Medical-Surgical Nurse Exam Practice Questions

Med-Surg Practice Test & Exam Review for the Medical-Surgical Nurse Examination

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Practice Test

Practice Questions

1. Using the average cost of a problem and the cost of intervention to demonstrate savings is:
   a. A cost-benefit analysis
   b. An efficacy study
   c. A product evaluation
   d. A cost-effective analysis

2. In Erikson’s psychosocial model of development, which stage is typical of those entering young adulthood?
   a. Identify vs role confusion
   b. Initiative vs guilt
   c. Ego integrity vs despair
   d. Intimacy vs isolation

3. A 30-year old patient has been diagnosed with advanced ovarian cancer. The patient says, “This is all my fault.” Which of Kübler-Ross’s five stages of grief is the patient probably experiencing?
   a. Denial
   b. Anger
   c. Depression
   d. Acceptance

4. A 68-year old man with mild COPD refuses to exercise because he tires easily. He spends most of every day sitting in a chair watching television. What is the most appropriate nursing diagnosis?
   a. Ineffective health maintenance
   b. Impaired physical mobility
   c. Risk for disuse syndrome
   d. Activity intolerance

5. Measuring the effectiveness of an intervention rather than the monetary savings is:
   a. A cost-benefit analysis.
   b. An efficacy study.
   c. A product evaluation.
   d. A cost-effective analysis.

6. A Hispanic patient is admitted to a hospital unit where a nurse is to obtain the patient’s admission history, but the patient speaks very little English. What should the nurse do?
   a. Ask the patient’s 12-year old son, who is fluent in English, to interpret.
   b. Use sign language and pictures to supplement questions
   c. Arrange for an interpreter.
   d. Ask the patient’s wife, who speaks fair English, to answer the questions for the patient.
7. When asking a patient to sign a consent form for a procedure, the most important factor is the
   a. explanation of the procedure.
   b. patient’s ability to give informed consent.
   c. reasons for the procedure.
   d. explanation of possible complications.

8. The nurse is teaching a 45-year old woman with a colostomy to perform a colostomy irrigation. The nurse has prepared written directions and a video, but the patient ignores them. Instead, the patient picks up the equipment and looks at each part, trying to figure it out. The patient’s learning style is probably:
   a. Auditory.
   b. Visual.
   c. Kinesthetic.
   d. Mixed.

9. A retrospective attempt to determine the cause of an event is:
   a. Root cause analysis.
   b. External benchmarking.
   c. Internal trending.
   d. Tracer methodology.

10. All departments in a healthcare institution should strive toward:
    a. Autonomy.
    b. A common vision of care.
    c. Increased budget allotment.
    d. A spirit of competition.

11. An Alzheimer patient walked away from the hospital and was found hiding in the parking lot. The most appropriate nursing diagnosis to account for his behavior is:
    a. Acute confusion.
    b. Risk prone health behavior.
    c. Impaired memory.
    d. Wandering.

12. Clinical pathways should be based on:
    a. A survey of current practices in the area.
    b. Committee recommendations.
    c. Evidence-based research.
    d. Staff preferences.

13. An 80-year old patient is dying of cancer and has been in and out of consciousness. The family should be encouraged to:
    a. Go home, as the patient does not know they are present.
    b. Talk to the patient, as hearing is usually the last sense to fail.
    c. Offer the patient frequent sips of water to avoid dehydration.
    d. Raise the head of the patient’s bed if respirations become rattling to help the patient clear secretions.
14. A patient with gastroenteritis has been diagnosed with severe dehydration (>15% fluid loss). Typical symptoms include:
   a. Dry mouth and increased thirst.
   b. Dizziness, lethargy, reduced skin turgor, and orthostatic hypotension.
   c. Resting hypotension, confusion, tachycardia, and oliguria.
   d. Marked hypotension and anuria in addition to other symptoms.

