should show which of the following signs or symptoms?**

- **Feeling sleepy or exhausted**
- **Stiffness over entire body**
- **Verbalizes having an aura**
- **Eyes fixed in one position**

- **Answer : A**

- **Standards of pain management dictate the nurses:**

- **Administer analgesic via injection whenever possible**
- **Avoid the use of the word “pain”**
- **Screen for pain at each encounter**
- **Discourage around-the clock dosage of analgesics**

- **Answer : C**

- **The nurse observes a patient who is eating. The patient suddenly stands up, places both hands onto the neck and is unable to speak when the nurse asks if the patient can speak. The nurse observes that the patient is neither coughing not cyanotic. The nurse should IMMEDIATELY:**
  - **Lay the patient flat before compressing the mediastinal area**
  - **Insert a finger into the patient's mouth to feel for any food**
  - **Stand behind the patient while performing abdominal thrusts**
  - **Activate the emergency call light near the patient**

- **Answer : C**

- **A patient required long-term antibiotic has a central line catheter inserted into the right subclavian vein by the physician .Which of the following must be verified prior to the first use of the catheter?**

- **Blood return**
- **X-ray**
- **Catheter potency**
- **Length of catheter**

- **Answer : B**

- **. When planning discharge teaching for a patient hospitalized for treatment of third-degree burns over 30% of the body, the nurse knows it is MOST**

important to include which of the following instruction regarding the loss of large amounts of serum occurring with burns and the resulting loss of immune function?

- **Wash hands frequently each day**
- **Wear masks while in public spaces**
- **Wear supplement oxygen at night**
- **Take a multiple vitamin tablet each night**

- **Answer : A**

- **. Which of the following is the MOST important discharge planning instruction for a patient with mononucleosis?**

- **Avoid activities that may increase injury to the spleen**
- **Avoid crowded areas to prevent the spread of infection**
- **Consume vitamin K rich food to decrease the risk of bleeding**
- **Take an antibiotics a prescribed to treat infection**

- **Answer : B**

- **. Which of the following tests measures the total quantity of prothrombin. In the blood and monitors the effectiveness of warfarin sodium (coumadin) therapy and prolonged defficiencies in the extrinsic factor?**

- **Thrombin time (TT)**

- **Prothrombin time (PT)**
- **Partial prothrombin time(PTT)**
- **Activated partialthromboplastin time (aPTT)**

- **Answer : B**

- **While conducting a class for expected mothers, the nurse explains the difference between true labor construction and false labor contraction by indicating that the labor contractions:**

- **Are located mainly in the abdomen and groin**
- **Have increasing intensity**
- **Occur with decreasing intervals**

- **Occur at regular intervals**

  - **Answer : B**

- **One month after starting new medications for hypertension, a patient returns to the clinic with blood pressure in the range. The patient admits to taking the medications only when "feeling bad" Which of the following actions would the nurse take?**
  - **Assess further determine the reason the reason for the patient's Actions**
  - **Add a new diagnosis of non-compliance**
  - **Re-educate the patient about the importance of following his medication plan**
  - **Reevaluate the need for daily medication since the blood pressure is acceptable**

- **Answer : C**

- **A home care nurse visits a patient who is wheelchair bound due to recent motor vehicle accident. The patient has been sitting in the wheel chair for extended periods of time which resulted in the development of a stage pressure sore on the right buttocks. What is the BEST nursing intervention?**

  - **Instruct caretaker to change the patient's position every 2 hours**
  - **Apply hydrogel to the stage I pressure sore every 8 hours**
  - **Refer the patient to wound care specialist for debridement**
  - **Encourage the patient to consume an**

increased amount of calcium

- **Answer : A**

- **. Following an open-cholecystectomy, the nurse would instruct the patient to expect to resume normal activities in:**
- **1 to 2 weeks**
- **2 to 3 weeks**
- **4 to 6 weeks**
- **6 to 8 weeks**

- **Answer : A**

- **A patient had a retinal detachment surgically repaired. The nurse identified that the detachment would**

MOST likely be correct and unlikely to reoccur if the retina remains attached at LEAST:

- **3 days**
- **2 weeks**
- **2 months**
- **3 months**

- **Answer : B**

- **. A home care nurse visits an elderly patient who had a surgical repair for fracture. The patient is taking opioid analgesics. Today, the patient complaints of decreased appetite and absence of a bowel movement for four days. Which of the following can be inferred?**

- **Constipation related to use of opioids**

- **Decreased appetite due to depression**
- **Constipation due to acute pain**
- **Decreased appetite due to use of opioid**

- **Answer : A**

- **. A child recently diagnosed with sickle cell anemia is being prepared for discharge. Which of the following statement by one of the parents would require ADDITIONAL teaching by the nurse?**

- **High altitudes can be beneficial**
- **Blood transfusion may be necessary in the future**
- **Strenuous physical activity should be**

avoided
- Increased fluid intake minimize pain

- Answer : A

- A 13-year-old child is hospitalized for treatment of sickle cell crisis. The nurse finds the child is crying and does not answer the nurse when addressed. What should nurse do FIRST?

- Interview the parents about the child's pain tolerance and usual medication requirements
- Medicate the patient with the medication ordered for breakthrough pain as soon as possible, the resume the evaluation
- Ask the child to describe the pain, it is located, and to rate it on the

wong/ baker pain scale.

- **Tell the child to rest while and the nurse will return at another time for the evaluation**

  - **Answer : B**

- **. The nurse is entering the room of a patient who is blind. The nurse should:**

  - **Speak before touching the patient**
  - **Talk to the patient using aloud tone of voice**
  - **Ask then patient questions that can be answered “yes”or “no”**
  - **Stand directly in front of the patient while talking**

    - **Answer : A**

- **A nurse has been visiting a bed-bound**

patient with decreased bowel mobility in the home for one month. The family tells the nurse that the patient is becoming incontinent of feces. The nurse evaluates the plan of care and notes which of the following intervention would MOST likely beneficial?

- **An enema two times a week**
- **Increased fiber in the diet**
- **Aroutinebisacodyl(Dulcolax) suppository**
- **An enema three times aweek**

- **Answer : B**

- **A bed-bound patient has a care plan with interventions to include re**

positioning every 2 hours. The patient develops a stage I pressure sore on the right heel. What intervention should be added to the care plan?

- **Massage the right heel four times per day**
- **Add a trapeze to the bed**
- **Float heels off bed with a pillow**
- **Add a bed cradle to the bed**

- **Answer : C**

- **A patient is receiving from surgery using spinal anesthesia. The patient develops a spinal headache. Which of the following nursing actions would be MOST appropriate?**

- **Elevate the head of the bed30 degrees**
- **Keep the patient well hydrated**
- **Limit intake of salty food**
- **Lower the temperature of the room**

- **Answer : B**

- **A nurse is giving discharge planning instruction to the parents of a 1-years old child with acute otitis media. Which of the following discharge instruction take FIRST priority?**

- **Administer antibiotics as prescribed**
- **Breastfeed as long as possible**
- **Administer influenza vaccination**
- **Avoid smoking around the child**

- **Answer : A**

- **Three weeks post amputation of the leg the patient is instructed to massage the residual limb. The MOST likely rationale for this to:**

- **Provide counter-irritation for pain control**

- **Prepare for a prosthesis**
- **Promote wound healing**
- **Promote acceptance of the limb's appearance**

  - **Answer : B**

- **A patient receives a blood transfusion for severe anemia after surgery. While evaluating the patient the nurse finds that the patient's oral temperature has began to rise from 98.2^{0}F (36.8^{0}F) to 101.0^{0}F(38.3^{0}C). What should the nurse do?**

- **Give the patient an anti-pyretic medication and continue the transfusion as ordered**
- **Discontinue the intravenousline and restart in anothersite**
- **Stop the transfusion, keep the vein open with normalsaline,and notify the**

doctor immediately

- **Use a blood cooling deviceto cool the blood as itinfuses**

  - **Answer : C**

- **The nurse is teaching a patient who has just diagnosed with bacterial conjunctivitis, The nurse should that the MOST effective way to transmission of this to other people is by**

- **Putting on clean gloves before cleansing the eye**
- **Taking medication as prescribe**
- **Wearing a gauze eye patch**
- **Performing hand hygiene**

- **Answer : D**

- **A nurse for a child with celiac disease (CD). The patient would have a permanent inability to tolerate:**
- **Protein**
- **Dairy**
- **Glutens**
- **Fruits**

- **Answer : C**

- **The nurse is caring for a patient who had an acute pulmonary edema. The nurse should understand that which of**

the following prescribed medications will help to reduce the increased pressure?

- **Morphine sulfate**
- **Potassium chloride**
- **Warfarin sodium(coumadin)**
- **Bisacodyl (dulcolax)**

- **Answer : A**

- **When planning discharge teaching for the parent of an infant with respiratory problems , the nurse should EMPHASIZE**

- **Use of supplemental oxygen at night**
- **Frequent hand washing**
- **Sleeping in the supine position**
- **Rice-thickened formula during night-time feedings**

- **Answer: C**

- **A nurse is caring for a child who is post-tonsillectomy and adenoidectomy. The nurse should plan to assess which of the following complications?**

- **Pulmonary hypertension**
- **Hemorrhage**
- **Hearing loss**
- **Corpulmonale**

- **Answer :B**

- **A patient has multiple sclerosis and complains of overwhelming fatigue. The nurse would be MOST correct in instruction the patient to:**

- **Conserve energy during activities of daily living**
- **Increase muscle strength through aerobic exercise**
- **Ignore fatigue and keep working**
- **Increase early afternoon intake of caffeine**

- **Answer : A**

- **While caring for an edentulous patient with multiple pressure sores, the nurse asked by the patient's spouse to evaluate several menus, Which of the following menus would be MOST therapeutic?**

- **Steamed carrots, milks and applesauce**
- **Tuna fish with mayonnaise, boiled eggs and yogurt**
- **Grilled steak, baked potato and peach**

pie
- Chicken noodle soup ,banana and cocoa

- Answer : A

- When administering an oral medication to a toddler, which of the following interventions should the nurse plan to use?

- Depress the child's chin with thumb to open the child's mouth
- Place the medication in a nipple for the child to suck
- Give the child a small plastic medication cup for day
- Tell the child that the medication tastes good

- **Answer : A**

- **The nurse is monitoring a patient's urine to determine hydration status what urine color would indicate the BEST hydration?**

- **Clear**
- **Amber**
- **Tea**
- **Pale gold**
-

- **Answer : B**

- **A patient is being evaluating due to**

onset of paleness, shortness of breath and sensations of heart palpitations. Which of the following component of complete blood count (CBC) should the nurse review to determine if the patient has anemia

- **Leukocytes**
- **Platelets**
- **Erythrocytes**
- **Thrombocytes**

- **Answer : C**

- **While a nurse is assessing a patient who reports indigestion that radiates into the jaw. The jaw pain is rated 8 scale of 0 (no pain) to 10 (severe pain). The patient reports the pain started an hour ago. The nurse should IMMEDIATELY:**

- **Assess the patient's oral temperature**
- **Determine what foods the patient ate**
- **Place the patient in reverse Trendelenburg position**
- **Obtain order and administer morphine sulfate**

- **Answer : D**

- **An elderly home-bound patient is visited by the community health nurse. During evaluation, decreased skin turgor is noted. When asked about fluids intake, the patient states that she does not drink any fluids after lunch each day, and wake sup very thirsty. The MOST appropriate question for the nurse to ask is:**

- **"How much protein does you normally eats for dinner?"**

- **“How much caffeine are you consuming each day?”**
- **“Are you having trouble controlling your bladder at night?”**
- **“Do you have enough money to buy liquids to drink?”**

- **Answer : C**
- **A nurse is caring for a patient who had rhinoplasty 2-weeks ago. Which of the following is an expected outcome?**

- **Oral mucus membranes dry ,but pink and intact**
- **Face and nose free from swelling**
- **Able to make needs know, speech therapy started**
- **Demonstrate throat clearing while eating**

- **Answer : B**

- **A patient presents to the emergency room with complaints of eye and drainage. In planning for the examination of the patients complaints, which of the following instruction would the nurse MOST likely select?**

- **Sphygmomanometer**
- **Thermometer**
- **Ophthalmoscope**
- **Otoscope**

- **Answer: C**

- **A home health nurse has completed**

the assessment of a 72-year-old patient with & gait disturbance that will begin home physical therapy. During the interview, the patient reported significant difficulty sleeping more than 4 hours at night. Which of the following responses would be appropriate for the nurse to make?