15. A 30-year old woman is hospitalized with severe depression and is incontinent of urine, although the urinary system is normal. The most appropriate nursing diagnosis is:
   a. Functional urinary incontinence.
   b. Stress urinary incontinence.
   c. Overflow urinary incontinence.
   d. Urge urinary incontinence.

16. A patient who sustained a head injury is to have a lumbar puncture to determine if there is CNS bleeding. Which of the following is the most important prior to the lumbar puncture?
   a. CT of the brain
   b. EEG
   c. Hemoglobin and hematocrit
   d. Coagulation studies

17. A 76-year old female with lung cancer was placed on hospice care by her physician 6 months earlier (two 90-day periods), but she is still alive. Her family asks the nurse if the patient will be removed from hospice care. The best response is:
   a. “She will be removed from hospice care until her condition worsens because she has exceeded the 6-month period.”
   b. “She has exhausted all of her hospice care benefits and will be removed from hospice care.”
   c. “She can continue with hospice care as long as the physician authorizes the care every 60 days.”
   d. “She can continue with hospice care if the physician continues to authorize care every 90 days.”

18. The best question to elicit information about a patient’s pain is:
   a. “Are you having pain?”
   b. “Will you describe your pain for me?”
   c. “What kind of pain are you having?”
   d. “What is your pain on a scale of 1 to 10?”

19. A patient who has been prescribed oral phenytoin (Dilantin) for seizure control should be advised to:
   a. limit alcohol intake to two to three drinks daily.
   b. have weekly blood tests.
   c. maintain superior dental care.
   d. stop the drug immediately if adverse effects occur.
20. How do team members usually deal with issues of power?
   a. By observing and emulating the leader.
   b. By arguing.
   c. By following strict rules of discourse.
   d. By rotating leadership roles.

21. Which assessment tool for dementia involves remembering and repeating the names of 3 common objects and drawing the face of a clock with all 12 numbers and hands indicating the time specified by the examiner?
   a. Mini-mental state exam (MMSE).
   b. Mini-cog.
   c. Digit Repetition Test.
   d. Confusion Assessment Method.

22. A patient who is supposed to be on a low carbohydrate diet has gained weight and reports eating frequent convenience foods that are high in carbohydrates. When questioned, the patient is knowledgeable about the diet, but states that poor vision and arthritis in her hands make food preparation difficult. The most appropriate referral for the patient is
   a. nutritionist.
   b. occupational therapist.
   c. social worker.
   d. home health agency.

23. When preparing materials to teach a 28-year old male auto mechanic about wound care, the first thing the nurse should do is:
   a. Prepare an audiotape.
   b. Prepare visual materials, such as pictures and diagrams.
   c. Assess the patient’s learning style.
   d. Prepare manipulatives, assuming that a male mechanic will be a kinesthetic learner.

24. The Occupational Safety and Health Association (OSHA) regulates:
   a. Patient right to privacy.
   b. Occupational exposure to infection.
   c. Reimbursement for services.
   d. Patient surveys.

25. A patient with end-stage bone cancer has elected hospice and palliative care. The patient is experiencing severe bone pain from a tumor, and the physician orders radiotherapy to reduce the tumor’s size and to reduce pain. Is this treatment acceptable under hospice care criteria?
   a. No, the patient has elected to forego curative treatment, so Medicare will not pay for the radiotherapy.
   b. No, the patient needs to be removed from hospice care first.
   c. Yes, hospice recommends only palliative care but curative treatment is acceptable.
   d. Yes, if the purpose of the treatment is to relieve pain, it is essentially palliative.
26. Which scale is used to assess and predict the risk of a patient developing pressure sores based upon sensory perception, moisture, activity, mobility, nutrition pattern, and friction and shear?
   a. Norton Scale.
   b. Pressure Ulcer Scale for Healing (PUSH).
   c. The Braden Scale.
   d. Diabetic Foot Ulcer Scale (DFS).

27. A primary purpose of interdisciplinary teams is:
   a. Sharing ideas and perspectives to solve problems.
   b. Cost-savings by involving multiple departments.
   c. Improved patient satisfaction by working together.
   d. Time saving by using multiple disciplines.