- **“Try doing some type of exercise two hours before bedtime”**
- **“Drink a cup of warm tea before you go to bed”**
- **“ Make sure the bedroom is dark when you get in bed”**
- **“ A nap in the middle of the day should help”**

  - **Answer : D**

- **A nursing is caring for a 3-weeks-old**

infant who was just admitted to the hospital. Which of the following nursing interventions does NOT support this infant's basic emotional and social needs?

- **Provide for continual contact between parents and infant**
- **Activity involve parents in caring for the infant**
- **Keep the infant's environment quiet, dim, and free of sensory stimulation**
- **Foster infant-sibling relationship as appropriate**

- **Answer : C**

- **. A home care nurse visits a patient who is discharged from a hospital after a treatment of urosepsis. Which of the following post discharge normal**

laboratory result BEST indicates desired outcome?

- **WBC count**
- **Hematocrit**
- **Platelet level**
- **Potassium level**

- **Answer : A**

- **A nurse visits a patient who is 37-weeks pregnant and asking for information about breast feeding versus feeding prepared infant formula. A beneficial reason to breast feed includes:**

- **Readily available and economical**
- **Keeps a baby full longer**
- **Larger curds than cow's milk and therefore is easier to digest**

- **Encourage greater deposits of subcutaneous fat in an infant**

  - **Answer : A**

- **When implementing a feeding schedule for a full term 2-weeks old infant, the nurse should expect the infant to be fed:**

- **2-4 times per day**
- **6-8 times per day**
- **10-12 times per day**
- **14-16 times per day**

  - **Answer : B**

- **A home care nurse makes a follow-up visit to a patient who had shingles. A month since the onset, the patient pain level is 6 on a scale of 1 to 10 where 1 is no pain and 10 is greater pain. Two weeks ago, the pain**
  Level decreases without any caring. The patient's condition has:

- **Met the expected outcome**
- **Partially met the expected outcome**
- **Has not improved**
- **Has worsened**
-
    - **Answer : A**

- **The nurse is in public area of the health care facility when an adult falls to the floor. Which of the following**

actions should the nurse take NEXT?

- **Open the airway**
- **Determine unresponsiveness**
- **Activate the emergency call system**
- **Obtain the automatic electronic defibrillator(AED)**

- **Answer : B**

- **When caring for a patient who is receiving anticoagulant medications, the nurse MUST monitor the patient, for signs of:**

- **Skin breakdown**
- **Bleeding**
- **Pain**
- **Confusion**

- **Answer : B**

- **A patient is being prepared for a right breast biopsy under general anesthesia. The patient asks the nurse about the surgical scar and possible postoperative complications. Which of the following actions would be appropriate for the nurse to take?**

- **Review the post operative risks with the patient**
- **Notify surgeon about the patient's questions**
- **Complete the patient's preoperative check list**
- **Show the patient photos of breast surgical scars**

- **Answer : B**

- **A patient with bowlegs due to abnormal bone formations and deformities has a calcium level of 7.5mg/ 100ml. Which of the following foods would the nurse MOST likely instruct the patients to add to a diet?**

- **Organ meats**
- **Whole grains**
- **Egg yolks**
- **Lean means**

  - **Answer : C**

- **A patient has just diagnosed with hypothyroidism. Which of the following instructions is correct?**

- **You will need to take thyroid hormone replacement therapy your Entire life**

- **You will need to take thyroid hormone replacement therapy until your laboratory result**
- **You will need to take thyroid hormone replacement therapy for about 2 months.**
- **You will need to take thyroid hormone replacement therapy for 1 year.**

- **Ans . A**

- **The stages of dying, as identified by Dr.Elizbathkubbler-ross, occur in what order?**
- **Anger, depression, bargaining, denial, acceptance**
- **Bargaining ,denial, acceptance, depression**
- **Denial, anger, bargaining, depression, acceptance**
- **Depression, Denial, Anger, bargaining,**

acceptance

- **Ans.C**

- **A co-worker informs that the nurse about experiencing increased level of stress associated with daily responsibilities to help cope with professional stress, the nurse should encourage the co-worker to ;**
  - **Make a list of unfinished tasks**
  - **complete complex mental task before physical tasks**
  - **Acknowledge daily accomplishments**
  - **Spend time with colleague away from work**

- **Ans . B**

- **A nurse is caring for a post operative patient who is on subcutaneous, low dose of heparin. When administering injection on the abdomen, the nurse avoids the umbilicus area because of the possibility of :**

- **Entering a larger body vessel**
- **Causing increased pain**
- **Precipitating hyper ventilation**
- **umbilical infection**

- **Ans . A**
- **A pt with conjunctivitis reports the presence of photophobia and moderate eye drainage. The nurse should teach pt to**

- **Avoid touching the eye**

- **use sterile gauze to remove the drainage**
- **Darken the room**
- **rest in the prone position**

- **ANS. C**
- **During surgery the pt has the following intake and output: IV fluid 650 cc ,IV antibiotic 50 cc , 1 unit of packed red blood cells 350 cc,nasogastric output 120 cc,estimated blood loss 80 cc,and urine in the folyes catheter 240 cc.wat is the patient's total intake**

- **650 cc**
- **700cc**
- **900 cc**
- **1050 cc**

- Ans. D

- A community health nurse assesses a 68-year-old patient who lives in a group home. The patient reports decreased appetite after transferring to the group home because the food tastes too bland. What type of data is the nurse collecting from the above information?

- Analytical
- Derived
- Objective
- Subjective

- Answer : D

- The home care nurse is providing wound care for a patient. The nurse evaluates the wound and notes the presence of granulation tissue in the wound bed. This observation

represents which phase of wound healing?

- **Maturation**
- **Inflammation**
- **Proliferation**
- **Finalization**

  - **Answer : C**

- **A nurse is caring for a 3-year-old child with a fractured arm. Which of the following interventions is the MOST appropriate for pain management?**

- **Administer analgesics when necessary**
- **Assess pain once a shift**
- **Anticipate pain and intervene early**
- **Encourage the use of self-quieting techniques**
  - **Answer : A**

- **Which statement by the patient with hyperlipidemia shows a basic understanding of the disease and it treatment?**

- **Exercise has no effect on cholesterol levels**
- **Hyperlipidemia is usually symptomatic until significant target organ damage is done**
- **HDL cholesterol level of greater the 60 mg/ dl increases the chance of coronary artery disease**
- **Cholestyramine (Quesram)should be taken in the morning with other medications**

  - **Answer : D**

- **A doctor has ordered an intramuscular**

injection (IM) for a 6 month-old infant after her IV infiltrated. Because infant have under developed muscles, the nurse should not administer the injection into which muscle?

- Vastuslaterlis
- Rectus femoris
- Ventrogluteal
- Gluteus maximus

- Answer : B

- A nurse caring for a patient with acute pulmonary edema observes that the patient's cough produces white, frothy and that the patient is extremely dyspneic. The patient has inspiratory and expiratory wheezing on auscultation of the lungs. The immediate objective of treatment is to

- **Improve oxygenation**
- **Decrease anxiety**
- **Improve tissue perfusion**
- **Decrease risk for aspiration**
-

- **Answer : A**

- **When discussing dietary choices with a patient who is on heparin therapy, the nurse should teach the patient that which of the following foods may increase clotting time?**

- **Grape fruit**
- **Oranges**
- **Bananas**
- **Red grapes**

- **Answer : B**

- **A 2-month-old child in the emergency department has projectile vomiting after feeding. The vomitus is nonbilious containing milk and gastric juices. Immediately after vomiting the child tries to feed again. The nurse palpates the child's abdomen during feeding and notes a firm area to the right of the umbilicus at the upper right quadrant. Which of the following is consistent with this history?**

- **Hypertrophic pyloric stenosis**
- **Hirschsprung's disease**
- **Gastro esophageal reflux**
- **Tracheoesophagel fistula**

- **Answer : A**

- **A patient undergoing cancer treatment has developed acute hypocalcaemia with sign of weakness, nausea and vomiting. Which of the following would the nurse anticipate to be the initial treatment?**

- **Thiazide diuretic**
- **Intravenous normal saline(0.9% NaCl)**
- **A potassium supplement**
- **Broad-spectrum antibiotic**

  - **Answer : B**
  -

- **The patient is receiving mechanical ventilation set at fraction of inspired oxygen (FIO2) 100%. The nurse should understand that which of the following**

can improve this patient's oxygenation?

- **Adding positive end expiratory pressure (PEEP)**
- **Placing the patient in Trendelenburg position**
- **Increasing the FIO2**
- **Suctioning the patient hourly**

- **Answer : A**

-

- **Which of the following nursing diagnosis takes PRIORITY for a patient after gastrointestinal surgery?**

- **Impaired skin integrity related to surgical incision**
- **Constipation related to surgery**
- **Risk for infection related to surgical**

incision

- **Acute pain related to surgical incision**

- **Answer : D**

- **Marijuana is an example of a drug classified as schedule:**

- **C-I**
- **C-II**
- **C-III**
- **C-IV**

- **Answer : A**

- **A patient with a weight loss of 12 in 60 days has a nursing care plan written interventions including offering a dietary supplement three times per day. After 2 weeks, the patient has had**

another 1% weight loss. The patient indicates no likely the supplements. The nurse should:

- **Continue the plan of care as written**
- **Replace the supplement with a high calorie food that the patient likes**
- **Encourage the patient drink supplements**
- **Offer smaller amounts of supplement more frequently**

- **Answer : B**

- **The nurse is caring for a patient with magnesium toxicity. Which of the**

following clinical manifestation should the nurse anticipate?