28. A patient is very confused and disoriented and insists that the sound of an ambulance is actually someone screaming. What is the best nurse response?
   a. “That sound was an ambulance siren.”
   b. “No one is screaming.”
   c. “How about if I turn on the TV for you?”
   d. “She has stopped screaming now, so everything’s ok.”

29. A 60-year old male is being treated for a myocardial infarction. While he is progressing well physically, he becomes upset when asked to make independent decisions and he rings the call bell constantly asking for reassurance that he will get well. This psychological response to stress is an example of:
   a. Dependence.
   b. Passivity.
   c. Depression.
   d. Confusion.

30. Which members of the healthcare institution are responsible for identifying performance improvement projects?
   a. Administrative staff.
   b. Nursing team leaders.
   c. Physicians.
   d. All staff.

31. The American Geriatrics Society’s “Guideline for the Prevent of Falls in Older Persons” recommends (among other things):
   a. Remediation of visual deficits where possible.
   b. Home health aide care in the home.
   c. Stretching exercises to help patients be more steady on their feet.
   d. Dietary modifications to strengthen bones.
32. Which of the following is part of the 12 leading health indicators outlined in Healthy People 2020?
   a. Mental Health.
   b. Chronic disease.
   c. Immunization.
   d. Family support.

33. Which of the following provides research and funding for the development of evidence-based practice guidelines?
   b. Food and Drug Administration (FDA).
   c. Health Insurance Portability and Accountability Act (HIPAA).
   d. Agency for Healthcare Research and Quality (AHRQ).

34. A 32-year-old single mother of a 4-year-old child is being discharged after a hysterectomy for cervical cancer. She states she is very depressed because she has lost her job, cannot feed her family, and will soon be homeless. Which referral is most appropriate?
   a. Food bank.
   b. Homeless shelter.
   c. Social worker.
   d. Mental health clinic.

35. A patient is being treated for renal disease and exhibits the following: ventricular arrhythmia with increasing ECG changes, weakness with ascending paralysis and hyperreflexia, diarrhea, and increasing confusion. The patient most likely has:
   a. Hyperkalemia
   b. Hypokalemia.
   c. Hypocalcemia.
   d. Hypercalcemia.

36. According to principles of adult learning, adult learners tend to be:
   a. Unmotivated.
   b. Lacking in self-direction.
   c. Practical and goal-oriented.
   d. Insecure.

37. The Instrumental Activities of Daily Living (IADL) tool includes an assessment of:
   a. Bathing.
   b. Toileting.
   c. Ascending or descending stairs.
   d. Financial responsibility.

38. According to the World Health Organization pain ladder (sometimes called the “analgesic ladder”), a patient with cancer and mild pain should begin treatment with:
   a. Acetaminophen or aspirin, followed by NSAIDs.
   b. NSAIDs.
   c. Acetaminophen or aspirin with codeine or a similar adjuvant.
   d. Complementary therapies, such as acupuncture.
39. The nurse must inform the family of a patient that the patient is dying. Which of the following is an effective strategy?
   a. Provide the information quickly.
   b. Tell the family and then leave and allow them to grieve.
   c. Ask the family if they have questions.
   d. Advise the family to ask the physician about the patient's condition.

40. The best time to initiate conflict resolution is:
   a. When those in conflict have had time to resolve their differences.
   b. When conflict first emerges.
   c. When conflict interferes with function.
   d. When those involved ask for conflict resolution.

41. A 30-year old male complains of frequent nosebleeds, abdominal pain, and nausea. He has burns on his fingers and a slight cough but no needle marks, and his pupils are constricted. He sniffs repeatedly because of nasal irritation. He has a slight fever and tachycardia, and he is malnourished. What substance has he likely been abusing?
   a. Cocaine.
   b. Heroin.
   c. Marijuana.
   d. Methadone.

42. The nurse is coaching a new graduate nurse in carrying out a procedure, utilizing a mannequin; however, the graduate nurse makes many errors and appears anxious. What is the best strategy for helping the graduate nurse master the procedure?
   a. Point out errors as the nurse makes them.
   b. Provide positive feedback, stressing the nurse's correct actions.
   c. Suggest the graduate nurse research the procedure and memorize the steps.
   d. Remind the graduate nurse that her lack of knowledge could endanger patients.

43. A patient is diagnosed with pneumonia. Which white blood cell (leukocyte) count level is indicative of a viral infection?
   a. 4,000.
   b. 5,200.
   c. 25,000.
   d. 40,000.

44. Which type of pain is best treated with opioids?
   a. Chronic back pain of more than 3 months duration.
   b. Acute pain in response to illness or injury.
   c. Psychogenic pain.
   d. Phantom pain after amputation.
45. The nurse is interviewing a 40-year old Chinese woman. The woman seems relaxed and answers all the questions fully, but she keeps her eyes downcast and does not make eye contact. This probably indicates:
   a. Respect.
   b. Fear.
   c. Depression.
   d. Dishonesty.

46. Following thyroidectomy for cancer, a patient reports numbness and tingling in the fingers, toes, and lips; muscle cramps; and twitching about the mouth. The patient appears anxious and fatigued. The most likely cause is
   a. hypoparathyroidism.
   b. hypothyroidism.
   c. thyrotoxic crisis.
   d. infection.

47. The nurse enters a patient’s room just after he talks to the doctor and finds the patient shaking and distraught. What is the best nurse response?
   a. “What's wrong?”
   b. “You are shaking and seem worried.”
   c. “Do you want me to call your family?”
   d. “You don’t need to worry. Everything will be all right.”

48. A nursing team leader delegates a task to an unlicensed assistant. Who is responsible for patient outcomes?
   a. The unlicensed person who completes the task.
   b. Both the team leader and the unlicensed person who completes the task.
   c. The team leader who delegates the task.
   d. The administrative staff.

49. A 40-year old male patient goes into septic shock after surgical repair of a ruptured bowel. Lab results show increased prothrombin time, partial thromboplastin time, thrombin time, D-dimer, and fibrin split products (FSP), while fibrinogen and antithrombin III are decreased. Platelet count is 85,000. This profile is indicative of:
   a. Pulmonary emboli.
   b. Disseminated intravascular coagulation (DIC).
   c. Multi-organ dysfunction syndrome.
   d. Deep vein thrombosis.

50. Identify the patient for whom the use of transcutaneous electrical nerve stimulation (TENS) to relieve pain is most appropriate.
   a. A man with chest pain and a pacemaker.
   b. A woman with pain in the anterior neck.
   c. A man with moderate dementia related to Alzheimer’s disease.
   d. A woman with chronic low back pain.
51. A patient with chronic ulcerative colitis has surgical removal of the colon and creation of a terminal ileostomy. How much fecal output should the patient be advised to expect initially?
   a. 200 to 400 mL daily
   b. 400 to 600 mL daily
   c. 500 to 1000 mL daily
   d. 1500 to 2000 mL daily

52. A 50-year old Middle Eastern woman from Saudi Arabia has a radical mastectomy. On postoperative day-1 a male nurse prepares to change her dressings. She becomes very upset and refuses care. Which is the best response?
   a. Explain that he is the only nurse available to do this treatment and that the hospital does not consider gender in assignments.
   b. Chart that the patient refused care and skip the dressing change.
   c. Reassure the patient that he understands her concerns and will make arrangements for a female nurse to change the dressing.
   d. Explain that she has no right to refuse care since she signed the surgery permit.

53. A 75-year old male patient had a stroke 2 months previously. He has residual left-sided paresis, a left visual field defect, and impaired motor skills. His language skills are intact, but he behaves impulsively, has difficulty following directions, and has short-term memory loss. His stroke most likely occurred in the:
   a. Right hemisphere.
   b. Left hemisphere.
   c. Brain stem.
   d. Cerebellum.