- **Paresthesia**
- **Decreased deep-tendon reflexes**
- **Cardiac palpitations**
- **Decreased cardiac output**

- **Answer : B**

- **A patient returning from a3-hour shoulder repair with generalanesthesia is being transported from the operating room (OR) to the post-anesthesia care unit (PACU). The nurse knows that the patient is at high risk for injury related to residual anesthesia. During this time period the patient is at LOWEST risk for**

- **Airway Obstruction**
- **Vomiting**

- **Impaired Circulation**
- **Fluid volume deficit**

- **Answer : B**

- **For a patient scheduled for a total pancrectectomy, the nurse would be instruct the patient that the procedure work MOST likely cause**

- **Pancreatic ascites**
- **Chronic pancreatitis**
- **Diabetes mellitus**
- **Diabetes insipidus**

- **Answer : C**

- **. A nurse is assessing an infant for possible deafness. Which of the following automatic reflexes would the nurse MOST likely check to best determine whether the child has a serious hearing problem?**

- **Blinking**
- **Vertical suspension**
- **Moro**
- **Perez**

  - **Answer : C**

- **. The nurse is teaching a group about aerobics exercises. When discussing the target heart rate for exercise, the nurse should state that this is calculated by:**

- **Counting the number of the heart beats during exercise for 6 sections, then multiply this number by 10**
- **Subtracting the chronological age from the number 220**
- **Counting then number of heart beats during exercise for 10 seconds, then multiply by 6**
- **Subtracting he chronological age from 240**

- **Answer : C**

- **. While performing an assessment on a post-surgical patient 2 days after surgery, the nurse notes shallow and rapid respirations. What should the nurse do NEXT?**

- **Asses the patient from pain**
- **Obtain an order from supplemental oxygen**
- **Elevate the head of the bed**
- **Place a warmed blanket on the patient**

- **Answer : C**

- **A patient is receiving intravenous fluids at a rate of 125 milliliters/ hour (ml/ hr). What volume fluids will the patient receive during an 8-hour shift?**
- **1,500 ml**
- **1 liter**
- **1.5 liters**
- **500 ml**

- **Answer : B**

- **A patient has a history of severe, uncontrolled epistaxis. The patient's blood pressure and patient count are normal. The nurse should teach the patient to**

- **Sleep with the head elevated on at least two three pillows**
- **Apply firm pressure to the nostrils four times a day**
- **Use a cotton-filled applicator to apply a water-soluble lubricant to the nasal septum twice daily**
- **Minimize the intake of caffeine while increasing theintake of fluids rich invitamin K**

  - **Answer : B**

- **A nurse is caring for an infant with respiratory distress syndrome. Which**

of the following nursing intervention is appropriate

- **Measure oxygen saturation level once a shift**
- **Suction frequently for 30-45second each time**
- **Monitor for symptoms of hyperglycemia**
- **Maintain infant temperature between 36.7^0& 37.8^0C(97^0& 98^0 F)**

- **Answer : A**

- **A nurse is caring a patient who had a left mastectomy with lymph node removal seven days ago. The patient asks about exercises to regain function of the left arm. Which of the followingactivities would be MOSTappropriate?**

- **Walking fingers up the wall**
- **Using five pound weights**
- **Knitting with a large needle**
- **Rhythmic clapping**

- **Answer : A**

- **. What occurs during cardiogenic shock and resultin inadequate tissueperfusion?**

- **Increased resistance of arterial vessels**
- **Decreased effectiveness of the heart as a pump**
- **Increased shunting of critical blood**

flow to heart
- Decreased capacity of the venous beds

- Answer : B

- The nurse is caring for child admitted with viralpneumonia. Which of the following nursingdiagnoses should receivePRIORITY?

- Nutrition altered: less thanbody requirements
- Ineffective airway clearance
- Fluid volume deficit
- Risk for injury

- Answer : B

- A child has ingested an entirebottle acetaminophen(Tylenol). Which ofthe following organs isaffected?

- **Liver**
- **Brain**
- **Kidneys**
- **Gallbladder**

  - **Answer : A**

- **A patient is seen in the emergency department with complaints of angina.Nitroglycerin (Nitrostat) isordered by the physician.This medication is to beadministered via which of thefollowing routes?**

- **Intradermal**
- **Buccal**
- **Parental**

- **Topical**
-
    - **Answer : B**

- **The nurse is teaching a groupof patient about hepatitis A(HAV). The nurse shouldstate that HAV is MAINLYtransmitted Via:**
    - **Blood contact**
    - **Food**
    - **Sexual activity**
    - **Saliva**

        - **Answer : B**

- **A child was recently diagnosed with spastic cerebral palsy. Which of the following statement by the parent would indicate to the nurse that parent**

understands teaching about illness?

- **Full recovery is possible**
- **This illness should not progress**
- **Cerebral palsy is a hereditary disease**
- **Surgery can sometimes improve walking**

- **Answer : D**

- **. A patient hospitalized with Crohn's disease has developed fever Increased respiratory rate, increased heart rate, chills, diaphoreses, and increased abdominal discomfort. The nurse knows that patient has MOST likely developed**

- **Intestinal obstruction**
- **Intestinal parasite infestation**
- **Intestinal perforation**

- **Ascites**

- **Answer : A**

- **A child is admitted to the hospital with dehydration. The nurse should Give PRIORITYto which of the followingnursing diagnoses?**

- **Anxiety related to hospitalization**
- **Fluid volume deficit related to vomiting**
- **Imbalance nutrition less than body requirementsrelated diarrhea**
- **Risk for infection relatedto presence of**

invasivelines

- **Answer : B**

- **The nurse is caring for patient with deep vein thrombosis(DVT). The patient's heparin sodium infusion has been discontinued and the patient is receiving prescribed warfarin sodium (Coumadin). The nurse should advise the patient that which of the following needs to be continued?**

- **Daily complete blood count (CBC)**

- **Laboratory tests for partialthromboplastin time (PTT)**
- **Strict bedrest**
- **Wearing elasticized support stockings**

- **Answer : C**

- **When teaching the parents of neonate with spina bifida techniques to promote bladder emptying, the nurse reviews a technique in which firm,gentle pressure is applied tothe abdomen, presstowardsthe symphysis pubis. Thismethod is known as:**

- **Crede's**
- **Intermittent**
- **Foley**
- **Prophylactic**

- **Answer : A**

- **A 50-year-old patient is being admitted to the hospital in a vegetative state of unknown etiology what is the PRIORITY nursing diagnosis?**

- **Risk for impaired skin integrity**
- **Impaired swallowing**
- **Altered cerebral tissue perfusion**
- **Altered thought processes**

- **Answer : A**
- **Prior to administering an enema, the nurse will assist the patient to assume what position**

- **Prone with pillow under knees**
- **Left-side with right knee flexed**
- **Right-side with left knee flexed**
- **On back with head of bed flat**

- **Answer : B**

- **A nurse interviews a patient, recently admitted to long term care facility, to**

obtain information on the patient's health perception. The nurse encourages the patient to elaborate about this change. Which type of questioning would be MOST effective in this situation?

- **Analytical**
- **Focused**
- **Closed**
- **Open-ended**

- **Answer : D**

- **When selecting activities to help develop a child's fine motor**

skills,which of the following would BEST meet this goal?

- **Sorting cardboard objects that are in different shapes**
- **Singing while turning the pages of a book that plays music**
- **Jumping rope**
- **Riding a three-wheeled cycle**

- **Answer : C**
- **60 years age a patient weighed 73 kilograms (161 pounds). During the current clinic visit the nurse note the patient has an unintended weight loss. This weight loss over 6 months would be considered clinically significant as soon as it reaches the point of being more than a:**

- **5% loss**

- **8% loss**
- **10% loss**
- **20% loss**

- **Answer : D**

- **A child with a diagnosis of tetralogy of fallot is scheduled to be discharged from the hospital the nurse planning discharge education should instruct the caregivers that during a hyper cyanotic spell the position MOST likely to benefit the child is:**

- **Supine**

- **Side-lying**
- **Prone**
- **Knee-chest**

    - **Answer : B**

- **A child is treated for possible acetaminophen (Tylenol) overdose. Thechild is currently stable with normal vital signs. Which of the following organ function system would be MOST affected?**

- **Liver**
- **Stomach**
- **Lungs**
- **Heart**

    - **Answer : A**

- **The nurse is caring for a patient with stage III pressure ulcer to the coccyx.**

Three days after initiating the plan of care, the nurse observes that the ulcer has hard black crust covering the center of the ulcer. The nurse should understand that this indicates

- **Healing**
- **Need for debridement**
- **Inadequate nutrition**
- **Infection**

- **Answer : A**

- **To limit drug interactions, the nurse should advise the parent of chronically ill child to:**

- **Refer to the medications by the generic name**
- **Teach the child the name of all medications prescribed**
- **Give all medications one hour apart**
- **Get all prescriptions filled at the same pharmacy**

  - **Answer : A**

- **The nurse receives an order to obtain an arterial blood gas (ABG) specimen on a patient. The nurse will use the radial artery to obtain the specimen. Which of the following will the nurse assess before puncturing the radial artery?**

- **Allen test**

- **Partial pressure of arterial oxygen**
- **Partial carbon dioxide**
- **Prothrombin time**

- **Answer : A**

- **For an infant with hydrocephalus, a nurse should plan to monitor for what sign or symptom of increased intracranial pressure?**

- **High-pitched, shrill cry**
- **Decrease in systolic blood pressure**
- **Depressed fontanelle**
- **Increase in respirations**

- **Answer : A**

- **During surgery requiring general anesthesia, the patient's heart stops,Ventilations using the end tracheal tube (ETT) are started with an ambu bag. Which of the following compression to ventilation rates is correct?**

- **10 to 2**
- **15 to 2**
- **30 to 2**
- **50 to 2**
-
- **Answer :C**

- **A patient with pneumonia has a temperature, 40 C (104 F); heart rate 20;respiratory rate 32 and dyspnea patient has an ineffective airway**

clearance related to excessive tracheobronchial secretions. Which of the following interventions would the nurse implement to enhance the patient's airway clearance?

- Administer oxygen as ordered
- Maintain a comfortable position
- Increase fluid intake
- Administer prescribed analgesic

- Answer : A

- A 57-year-old patient in a hospital clinic is scheduled for a colon biopsy. The patient speaks a different language than the hospital staff, but does understand simple communication in the language of the

staff. When conduction patient education prior to the procedure, the nurse should plan to:

- **Write all communication and avoid speech**
- **Raise the volume and pitch of the voice**
- **Obtain an interpreter**
- **Smile and nod frequently**

- **Answer : C**

- **. The following pain medications are ordered for a patient who had a right leg debridement.Oxycodone 5 mg every 4 hours as needed and morphine 5 mg every 4 hours as needed. The nurse administered oxycodone 2 hours ago, but the patient report pain Rated 8 on a scale of 0 (no pain) to 10 (Severe**

pain) as the dressing change begins.Vital signs are: blood pressure level, 169/ 98 mmHg; heat rate, 112; Respiration rate 22; temperature 36.7 C (98.1 F).After evaluating the effectiveness of the pain Medication, what action should the nurse take?

- **Administer additional oxycodone 5 mg**
- **Administer morphine 5 mg**
- **Change the dressing quickly**
- **Encourage deep breathing**

  - **Answer : B**

- **A nurse is assessing the peripheral circulation of patient's extremities. The chart indicates the patient has edema in both lower extremities.**

Which of the following assessment techniques would the nurse MOST likely use to assess for this?

- **Inspection and auscultation**
- **Inspection and palpation**
- **Palpation and percussion**
- **Percussion and auscultation**

- **Answer : B**

- **A child is admitted with temperature of 38.5 C (101.3 F), loss of appetite and vomiting The nurse observes several joints are red, swollen, warm and tender to touch. A non pruritic rash is on the child's trunk. Laboratory test results include an elevate erythrocyte sedimentation rate (ESR), a positive c-reactive protein, and an elevated white**

blood cell count (WBC). The nurse should initiate the plan of care for:

- **Congestive heart failure**
- **Meningitis**
- **Rotovirus**
- **Acute rheumatic fever**

- **Answer : D**

- **A nurse is caring for a hospitalized diabetic patient with advanced peripheral recovery. Which of the following nursing action is MOST important?**

- **Moisturizing the skin with lotion each**

day

- Ensuring that foods are not too hot
- Facing the patient when speaking
- Assessing the heels for breakdown

  - Answer : D

- . A patient in a long-term care facility is in persistent vegetative state with a right contracture of the right arm and hand. What is the BEST goal over the next 90days for this patient related to the nursing diagnosis of impaired mobility?

- Develop no further contractures
- Wear an arm and hand splint
- Have no pain related to the contractures

- ANS C

-
- **To facilitate self-care for a 2-year-old child with spastic cerebral palsy, the nurse should recommend:**

- **Placing straws into beverage containers**
- **Obtaining eating utensils that have large handles**
- **Replacing zippers on clothing with metal snaps**
- **Purchasing shoes that have an open heels area**

  - **Answer : D**
  -

- **. A 21-year-old female is being discharged after a 2-day admission for pelvic inflammatory disease (PID). Which statement BEST identifies the**

patients understanding of follow-up care for PID?

- **"My sexual partner needs to be treated with antibiotics"**
- **"It's OK to resume sexual relation now"**
- **"I need to inform any sexual partners I have had in the past 30 days that I had PID"**
- **"In order to prevent getting PID I need to continue to take birth control pills"**

- **Answer : A**

- **A healthy 2-years-old child is brought to the community health clinic for a routine checkup. At this visit the nurse should administer the following vaccine:**

- **Rotavirus**

- **Hepatitis B**
- **None at this time**
- **Varicella**

- **Answer : C**

- **. During an evaluation at a community clinic, the patient completes the medical history. Which of the follow is NOT a risk factor for an acute myocardial infarction?**

- **Coronary artery disease**
- **Smoking**
- **Hemophilia**
- **Hyperlipidemia**

- **Answer : C**

- **Which of the following is the MOST common type of cardiomyopathy in children and is treated with medications such as digoxin (Lanoxin) and warfarin (Coumadin)?**

- **Hypertrophic**
- **Dilated**
- **Restrictive**
- **Diastolic**

- **Answer : A**

- **The responsibility for teaching patients how to take medications safely when they are discharged from the hospital belongs to the:**

- **Nurse**
- **Physician**
- **Dietitian**

- **Therapist**

- **Answer : B**

- **A nurse is discharging a patient after hospitalization due to myocarditis. Which of the following statements should be included in discharge teaching?**

- **There is usually some residual heart enlargement**
- **May resume previous activities as before hospitalization**
- **Avoid immunizations against infectious disease**
- **Rapidly beating heart is a common side effect of the illness and is not dangerous**

- **Answer : A**

- **A nurse is assessing a 4-month-old formula-fed infant. The parent reports the infant has been irritable, crying excessively, not sleeping well, and vomiting. Gastro-esophageal reflux is expected. What nursing intervention should the nurse expect to teach the parent?**

- **Place the infant in an infant seat after eating**
- **Give large frequent feedings**
- **Position the child in a swing**
- **Thin formula with water**

- **Answer : C**

- **An adult arrived at the outpatient facility due to the onset of chest pain. The patient suddenly falls to the floor and is unresponsive. What action should the nurse take NEXT?**

- **Activate emergency call system**
- **Open the patient's airway**
- **Check for a carotid pulse**
- **Administer 2 rescue breaths**

- **Answer : C**

- **A patient suffered a head trauma which resulted in a nasal fracture requiringsurgical intervention. Which of the following nursing diagnoses would MOST likely be a problem this patient?**

- **Delayed surgical recovery**
- **Impaired gas exchange system**
- **Ineffective breathing pattern**
- **Risk for perioperative-positioning injury**

- **Answer : C**

- **After administering inhaled corticosteroids to hospitalized child with asthama, the nurse plans to have the child rinse the mouth and gargle with water. The nurse knows the rationale for this action is prevention of:**

- **Tooth decay**
- **Oral candidiasis**
- **Dehydration**
- **Hypertrophy of the gums**

- **Answer : B**

- **The nurse is assessing a patient who is 2-weeks postoperative a kyphoplasty**

ofL2 and L3.The patient has been participating in physical therapy and has been doing daily stretching and strengthening. Which of the following would indicate that the patient has met discharge goals?

- Reports pain in legs while sitting
- Urinating every two hours while awake
- Fatigue after performing activities of daily living
- Ambulates outdoors without assistive devices

- Answer : D

- When a child is brought to the emergency department with acute epiglottitis, which of the following nursing diagnoses should receive PRIORITY?

- **Ineffective airway clearance**
- **Activity intolerance**
- **Fluid volume deficit**
- **Impaired verbal communication**

- **Answer : A**

- **The nurse is reviewing the medication of a patient who is scheduled for a coronary artery bypass graft (CABG) in three days. Which of the following medications MUST be discontinued at least a week prior to surgery?**

- **Digoxin (Lanoxin)**
- **Furosemide (Lasix)**
- **Propranolol hydrochloride(Inderal)**
- **Warfarin sodium(Coumadin)**

- **Answer : D**

- **A patient with pneumonia experiences ineffective airway clearance related to the presence of thick secretions secondary to infection. Oxygen saturation is 89% on room air. Which of the following nursing interventions takes priority?**

- **Deliver oxygen with humidity**
- **Encourage fluid intake**
- **Assist patient into position ofcomfort**
- **Inspect sputum for odor andcolor**

- **Answer : A**

- **A nurse is assessing a 5-month-old infant. The parents' state that the infant is irritable, crying excessively, vomiting formula (not projectile), arching, and stiffening. Based on this assessment, what diagnosis should the nurse anticipate?**

- **Esophageal astresia withtracheoesophageal fistula**
- **Gastroesophageal reflux**
- **Hirschsprung's disease**
- **Celiac disease**

- **Answer : B**

- **A Patient presents at the clinic with weight loss and complains of trouble seeing at night. The nurse also observes numerous teeth with decay. Upon Learning that the patient has avitamin deficiency, which of thefollowing foods would the nurse MOST likely instruct the patient to add to diet?**

    - **Cheese and breads**
    - **Liver and rice**
    - **Fish and rice**
    - **Fruits and vegetables**

- **Answer : D**

- **While providing discharge teaching for the parents of a child newly diagnosed with cystic fibrosis, the nurse includes teaching regarding the role of salt in the disease. Which of the following statements by the patient indicates the need for further teaching?**

- **Salty foods may be eatenon occasion**
- **My child does not need torestrict salt intake**
- **Salt is lost more rapidlyin hot weather**
- **Salt replacement shouldoccur every day**

- **Answer : D**

- **A patient visiting the clinic 10 days after sinus surgery for checkup complains of having a bad taste in the mouth. When the nurse smells a foul odor while examining the patients mouth, the nurse suspects the patient have an:**

- **Pulmonarydecompensation**
- **Hemorrhage**
- **Aspiration**
- **Infection**

- **Answer : D**

- **A patient is scheduled for a total hip arthroplasty. The preoperative nurse reviews the chest and notes the following: serum potassium level of 2.8 mEq/ l, AB positive blood type, and elevated ST Segments on the electrocardiogram (ECG). Which of the following would be the MOST appropriate action for the nurse to do next?**

- **Report abnormaldiagnostic results to thesurgeon**

- **Review the patientconsent for the surgicalprocedure**
- **Educate the patient on therisk factors and side-effects of the surgery**
- **Ensure that the patient hasa post-surgery physicaltherapy order**

- **Answer : A**

- **Which of the following discharge planning instructions takes PRIORITY in patient with congestive heart failure?**

- **Maintaining a lowcholesterol, low**

sodiumand low potassium diet

- Recognizing signs andsymptoms that requireimmediate medicalattention
- The importance ofremaining physicallyactive
- The importance ofdrinking plenty of fluid

- Answer : B

- Following ocular surgery the nurse establishes care interventions to include orienting the patients to new changes in environment and supervising the Patients ability to feed themselves and perform self-care activities. Which of the following

nursing diagnosis do these activities support?

- **Activity intolerance**
- **Impaired environmental interpretation syndrome**
- **Disturbed sensoryperception**
- **Risk for autonomicdysreflexia**

- **Answer : B**

- **During the immediate postoperative period, a patient reveals an oxygen saturation level of 91%. The nurse should:**

- **Position the patient onthe left side**

- **Administer supplemental oxygen**
- **Continue to providesupportive care**
- **Lower the temperature ofthe room**

- **Answer : c**

- **Which of the following goal take PRIORITY when recovering from general anesthesia in post anesthesia care unit (PACU)?**

  - **Thermoregulation**
  - **Plastic skin turgor**
  - **Patent airway**
  - **Patient voids freely**

- **Answer : C**

- **A patient is to receive heparin sodium,**

5,000 U, subcutaneous on call to the operating room.Prior to administering this medication, the nurse should advise patient that this will help to prevent:

- **Infections**
- **Atelectasis**
- **Thrombosis formation**
- **Positioning injuries**

- **Answer : C**

- **When administering an intramuscular injection to an infant, which of the**

following sites appropriate for the nurse to use?

- **Rectus femoris**
- **Deltoid**
- **Dorsogluteal**
- **Ventrogluteal**

- **Answer : D**

- **A patient is admitted to the medical unit with a diagnosis of fluid volume deficit would the nurse expect the doctor to order?**

- **0.9% Sodium chloride**
- **0.45% Sodium chloride**
- **Dextran in normal saline**

- **5% Sodium chloride**

  - **Answer : A**

- **The nurse is discussing the human immunodeficiency virus (HIV) with a group of high-risk patient. The nurse should state that this virus is found MOSTcommonly in which of the following body fluids?**

  - **Blood**
  - **Saliva**
  - **Breast milk**
  - **Vaginal secretions**

  - **Answer : A**

- **A parent is concerned their 8-year-old**

child has 23kg (5lb) over the past 2 weeks and has been urination up to 30 times per day. The child also seems to be eating and drinking constantly. Which test would be MOST helpful in evaluating the child's condition?

- **Chest X-ray**
- **Complete blood count**
- **Body fat analysis**
- **Blood glucose level**

- **Answer : D**

- **A patient has been transferred to the medical unit following a**

parathyroidectomy.Surgery was performed under general anesthesia and the patients diet my advanceas tolerated. The patient requests a sip of apple juice. The nurse should FIRST assessthe patient's:

- **Skin turgor**
- **Cough reflex**
- **Lung sounds**
- **Bowel sounds**

- **Answer : B**

- **The nurse sustains a needle-stick injury after administrating an intramuscularinjection to a patient.It is recommended that the nurse be tested for humanimmunodeficiency virus (HIV):**

- **Immediately with repeat testin 6 weeks**
- **If the patient refuses HIVtesting**
- **If the patient has symptomsof HIV infection**
- **A month after takingprophylactic antiviral**

  - **Answer : A**

- **A parent brings their teenage child the pediatrician's office. The parent**

reports that the patient frequently complains of abdominal bloating and stomach pain after eating and also has a chronic sore throat. The patient's labs show hypokalemia.Which of the following diagnosis should the nurse anticipate?