54. The “5 rights of delegation” include:
   a. Right time, right place, right person, right direction, and right evaluation.
   b. Right person, right place, right time, right assignment, and right supervision.
   c. Right task, right time, right circumstance, right place, and right supervision.
   d. Right task, right circumstance, right person, right direction, and right supervision.

55. A 26-year old woman with 2nd degree burns on her hands has received repeated doses of morphine intravenously. She now has a respiratory rate of 8/minute, hypotension, and pinpoint pupils. What treatment is appropriate?
   a. Naloxone (Narcan®)
   b. Flumazenil.
   c. N-acetylcysteine (NAC).
   d. Charcoal.

56. A patient is admitted to the unit after vomiting excessively for 4 days at home. The patient's serum pH is elevated, PCO2 is relatively normal, and urine pH is >6. The patient is dizzy, confused, and is exhibiting tremors, seizures, tingling, tachycardia, arrhythmias, and hypoventilation. The patient is most likely exhibiting symptoms of:
   a. Respiratory alkalosis.
   b. Metabolic alkalosis.
   c. Respiratory acidosis.
   d. Metabolic acidosis.
57. When evaluating a patient's level of consciousness, a patient who requires vigorous and continuous external stimuli to arouse and who exhibits withdrawal as a motor response is categorized as
   a. comatose.
   b. obtunded.
   c. lethargic.
   d. stuporous.

58. A 35-year old female patient attempted suicide by stabbing herself in the chest but caused only minor injury. She had made two previous attempts at suicide using pills and has no family or close friends. Her affect remains flat, but she states that the antidepressant is helping her and she no longer feels depressed. Which best characterizes her risk for suicide?
   a. Low risk because she was probably just trying to get attention.
   b. High risk because she used a knife and had previous suicide attempts.
   c. Low risk because she is responding well to the antidepressant.
   d. No risk because she is no longer depressed.

59. While suctioning a tracheostomy, the nurse should:
   a. Suction intermittently during both insertion and withdrawal.
   b. Suction continuously during both insertion and withdrawal.
   c. Suction continuously during insertion only.
   d. Suction intermittently during withdrawal only.

60. The Disaster-Preparedness Committee is responsible for:
   a. Instituting infection control procedures.
   b. Establishing guidelines for the use of patient restraints.
   c. Posting exit routes from each area of the hospital.
   d. Ensuring compliance with air ventilation guidelines.

61. During an interview with a patient, what type of patient response provides the most useful information about the patient?
   a. Verbal responses.
   b. Non-verbal responses.
   c. Silence.
   d. Both verbal and non-verbal responses.

62. A patient with Crohn's disease is placed on the elemental diet to control symptoms. The elemental diet comprises primarily
   a. complete proteins and fats.
   b. amino acids and glucose.
   c. glucose and fats.
   d. complete proteins, vitamins, and minerals.
63. The best determinant of the effectiveness of patient education is:
   a. Patient satisfaction.
   b. A patient’s ability to demonstrate a procedure.
   c. A patient’s ability to explain a procedure and demonstrate understanding.
   d. A patient’s behavior modification and compliance rates.

64. After a spinal tap, the patient complains of severe headache, visual disturbances, and nausea. An autologous blood patch may be injected epidurally near the puncture site in order to:
   a. Prevent infection.
   b. Relieve local pain at the puncture site.
   c. Plug the puncture hole in the dura.
   d. Reduce edema at the puncture site.

65. Which right is included in the Patients’ Bill of Rights?
   a. Affordable healthcare.
   b. Pain control.
   c. Right to sue.
   d. Access to latest medical technology.

66. What type of assessment would evaluate hazards in the home, such as loose carpets, rotting food, or piles of paper on the floor?
   a. Physical assessment.
   b. Functional assessment.
   c. Environmental assessment.
   d. Psychosocial assessment.

67. The nurse is responsible for four patients and must delegate some tasks to unlicensed assistive personnel (UAP). The tasks that should be delegated are those
   a. with the highest priority.
   b. that are most time-consuming.
   c. with the lowest priority.
   d. that are least time-consuming.