- **Anorexia nervosa**
- **Bulimia**
- **Morbid obesity**
- **Impulsive behavior**

  - **Answer: B**

- **A urinalysis is best evaluated for accurate result if specimen is analyzed within:**

- **1 hour of collection or refrigerated until analyzed**

- **1 hour of collection or left at room temperature**
- **2 hours of collection**
- **4 hours of collection**

- **Answer: C**

- **The nurse has started intravenous fluid therapy on a child. Which of the followingaction is appropriate?**
- **Using a padded arm board only if the child is active**
- **Checking the site at leastonce every two hours**
- **Determining the total volumeinfused every four hours**
- **Using an infusion pump toprovide controlled rate ofinfusion**

- **Answer : D**

- **During the assessment phase of a preoperative interview, the patient reports feeling nervous. The patient conveys to the nurse that a parent died in surgery due to malignant hyperthermia. To whom would this information be MOST pertinent?**

- **Post-anesthesia care unit(PACU) nurse**
- **Scrub nurse**
- **Anesthesia team**
- **Charge nurse**

  - **Answer : C**

- **A child presents to the emergency department with difficulty breathing. The child'sParents report that child has a history of bronchial asthma and has recently had an Upper respiratory**

tract infection (URI). Upon auscultation, the nurse decreased Breath sounds in the left-lower lung field. The nurse should NEXT assess the child's:

- **Oral temperature**
- **O2 saturation**
- **Apical pulse**
- **Level of comfort**

- **Answer : B**

- **A patient with diabetic retinopathy is experiencing an episode of unresolved hemorrhage in the eye. The nurse identifies the MOST likely procedure to benefitthis patient would be:**

- **Enucleation**
- **Radial keratotomy**
- **Vitrectomy**
- **Peripheral Iridectomy**

- **Answer : C**

- **. A patient admitted to the hospital with acute cholecystitis, is scheduled for surgery in the morning and is NPO. At 8amthe patient develops a fever of 102.4 F (39.1 C).medication orders include acetaminophen 650 mg orally every four hours asneeded. The nurse should:**

- **Give the medication asordered by the physician**
- **Administer the ordered dose rectally**
- **Put moist cool cloths on thepatient's**

forehead and axillac

- **Notify the physician andrequest other orders**

- **Answer : A**
- **A home health nurse is preparing to administer a subcutaneous injection of heparin.When site on the abdomen, the nurse will choose a site:**

- **More than 6 inches from theumbilicus**
- **More than 2 inches from theumbilicus**
- **As close as possible to theumbilicus**
- **As close as possible to theumbilicus**

- **Answer : B**

- **. A patient withpulmonary emboli**

complains of pain, dyspnea, and a fear of dying.Which of the following interventions would MOST likely help to reduce the patient's anxiety level?

- **Administer oxygen asordered**
- **Administer pain medicationas ordered**
- **Observe closely for signs ofpain and discomfort**
- **Listen to the patient'sconcerns**

- **Answer : D**

- **A patient with bacterial meningitis is treated with intravenous antimicrobial agent.Which of the following BEST indicates effectiveness of treatment?**
- **Severe headache**
- **Negative kernig's sign**
- **Nuchal rigidity**

- **Photophobia**

- **Answer : B**

- **While caring for a patient with potassium deficiency, the nurse should expect that the patient may exhibit:**
- **Dysrhythmias**
- **Oliguria**
- **Diminished deep-tendonreflexes**
- **Hypertension**

- **Answer : A**

- **A patient who underwent hand surgery requiring general anesthesia presents**

to the post anesthesia care unit (PACU) after extubation, The nurse should FIRST assess

- **Circulatory status**
- **Wound status**
- **Respiratory status**
- **Hydration status**

- **Answer : C**

- **Prior to administration of an albuterol nebulizer, the nurse should help the patient assume what position?**

- **Sitting and leaning forward**
- **Feet elevated above level ofheart**
- **High fowler's**
- **Standing**

- **Answer : C**

- **A patient presents to the doctor's office 2-weeks status post-right-sidedmastectomy.The nurse needs to measure the blood pressure. Which would be the BEST site?**
  - **Above the left brachial artery**
  - **Right popliteal artery**
  - **Above the right brachialartery**
  - **Left popliteal artery**

- **Answer : A**

- **A child with cystic fibrosis exacerbation presents to the**

emergency room. Which nursing diagnosis takes FIRST? Priority in planning for intervention?

- **Imbalanced nutrition relatedto increased metabolicrequirements because ofmalabsorption**
- **Deficient knowledgeregarding prevention ofcystic fibrosis exacerbation**
- **Impaired gas exchangerelated to airwayobstruction due to mucous**
- **Interrupted familyn processes related to hospitalization**

- **Answer : C**

- **A nurse is evaluating the home of patient with left-sided paralysis. Which of thefollowing observations would**

indicate that the patient is complying with home-based safety?

- **The telephone is on a bedsidetable with is next to the headof the bed**
- **The bedside commode is onthe left-side of the bed withthe back of the commodefacing the foot of the bed**
- **The walker has wheels on itsback legs and has tennis ballson the front legs**
- **The stairs leading from thebedroom to the living area ahandrail on the right-side ofthe stairway**

- **Answer : A**

- **A patient is admitted to the hospital**

with a cerebrovascular accident, accident, right hemiplegia, and expressive aphasia. With a nursing diagnosis of impaired verbal communication, what is the BEST term goal for this patient?

- **Learn to speak clearly within30 days**
- **Communicate effectivelywithin one week**
- **Have all needs anticipated bystaff daily**
- **Make basic needs knowndaily**

- **Answer : D**

- **A Patient has a dissection aortic aneurysm. The patient's surgery would be categorized as:**

- **Elective**
- **Urgent**
- **Emergency**
- **Diagnostic**

- **Answer : C**

- **A patient presents to the emergency room due to an overdose of morphine sulfate.Which of the following should the nurse has readily available?**

- **Glucagon**
- **Antibiotic**
- **Acetylcysteine (Mucomyst)**
- **Naloxone (Narcan)**

- **Answer : D**

- **A patient with iron deficiency anemia due to an insufficient iron intake needs to learn to select better food choices. The nurse works with this patient to establish aplan of care and provide education on proper nutrition and good sources of iron. Besides educating the patient on a well-balanced diet the nurse would MOST likelyteach the patient that good source of iron include:**

- **Seafood, cheese, soybean oil,and chocolate**
- **Animal proteins, egg yolks,dried fruits, and nuts**
- **Dairy products, citrus fruits,fish liver oils, and poultry**
- **Seafood, fruit, poultry, andtomatoes**

- **Answer : C**

- **A 45-year-old patient is in a lower body cast following a motor vehicle accident. In order to minimize muscle strength loss while in the cast, the nurse will instruct the patient in the performance of:**

- **Isometric exercises**
- **Passive range of motion exercises**
- **Active-assistive range of motion exercises**
- **Resistive range of motion exercises**

- **Answer : C**

- **A patient is being followed in the clinic for hypertension, adult onset diabetes, and obesity. The patient is apathetic about learning nutritional guide lines to reach the goals of weight loss and consumption of a healthy diet. The patient admitted to eating "what ever is put in front of me". Which of the following actions would the nurse take?**
  - **Collaborate with the patient to set goals**
  - **Add a nursing diagnosis of non-compliance**
  - **Refer for Psychiatric screening for depression**
  - **Discuss nutritional interventions with the spouse**

- **Answer : A**

- **A child is admitted to the pediatric ward with fever, lethargy, joint pain and abdominal pain for several weeks. The patient has a history of recurrent respiratory and ear infections. Physical findings include wide spread ecchymosis, generalized lymph adenopathy, hepato splenomegaly, and pallor. Lab work show a low hemoglobin level, low RBC count, low hematocrit, and low platelets. The nurse should expect the bone marrow stain to show a:**
  - **Large number oflymphoblasts and lymphocytes**
  - **Low number of lymphoblasts and large number oflymphocytes**
  - **Low number of lymphoblasts and lymphocytes**

- **Large number oflymphoblasts and low number of lymphocytes**

  - **Answer : C**
- **Immediately following the birth of a full term newborn, which of the following nursing diagnoses should take PRIORITY?**

- **Ineffective airway clearance related to nasal and oral secretions**
- **Ineffective thermoregulation related to environmental factors**
- **Risk for imbalanced fluid volume related to weak sucking reflex**
- **Risk for injury related to immature defense mechanisms**

- **Answer : A**

- **A patient receives intravenous therapy of 1000 cc normal saline with 20mEq potassium chloride at a rate of 75cc per hour. Upon evaluation of the site, there is no edema, the vein appears slightly red, and the patient complains of pain. What should the nurse do?**

- **Slow the rate to prevent burning from the solution and continue to monitor**
- **Discontinue the intravenousline and restart in another site**
- **Monitor at least every half-hour for edema but continueas the order state**
- **Notify the doctor that thepatient is having an adversereaction to the medication**

- **Answer :A**

- **A healthy 26-year-old patient is at 39-weeks-gestation. The patient is not considered high risk at the time of admission to the labor and delivery unit.Which of the following pending laboratory test results should receive PRIORITY?**

- **Red blood cell count**
- **Hematocrit**
- **White blood cell count**
- **Blood type**

- **Answer : D**

- **A patient comes to the emergency department with extreme dyspnea, orthopnea,anxiety and complains of feeling panicky. The patient is coughing up white frothy sputum and is cyanotic with profuse perspiration. Inspiratory and expiratory wheezing and bubbling sounds are auscultated. The patient is diagnosed with acute pulmonary edema. What should the nurse do FIRST?**

- **Identify precipitating factorsand underlying conditions**
- **Administer morphine(Duramorph) to reduceanxiety**
- **Assess oxygen saturation rate**
-
- **Administer digoxin(Lanoxin) to decrease fluidbacking up into the lungs**

- **Answer : C**

- **. During surgery, the patient has the following intake and output: intravenous fluid 650cc, intravenous antibiotic 50cc, I unit of packed red blood cells (PRBC) 350cc,nasogastric output 120cc, estimated blood loss 80cc, and urine in the Foley catheter 240cc. What is the patient's total output?**

- **120cc**
- **200cc**
- **240cc**
- **440cc**

- **Answer : D**

- **A 25-year-old female presents to the emergency room with lethargy, decreased reflexes, hypoventilation, hypotension, and fixed and dilated pupils. A family member who is accompanying the patient has an empty bottle of diazepam(Valium) which the label states was recently refilled.The family member also indicates that the patient has a history of depression what intervention should thenurse expect to administer?**

- **Flumazenil or (activated charcoal)**
- **A tap water enema**
- **Magnesium sulphate to reduce the risk of seizure**
- **Nalaxazone**
  A

- **An asthmatic patient presents with wheezing and coughing. Oxygen saturation is 88% on room air. Which of the following nursing diagnosis would take priority?**
- **Imbalanced nutrition related to decreased food intake**
- **Activity intolerance related to inefficient breathing.**
- **Anxiety related dyspnea and concern**

of illness.

- Ineffective gas exchange related to bronchospam

D

- A child is admitted to the hospital with congenital heart disease. Which of the following nursing diagnoses should receive Priority?
- Decreased cardiac output related to decreased myocardial functions.
- Activity intolerance related to cachexia
- Impaired gas exchange related to altered pulmonary blood flow

- **Imbalanced nutrition : less than body requirement related to excessive energy demands**

  - **Ans: A**

- **A patient scheduled for an abdominal aneurysm repair. This is what type of surgical intervention?**

- **Diagnostic**
- **Transplant**
- **Curative**
- **Palliative**

- **Ans: C**
- **The patient present to the hospital**

voicing a concern about being eposed to HEP A (HAV) 1 week upon questioning the nurse finds the patient purchased food from a person recently diagnosed with HEP A . Nurse would be most correct when instruct the patient

- **The incubation period is 3-5 wks**
- **HAV is spread by seual contact**
- **HAV is spread by blood contact**
- **The incubation period is 2-6wks**

ANS –d

- **While performing a pre operative assessment on a pt having arthroscopy of the right knee , a nurse examine the right leg for baseline assessment . The nurse should include all the following**

EXCEPT

- **Position and length of the leg**
- **Bilateral pulse**
- **Bony prominence of ankles and feet**
- **Rotation of patella**

ANS – D

- **A patient had right knee surgery and is being transferred to the post anesthesia care unit. which of the following information is ESSENTIAL to discuss**
- **Pre operative weakness of the lower extremities**
- **Anxiety related to inherited risk factors of surgery**
- **Fear related to body image disturbances**

- **Allergy to aspirin based products**

ANS- B

- **A patient who underwent a right knee arthroplasty 2 days ago has a nursing diagnosis of impaired mobility. The patient refuses to get out of bed and ambulate due to chest pain. which of the following action would the nurse MOST LIKELY implemented**
  - **Medicate the patient prior to ambulation**
  - **Add a nursing diagnosis of non compliance**
  - **Let the patient rest now and then try to ambulate later**
  - **Assess to determine the course of the chest pain**

ANS – D

- **After total knee replacement a patient being discharged to have after which he will ambulate with for-prong cane. When providing patient teaching regarding giving up and down stairs with the cane, the first step in going up stairs is to ..,**
- **Place the cane and the affected extremities upon the step**
- **Place the cane and the unaffected extremity upon the step**
- **Step up on the affected extremity**
- **Step up on the unaffected extremity**

ANS – A

- **A nurse is caring a patient who had right mastectomy 2 days ago. Which of the following is the appropriate nursing goal for this type of surgery**
- **Acceptance of altered body image**
- **Avoid large crowd**
- **Limit right arm movement**
- **Perform range of motion for left arm**

ANS – A

- **Which instruction take priority in reducing anxiety related to Surgical procedure and post operative exercise**

- **Risk of infection after surgery**
- **Advanced directives and what it means**
- **Pre operative laboratory result and what to expect on it**

ANS-b

- **The nurse is assigned a patient who had surgery under GA. The patient respiratory rate is 4/mnt and the O2**

saturation on 3mL/mnt of O2 via nasal canula is 84%. The nurse is awaiting the result of an ABG and anticipate that which of the following elevated ?

- **Arterial O2 saturation (SaO2)**
- **HYDROGEN ion concentration (PH)**
- **Partial pressure of arterial CO2 (PaCO2)**

Ans – c

- **The traction and urinary catheter have been discontinued for a patient who was immobilized in traction for 6 weeks . The pt is now having a problem with urinary incontinence .which of the following interventions would the nurse most likely implement ?**
- **Behavioural training**

- **Bladder training**
- **Scheduled toileting**
- **Prompted voiding**

ANS - B

- **A nurse is assigned to care for a patient with a diagnosis of thrombotic stroke. The nurse knows that this type of stroke is most likely caused by:**
  - **Blockage of large vessels as a result of atherosclerosis**
  - **Emboli produced from valvular heart disease**
  - **Decreased cerebral blood flow due to circulatory**

failure

- A temporary disruption in oxygenation of the brain

Ans: A

- The nurse administered a prescribed intramuscular medication to a patient during a home health visit. How should the nurse dispose of the used needle and syringe?
    - Recap the needle, then place the needle and syringe into a waterproof container until safe disposal can be made
    - Bend the needle back towards the barrel of the syringe before putting the

needle and syringe in a metal trash container

- Wrap the needle and syringe in disposable paper before putting the needle and syringe into the dirty section of the nurse's equipment bag
- Put the needle and syringe directly into a puncture-resistant plastic container that has a lid

Ans: B

- What is the most common characteristic of a stage IV pressure ulcer?
    - Pink skin

- **Presence of sinus tracts**
- **Exposure of bone**
- **Infection**

Ans: C

- **While visiting a patient with a new colostomy, the home care nurse observes that the skin around the stoma site is red. Which intervention should the nurse do next?**
    - **Apply pectin, gelatin or synthetic skin barrier around the stoma**
    - **Apply triple antibiotic to the**

raw skin and leave it open to the air

- Instruct to empty the pouch as soon as stool is present
- Instruct to remove the bag and skin barrier after each stool

Ans: A

- A nurse educates a patient about the use of incentive spirometry to prevent atlectasis after a surgery. The nurse is performing what step of the nursing process?
    - Diagnosis
    - Assessment
    - Implementation

- **Evaluation**

Ans: C

- **A nurse evaluates a patient for signs of rebleeding from ruptured intracranial aneurysm that required surgical ligation. The highest risk for aneurysm rebleed is within:**
  - **6 hours**
  - **24 hours**
  - **48 hours**
  - **72 hours**

Ans: A

- **When discussing dietary choice with a patient who is receiving heparin therapy, the nurse should state that which of the following foods affect the clotting time?**
    - **High protein foods**
    - **Soy- based foods**
    - **Foods high in vitamin K**
    - **Foods containing goat's milk**

Ans: C

- **A patient admitted to the hospital for pneumonia finishes a course of levofloxacin, lungs are clear and the**

patient is no longer coughing. Which of the following post-discharge laboratory results best indicates desired outcome?

- **Normal white blood cell count**
- **Normal hematocrit count**
- **Normal platelet level**
- **Normal potassium level**

Ans: A

- **A home health care nurse visits a patient diagnosed with rheumatoid arthritis. The nurse gathers information about the pain level after the use of prescribed pain medication to check on the effectiveness of the intervention. This phase of nursing**

process is called:

- **Assessment**
- **Diagnosis**
- **Implementation**
- **Evaluation**

Ans: D

- **A plan of care for a child with cerebral palsy should include all the following except:**
  - **Physical therapy**
  - **Play**
  - **Feeding**
  - **Bowel and bladder training**

Ans: D

- **A patient is admitted to the hospital with klebsiellapneumoniae. During the initial intravenous dose of Amikin (amikacin sulfate), the patient develops severe respiratory distress. This is most likely:**
    - **A side effect**
    - **An indication of drug tolerance**
    - **A drug allergy**
    - **A toxic effect**

    Ans: A
- **A patient is diagnosed with peptic ulcer. What would be the long term goal for this patient?**
    - **Patient remains free of signs and symptoms of**

gastrointestinal bleeding

- Patient maintains lifestyle alterations to prevent recurrence of ulcer
- Patient expresses decreased pain level
- Patient performs activities of daily living without difficulty

Ans: B

- A patient visits the clinic for the first time. Inorder to perform an accurate and complete assessment, which of the following would be the nurse first step?
    - Obtain a temperature, pulse and respiration

- **Obtain a complete history**
- **Obtain a blood pressure**
- **Perform a review of systems**

Ans:B

- **The nurse is assigned to care for a patient who has recently been diagnosed with Crohn's disease. The initial treatment is usually:**
  - **Dietary changes**
  - **Reversible colostomy**
  - **Permanent colostomy**
  - **Watchful waiting**

Ans: A

- **A patient comes to the medical office with complaints of some urinary incontinence. The nurse discovers the incontinence occurs because of an inability to delay voiding long enough to reach a toilet after the patient feels a sensation of bladder fullness. This type of incontinence is:**
  - **Stress**
  - **Urge**
  - **Overflow**
  - **Functional**

Ans: C

- **When caring for child with spina bifida, the nurse knows that the child**

has an increased risk of allergy to:

- **Peanuts**
- **Strawberries**
- **Eggs**
- **Latex**

Ans: D

- **When planning a class on pregnancy, the nurse should include symptoms of pregnancy that must be reported immediately, such as:**
  - **Leg cramps**
  - **Vision disturbance**
  - **Swelling of the legs**

- **Constipation**

Ans: B

- **Which of the following reacts to viruses and bacteria by increasing in number?**
  - **Antigens**
  - **Antibodies**
  - **Rh factors**
  - **Platelets**

Ans: B

- **A nurse is assessing a child with cystic fibrosis. After thoroughly assessing respiratory status, the nurse should**

assess which of the following?

- **Level of pain**
- **Skin turgor**
- **Genitourinary status, clarity of urine**
- **Nutritional status, characteristics of stool**

Ans: A

- **The nurse is preparing to administer 100 ml potassium chloride solution. The prescriptions indicate that this should be infuse for 2 hours. The nurse should administer how many ml**

per hour?

- **10**
- **25**
- **50**
- **100**

Ans: C

- **A nurse is caring for a patient who is 6 -hours post-left lobectomy. On assessment the nurse observes that the patient has become very restless and the nail beds are blue. The vital signs reveal tachycardia, tachypnoea and the blood pressure is rising. Which of**

the following complications is most likely?

- **Pneumonia**
- **Hypoxia**
- **Postoperative bleeding**
- **Bronchopleural fistula**

Ans: B

- **A patient with heart failure has the following vital signs: blood pressure level, 136/84 mmHg, heart rate 48, temperature 37.1 C (98.8 F); and respiration rate 20 per minute. Which of these vital signs should be reported**

to the physician prior to administering the next dose of digoxin?

- **Blood pressure**
- **Pulse**
- **Temperature**
- **Respiration rate**

Ans: B

- **The nurse is caring for a patient two hours after a pacemaker placement. The patient suddenly starts complaining of chest pain. The nurse observes dyspnoea, cyanosis and**

absent breath sounds on the right side. The nurse should anticipate what complications?

- **Hemothorax**
- **Perforation of the heart**
- **Pneumothorax**
- **Hemorrhage**

Ans: C

- **A community health nurse is instructing a neighborhood class about botulism. The nurse teaches the group that the most likely mode of infection would be by:**
  - **Direct contact with contaminated soil**

- **Direct contact with respiratory secretions**
- **Sexual intercourse**
- **Ingestion of contaminated food**

Ans: d

- **A 32 year old female comes in for evaluation 14 days after an uncomplicated caesarean section . The patient is very anxious and complaining of sharp stabling pain in her chest .The patient has dyspnea , tachypnea , and hypoxemia .Which of the following postoperative**

complications is likely?

- **Pulmonary embolism**
- **Atelectasis**
- **Pneumonia**
- **Aspiration**

- **Answer A**

- **A home care nurse reviews the laboratory results for a postpartum patient who had a caesarean section . Which of the following indicates possible wound infection ?**
- **Increased WBC**

- **Decreased haematocrit level**
- **Increased haemoglobin**
- **Decreased platelet**

- **Answer A**

- **Three days ago a patient underwent an invasive surgery with an open wound . The patient is febrile with drop in blood pressure . Laboratory test results shows elevated WBC count . This could be possible presentation of :**

- **Sepsis**
- **Atelectasis**
- **Internal haemorrhaging**

- **Excess fluid volume**

- **Answer A**

- **A conscious victim of motor vehicle accident arrives at the emergency department . The patient gasping of air , is extremely anxious , and has a deviated trachea . What diagnosis should the nurse anticipate ?**

- **Pleural effusion**
- **Tension pneumothorax**
- **Pneumothorax**
- **Hemothorax**

- **Answer B**

- **A patient is brought to emergency room with a severe head injury . A craniotomy is performed to evacuate a blood clot . Which of the following is a desired expected outcomes 24 hours postoperatively ?**
- **Gag reflux present**
- **Cerebral perfusion pressure , 68mm Hg**
- **Intracranial pressure , 21 mm Hg**
- **Decreased lacrimation**

- **Answer C**

- **A nurse is assigned to a patient who is scheduled for an above the knee amputation of the left leg . During the preoperative procedure the nurseshould ask the patient to :**
- **Write YES on the leg**
- **Write OTHER ONE on the right leg**
- **Draw an arrow on the left knee pointing upward**
- **Draw an arrow on the left knee pointing downward**

    - **Answer C**

- **A patient who is 18-hour postoperative after an above-the knee amputation complaints of feeling like something is crawling under the dressing as well as**

increased pressure of the dressing . The nurse suspect haemorrhage . The patients vital signs remains within the normal range . What should the nurse do FIRST?

- **Call the physician**
- **Place ice around the dressing**
- **Encourage patient to discuss fears**
- **Lower the temperature of the room**

  - **Answer A**

- **A patient is admitted for pain management due to lung cancer with metastasis of the bone . With a nursing diagnosis of alteration in comfort , the nurse would anticipate the best shot-term goal for this patient would be to :**

- **Not complain of pain**
- **Appear comfortable and sleep well**
- **Verbalize that pain is relived**
- **Verbalize that pain is tolerated**

    - **Answer A**

-
- **A nurse is assessing a patient who just arrived in the emergency department (ED) after a motor vehicle collision . The patient has a strong smell of alcohol on the breath , is restless , and has a bluish discolouration on the abdomen by the umbilicus . The patients vital signs are temperature 37.20C (98.90F) , heart rate 120/min ,**

respiration rate 24/min , and blood pressure level 100/62 mmHg . While other members of the team are evaluating the patient , the nurse should obtain :

- **A pair of elastic support stockings**
- **A chest tube insertion tray**
- **Supplies for peritoneal lavage**
- **A vial of hydralazine**

- **Answer D**

- **While caring for a terminally ill preschool-aged child whose death is eminent , the child asks the nurse “**

Am I going to die”? The best nursing response is :

- **I’m not sure what is wrong with you, but I hope not**
- **Don’t worry, when you die, you will be the angels**
- **We all die someday , but you are not going to die today or tomorrow**
- **I can’t talk to you about that , you will have to ask your doctor**

- **Answer A**

- **A patient with chronic obstructive pulmonary disease complains of a**

frequent cough , bilateral wheezing is auscultated in the lung fields . The nurse administer albuterol nebulizer treatment , as ordered and educates the patient on way to decrease exacerbation . Which of the following actions indicate that the patient understands the instruction?

- **The patient reduces number of cigarettes smoked per day**
- **The patient requested a pneumococcal vaccination**
- **The patient increases sodium and potassium intake**
- **The patent exercises whenever experiencing shortness of breath**

- Answer A
-

- A nurse administers albuterol nebulizer to a child with asthma exacerbation. The nurse measures pulse oximetry and auscultates the lungs to determine whether the goal of clear respiratory status has been met. The step of nursing is called :
  - Assessment
  - Diagnosis
  - Implementation
  - Evaluation

- Answer D

- The home care nurse observe that the asthmatic patient has a cough wheezing . The nurse administers an albuterol (Proventil) nebulizer treatment as ordered. Which type of implementation is this?
- Discharge planning
- Instruct
- Monitoring and surveillance
- Therapeutic interventions

- Answer D

- A child with asthma has an order for albuterol . Prior to administration of medication the nurse must:

- **Pre-oxygenate the patient**
- **Assess the patient's heart rate**
- **Obtain venous access**
- **Feed the patient a snack**

- **Answer B**

- **To reduce the risk of treatment methicillin resistant staphylococcus aureus from an infectious wound which of the following standard precautions should be implemented**
- **Airborne**
- **Contact**
- **Droplet**

- **Reverse isolation**

Ans – B

- **A patient is experiencing intermittent claudication in the legs while at rest . Which of the following should the nurse take ?**
  - **Vigorously massage the extremity**
  - **Place ice on the ankles every 20 mnts**
  - **Elevate the legs to heart level**
  - **Position the legs in dependent position**

ANS – C

- **The nurse is caring for a patient with chest tubes connected to close suction .the nurse should make sure that**

which of the following remains readily available at the patients bed side?

- **A sterile towel**
- **Petroleum gauze**
- **Normal saline solution**
- **Sterile gloves**

ANS—C

- **The nursing a 15 year old patient who is being admitted due to an exacerbation of bronchial asthma. The nurse should give PRIORITY to asking if the patient has history of?**
- **Indoor allergies**
- **Intubation**
- **Chest trauma**
- **Co sack virus**

ANS – A

A community health nurse visits a patient who had right foot amputation. Which of the following would suggest that the patient is meeting expected outcome for this type surgery?

- **Stays in bed**
- **Verbalize constant pain**
- **Avoids social gathering**
- **Accepts altered body image**

D

While reviewing stress management techniques with a patient diagnosed with multiple sclerosis, what would the nurse identify as most appropriate?

- **Relaxing in a warm bubble bath**
- **Yoga in a cool room**
- **Sunbathing**
- **Cross-country running**

ANS –B

- **A child comes in the clinic with several lesions to scalp .the round lesions have dandruff like scaling with hair loss . what is the most likely diagnosis**
- **Impetigo**
- **Ringworm**
- **Ascariasis**
- **Amoebiasis**

B

The nurse is measuring the chest tube drainage of a patient who had open heart surgery 4 hours ago. Which of the following is the MAXIMUM hourly amount of chest tube drainage that is expected in this time frame?

- **100ml**
- **200ml**
- **300ml**
- **400ml**

A

A patient report difficulty sleeping through the night since the death of spouse 6 months ago which of the following is an appropriate LONG term goal?

- **Feeling well rested each morning**
- **Not feeling tired each afternoon**
- **Taking brief nap in the middle of the day**
- **Using sleep aid on a nightly basis**

A

A patient with SLE(systemic lupus erythematous) report decreased urinary output during the past 2-4 days and chest pain that is aggravated by breathing and coughing. The patient vital signs remain within the baseline normal range s1 and s2

are present with audible friction rub. Which of the following statement would be appropriate for the nurse to make?

- **It sounds like SLE is being well controlled**
- **I need to get some nitroglycerine for your chest pain**
- **There may be some inflammation surrounding your heart**
- **Your symptoms may be due to a urinary tract infection**

C

A patient has been hospitalized with a new diagnosis of crohn's disease. The nurse best determine the patients hydration level by monitoring the

- **Color of urine**

- **Brightness of eyes**
- **Capillary refill in nail beds**
- **Temperature of lower extremities**

C

A patient who had abdominal surgery 6 days ago , has been ambulating the halls without much difficulty. However, on day 7 postoperative the patient complains of increased pain at incisional site and is walking hunched over the MOST likely cause of the change is

- **Over assertion the day before**
- **Pulmonary edema**
- **wound infection**
- **deep vein thrombosis**

C

A diabetic patient comes to the office for follow-up six weeks undergoing below the knee amputation of the right leg for gangrene. The nurse observes that the patient is progressing well with the use of a prosthesis and that the skin is intact. The patient reports being generally pain free but occasionally feels severe pain and itching of the right ankle. What should the nurse do?

- **Notify the doctor that there appears to be nerve damage of the right leg**
- **Refer to pain management specialist for long term management**
- **Refer to psychiatrist for evaluation since the patient has no right ankle**
- **Explain the phenomena of phantom pain and phantom sensation to the**

patient

D

A 1 year old child presents at the clinic one week after hospitalization for surgical repair of a fractured right femur. The patient is receiving pain medications every morning and evening. The best way to evaluate the effectiveness of the pain management plan is;

- **To ask the child in simple terms about the comfort level of the past week**
- **By direct observation of the child's non -verbal behaviors during the visit**
- **To teach the child how to use wong/ baker faces pain rating scale**
- **To interview the parent about behavior, moods, and sleep patterns over the**

past week

D

The nurse is caring for a patient scheduled for left arm amputation due to bone carcinoma. Adequate assessment and management of preoperative pain will result in

- Decreased phantom limb sensation
- Increased range of motion after surgery
- Decreased depression after surgery
- Decreased likelihood of cancer recurrence

A

A 34 year old quadriplegia patient resides at home with his wife. In order to prevent contractures of all extremities, the

community care nurse will instruct the patient's wife in the performance of

- **Active range of motion exercise**
- **Passive range of motion exercise**
- **Active assistive range of motion exercise**
- **Resistive range of motion exercise**

B

A 7 year old child is brought to the emergency room with complaints of feeling sick for 3 weeks with sore throat, cough, and muscle pain. Upon examination, the nurse notes a low grade fever, shortness of breath, and a wheeze on auscultation. The child lives with parents, 6 siblings, and grandfather in a 3 bedroom house. Based on these findings,

which of the following diagnosis MOST likely?

- **Staphylococcal pneumonia**
- **Pneumocystis carinii pneumonia**
- **Bronchiolitis**
- **Mycoplasma pneumonia**

D

A patient comes to the emergency department complaining of severe crushing substernal pain that radiates to the left arm and jaw. The patient is diaphoretic and pale with cool clammy skin. The patient is diagnosed with acute myocardial infarction. The nursing diagnosis would be decreases cardiac output related t:

- **Structural factors (incompetent valves)**

- **Impaired ventricular expansion**
- **Impaired contractility**
- **Fluid volume deficit**

C

After a hearing restoration operation, a patient has no signs of complications and soon recovers which of the following is an expected outcome 5 days after the hearing restoration surgery?

- **Regain full hearing**
- **Minimal facial nerve paralysis**
- **Minimal urinary incontinence**
- **Ambulate without difficulty**

A

When teaching a patient how to use a cane after a cerebral vascular accident

(CVA), the nurse should make sure the patient:

- **Uses the cane on the unaffected side**
- **Advances the cane simultaneously with affected limb**
- **Holds the cane away from the body**
- **Moves the cane past the toes of the affected limb**

A

A home care nurse visits a patient diagnose with diabetes mellitus whose current glucose level ranges from 150mg/ dl to 200mg/ dl. The patient has not been able to self-administer prescribed insulin and complains of blurred vision and an inability to read the marking on the syringe for proper insulin dosage.

Which of the following referrals would be MOST beneficial to the patient?

- **A dietician**
- **An endocrinologist**
- **An ophthalmologist**
- **A physical therapist**

C

Which nursing diagnosis takes priority for newly diagnosed patient with a left-sided stroke?

- **Risk for impaired swallowing related to absent gag reflex**
- **Risk for impaired skin integrity related to immobility**
- **Risk for infection related to invasive line placement**

- **Risk for impaired speech related to left side stroke**

A

A nurse is taking care of a patient who underwent abdominal surgery 3 years ago. The patient has not been breaths deeply and refuses to get out of bed since the surgery due to pain. Also the patient complains of shortness of breath and the lung sounds are diminished upon auscultation. Vital signs are. Blood pressure level 120/ 70mm Hg, heart rate 22, temperature 36.4C(97.6 F), o2 saturation 89%. Which of the following condition should the nurse suspect?

- **Sepsis**
- **Atelectasis**

- **Congestive heart failure**
- **Emphysema**

B

A nurse visits the home of a patient who is 1 week post-left-breast mastectomy. Which of the following should be including in patient education?

- **It is OK to use a straight edge razor when shaving**
- **Blood pressure checks should be done in the left arm**
- **Cuticle should not be cut**
- **Avoid insect repellent on the left arm**

C

A patient is 24 hours post-operative after having a right total hip arthroplasty, the

patient complains of pain in the right calf rated 6 on a scale of 0 no pain10 severe pain. The nurse observes that the right calf is warm and tender to touch, while the right foot is pale and cool. There is edema from the toes up the knee. The nurse recognizes that these are the classic signs of:

- **Ineffective tissue perfusion**
- **Fluid overload**
- **Arterial occlusion**
- **Deep vein thrombosis**

D

A patient with dementia is being treated for dehydration. The patient is confused and has been immobile for the past month. Currently, the patient is incontinent and

unable to feed self. The nursing care plan should include

- **Coughing and deep breathing every 30 minutes**
- **Positioning and turning every 2 hours**
- **Range of motion exercise to all extremities every hour**
- **Ambulates at least 20 steps every shift**

B

A patient is 3 week postoperative left below the knee amputation. Which of the following is an expected outcome for this patient?

- **Verbalize relief of incisional pain, has intense phantom sensation**
- **Participates in care plan, express concern about independence**

- **Full passive range of motion, requires assistance with transfers**
- **Low grade temperature, dressing reinforced every hour**

B

During postoperative neuromuscular assessment of a patient who had a total knee replacement nurse assesses the peroneal nerve by testing sensation:

- **On the bottom of the foot**
- **In the space between great and second toe**
- **In the anterior to the rectum**
- **In the anterior portion of the calf**

B

The nurse is caring for a patient who

sustained a traumatic brain injury 4 days ago. The patient remains in a pharmacologic induced coma while receiving mechanical ventilation. The patient is on NPO status and the vital signs are within the normal range. The patients bowel sounds are absent and nasogastric tube is connected to low, intermittent suction. The nurse should prepare to begin:

- **NG feeding**
- **Rapid weaning from the ventilator**
- **Total parenteral nutrition**
- **Chest physiotherapy**

C

The doctor has ordered the patient to be on 1 to 3 litters of oxygen using a nasal

cannula

at all times. the home care nurse notes the oxygen is currently at 2 L/ minut. the oxygen saturation(SaO2) reading is currently 85% and the partial pressure of CO2 is within normal limits. Based on an evaluation of this information, which of the following actions would the nurse MOST likely perform?

- **Decrease the O2 to 1 L/ minut and monitor O2 saturation**
- **continue the O2 at 2 L/ minut and monitor O2 saturation**
- **Increase the O2 to 3 L/ minut and monitor O2 saturation**
- **continue to monitor O2 saturation and call the doctor for new orders**

C

A child is treated for bacterial meningitis with an intravenous antimicrobial agent. Which of the following BEST indicates effectiveness of the treatment?

- **Increased appetite**
- **Temperature 37.2 C(99 F)**
- **Episodes of apnoea**
- **Increased intra cranial pressure**

B

A patient with gastro esophageal reflux disease (GERD) is to start taking prescribed omeprazole (prilosec). The nurse would istruct the patient to take the medication:

- **30 to 60 minutes before meal**

- **90 to 120 minutes before meal**
- **With apple sauce**
- **With milk**

A

A patient recently diagnosed with multiple sclerosis has been taking the following prescribed medications: baclofen(lioresal), diazepam(valium), Amantadine(symmetrel), and phenytoin(dilantin). When the patient presents with complaints of fatigue, the nurse should address the dosage and frequency of which medication?

- **Baclofen**
- **Diazepam**
- **Amantadine**
- **Phenytoin**

B

A 12 year old patient had a cast removed from the left leg after wearing it for 8 weeks. The patients wants to resume sports as soon as possible. In order to regain muscle strength lost while wearing the cast, the nurse will instruct the patient in the performance of:

- **resistive range of motion eercise**
- **passive range of motion exercise**
- **Active assistive range of motion exercise**
- **Active range of motion exercise**

B

During the intra operative period of surgical procedure a 39 year old male has the following vital signs: core temperature

37 C(98.6F)(heart rate 62, blood pressure126/ 78 mm Hg,and an O2 saturation level of 89%. The patient has received two units of packed cell volume(PRBs) and is intubated. Which of the vital signs is considered out of normal range?

- **heart rate**
- **O2 saturation**
- **Core temperature**
- **Blood pressure**

B

A 28 year old male is recovering from a moderate concussion following a motor vehicle accident 2 weeks ago, when he suddenly develops an increased thirst, craving coldwater. The patient urinates

very large amount of dilute, water like urine with aspecific gravity of 1.001 to 1.005 the patient is MOST likely develop[ing

- **Diabetic mellitus**
- **Diabetic insipidus**
- **Hypothyroidism**
- **THyroid storm**

B

- **A nurse is caring for a patient who is 6 hours post left lobectomy.On assessment the nurse observes thatthe patient has become very restless and the nail beds are blue. the vital signs reveal tachycardia, tachypnea and blood pressure is rising.Which of the following complication is MOST likely?**

- **Pneumonia**
- **Hypoxia**
- **Postoperative bleeding**
- **Broncho pleural fistula**

B

A patient presents to the office for a physical assessment. The patient is found to be healthy and fit but occasionally drinks alcohol and has unprotected sex. What is the BEST nursing diagnosis?

- **Health- seeking behavior**
- **knowledge deficit , high risk behavior**
- **Low self esteem**
- **Altered thought process**

B

During surgery, the nurse is assigned the

following duties: setting up the sterile field, preparing sutures and ligatures assisting the surgeon during the procedure by anticipating the instruments and supplies that will be required and labeling tissue specimen obtained during surgery. The nurse MOST likely performing in what role?

- **Circulating nurse**
- **Scrub Nurse**
- **RN first assistance**
- **Nurse anaesthetist**

A

A nurse completes discharge instruction for patient who was admitted 5 days ago with pneumonia. Which statement by the patient would alert the nurse that more

discharge teaching is needed?

- **I need to gradually increase my activities**
- **I will not need the influenza or pneumonia vaccine**
- **I may experience fatigue and weakness for a prolonged time**
- **I need to have another chest x-ray in 4-6 weeks**

B

The nurse is assessing a patient recently diagnosed with acquired immuno deficiency syndrome(AIDS). Which of the following nursing diagnosis has PRIORITY?

- **Fear of disease progression, treatment effects, isolation and death related**

having aids

- Risk for infection related immunodeficiency
- Ineffective breathing pattern related to opportunistic infection
- Disturbed body image related to rapid body changes from debilitating disease

C

A patient to hav an elective surgical procedure to repaire an umbilical hernia. The patient is 68 year old, weighs 136 kg(300lb), and has diabetis mellitus. Which of the following approaches would be the MOST beneficial inorder to reduce the patient surgical risk?

- Monitor blood glucose level monthly
- Avoid fluid overload by restricting fluid

- **Discourage any changes in routine before surgery**
- **Encourage weight reduction**

D

A nurse caring for a patient following cardiac catheterization evaluates the patient post procedure, Which of the following signs and/ or syptoms would MOST likely indicate the patient is having a vagal reaction?

- **diaphoresis**
- **Chest pain**
- **Tingling in extremities**
- **Hematoma formation**

B

A home health nurse visits a patient who

is newly diagnosed with diabetes . The glucose level ranges from 120mg/ dl to 150mg/ dl while current glycosylated hemoglobin (hbA1C)level is 6.9 %. The patient is complaint with taking prescribed hypoglycemic medications and eats 3 meals a day followed by desserts sweetened with granulated sugar. The patient also exrcises 30 minutes a day 3 times a week. Which of the following educational intervention takes PRIORITY?

- **Glucose monitoring**
- **Medications**
- **Dietary requirements**
- **Exercise regimen**

C

Which of the following BESt describes the

assessment step of the nursing process?

- **Identifying nursing interventions as appropriate for short- term, intermidiate, and long-term goal attainment**
- **Assigning priorities to the nursing diagnosis**
- **Establishing goals or epected outcomes**
- **Obtaining a nursing history and complete a physical examination of the patient**

D

A nurse is providing care to a patient with a new skin graft on left leg. The patient is upset and the nurse notes copious red drainage oozing around the dressing. The

nurse should immediately:

- **Lift the dressing to assess the area**
- **Ask if the patient is having any pain**
- **Apply firm pressure for 10 to 15 minutes**
- **Assess the apical pulse**

C

An elderly patient had surgery two days for an intestinal obstruction. Vital signs at 10 am are temperature 37.5c (99.5 f), heart rate 86, respiratory rate 16 blood pressure level 132/ 72 mm Hg, pain level of 4 on a scale of 0 to 10. The abdominal dressing is dry and intact. The nasal gastric tube to low intermittent suction. The patient is on strict input and output every two hours. At 12.20 pm, the patient complains abdominal pain, upon assessment the vital

signs are temperature 37.5 C, heart rate 98, respiration rate 24, blood pressure level 146/ 88 mm Hg, pain level is 8 out of 10. The patient abdomen is distended and rigid, the dressing remains dry and intact. The nurse should first:

- **Reposition the patient on the right side**
- **Irrigate the nasal gastric tube to check patency**
- **Medicate the patient for pain as ordered**
- **Increase the suction on his nasal gastric tube to high intermittent suction**

C

While preparing post operative paper work for a patient scheduled for neurosurgery, the nurse asks about the patient's use of

medications, the patient reports taking an aspirin tablet every day, but has not taken it today. The patient has had nothing by mouth since midnight of the day before, the nurse should:

- **Inform the anesthesiologist immediately**
- **Tell the patient the surgery must be rescheduled**
- **Record the information on the form in red ink**
- **Obtain blood sample and notify the attending physician**

C

A nurse is preparing an assessment of a patient's nutritional status. Which of the following diagnostic test would be the best measure of the patient's recent

nutritional status with a half- life of 2-3 days?

- **Prealbumin**
- **Hemoglobin**
- **Albumin**
- **24- urine creatinine**

B

A nurse is caring for a patient who had a pneumonectomy 2 days ago for lung cancer. Which observation would indicate that the patient is progressing towards discharge goal?

- **Cough productive of serosanguineous fluid**
- **1+ pretibial edema**
- **Nap after completing bed bath**
- **Frequent premature ventricular contractions (PVC)**

C

The nurse is caring for a patient with parkinson's disease. Which of the following is an expected outcome related to the nursing diagnosis of constipation related to diminished motor function, inactivity and medications?

- **The patient will use a laxative every other day**
- **The patient will have a soft bowel movement daily**
- **The patient will report minimal pain with bowel movements**
- **The patient will limit the intake of complex carbohydrates**

B

The parent of a child with chronic asthma is hesitant to discipline because the child

often doesn't feel well. The nurse should encourage the patient to:

- **Set consistent behavior limits**
- **Be more lenient during times of illness**
- **Cherish the limited time the child has to live**
- **Avoid upsetting the child with limit setting**

A

In developing care plan for a hospitalized 3 year old child with asthma, the nurse plans to talk calmly in an appropriate language and explains all procedures. Which of the following statements by the BEST demonstrates implementation of the approach?

- **"You can use the stethoscope to listen to your heart and your doll's, and then**

I will listen’

- “you must not wiggle while listen to your heart. You can hold your doll’
- The stethoscope will feel cold on your chest. You can tell your doll how cold it feels”
- “ let go of your doll and place your hands on your tummy while I use the stethoscope”

A

A nursing process which involves the performance of the nursing plan care is:

- Assessment
- Nursing diagnosis
- Implementation
- Evaluation

C

A patient who is receiving chemotherapy has a platelet count of 49,000/ mm^3 (normal value 150,000 to 400,000/ mm^3). Which of the following nursing action is necessary?

- **Minimize invasive procedure**
- **Crush oral medications**
- **Limit intake of vitamin K rich foods**
- **Monitor the temperature every 4 hours**

A

An elderly patient with a long history of diabetes mellitus comes in for a routine check-up. Which of the following nursing diagnosis would the nurse anticipate?

- **Risk for impaired skin integrity related to decreases sensation and circulation**
- **Excess fluid volume related to disease process**

- **Risk for injury to decrease gastric mobility and stress response**
- **Deficient fluids volume related to diarrhea and loss of fluids and electrolytes**

A

A 3 year old child is brought to the office by the parents who have been toilet training the child for the past 5 months, with little success. The parent has been using rewards for the keeping the parent clean and dry. Today the parent realizes that the child abdomen was very firm, the appetite was poor, and there had not been bowel movement for 6 days. With a nursing diagnosis of alteration in bowel elimination, what is BEST goal?

- **The child will recognize the urge to**

defecate daily

- **The parent will use praise when the child defecates in the toilet**
- **Predictable, regular bowel habits will be restored and maintained**
- **Toilet training will be delayed until the child is cognitively ready**

A

The nurse is teaching a patient about spironolactone (aldactone). Which of the following instructions should the nurse review with the patient?

- **Increasing intake of foods that are high in potassium**
- **Taking the medication right before going to sleep**
- **Avoiding seasoning that are labeled as salt substitutes**

- **Scheduling the medication so that a multi vitamin is taken an hour later**

A

- **Position maintained in self enema administration**

  ANS - SIMS

- **Position maintained post vitrectomy**

  ANS – PRONE

- **respiratory distress exercises**

  . GCS
  APGAR SCORE
  ECG
  PLAYS

WEIGHTS OF CHILD