68. A 26-year old gay male has suffered a concussion, ruptured eardrum, facial cuts, and large bruises on his back and both arms. The patient and his partner, who stays with the patient, both state that the patient fell down the stairs but they provide inconsistent explanations. These types of injury most suggest that:
   a. The patient is probably telling the truth.
   b. The patient may have been drinking or taking drugs, causing him to fall.
   c. The patient probably had a different type of accident than the one reported.
   d. The patient may be a victim of domestic abuse.
69. A burn patient is upset and argues loudly with the nurse, refusing wound care and stating that the treatment is too painful. Which response is an example of therapeutic communication?
   a. "You should stop arguing with the nurses."
   b. "Everyone gets upset at times."
   c. "Let's talk about this and see if we can figure out a way to make the treatment more comfortable for you."
   d. "You should be happy that the burns are healing so well."

70. Which of the following complies with the American Medical Association guidelines for informed consent?
   a. A patient with a meningioma is provided a list of treatment options: Wait and observe, radiosurgery, or craniotomy.
   b. A patient with possible breast cancer is told that her only option for diagnosis is a fine needle aspiration.
   c. A preoperative patient is advised that she has nothing to worry about because gall bladder surgery poses almost no risks.
   d. A patient with 4th stage pancreatic cancer is advised that he must have chemotherapy, or he will die.

71. The primary reason for completing continuing education courses is:
   a. To meet state requirements for licensure.
   b. To remain current in the field of nursing.
   c. To meet institution requirements for employment.
   d. To meet requirements for salary increase.

72. A woman caring for her elderly father in the home complains that he is frequently incontinent of urine on the way from the living room (where he spends most of the day) to the bathroom near his room. The best solution is:
   a. Leave the father in the bedroom during the day, close to the bathroom.
   b. Ask the doctor to insert a Foley catheter.
   c. Utilize adult diapers.
   d. Provide a urinal near his chair in the living room.

73. Which immunizations are routinely ordered for all adults >60 to 65?
   a. Pneumococcal polysaccharide-23, influenza vaccine, and herpes zoster vaccine.
   b. Influenza vaccine only.
   c. Hepatitis A and hepatitis B vaccine.
   d. Influenza vaccine and hepatitis C vaccine.

74. An 88-year old male with moderate Alzheimer’s disease has been cared for at home by his frail 84-year old wife. The man has weight loss related to malnutrition and is not wearing his dentures. His clothes are unkempt and dirty. He clings to his wife, who remains attentive. This man’s condition is probably related to:
   a. Elder abuse.
   b. Active neglect.
   c. Passive neglect.
   d. Poverty.
75. A 65-year old woman with renal disease is scheduled for magnetic resonance imaging (MRI) with IV contrast. What screening test should be completed prior to the MRI?
   a. Hematocrit.  
   b. Creatinine.  
   c. Sedimentation rate.  
   d. Prothrombin time.

76. A patient has been treated for septicemia and is demonstrating depressed cardiac function, renal failure, respiratory distress syndrome, thrombocytopenia, and disseminated intravascular coagulation (DIC). The most-likely diagnosis is:
   a. Systemic inflammatory response syndrome  
   b. Sepsis  
   c. Septic shock  
   d. Multiple organ dysfunction syndrome.

77. Which of the following would be considered a patient restraint, requiring a physician’s order with a specified duration of use?
   a. Wrist strap restraint.  
   b. Wrist board to protect an IV.  
   c. Cervical traction.  
   d. Bed half side rails (2 rails).

78. The nurse should identify learner outcomes as part of plan for an educational offering. A learner outcome for teaching diabetics about insulin reaction is:
   a. Identify different types of insulin.  
   b. List and describe the symptoms of insulin reaction.  
   c. Identify foods high in carbohydrates.  
   d. Explain the difference between Type I and Type 2 diabetes.

79. When a patient presents with hematochezia, the most likely site of GI bleeding is the
   a. esophagus.  
   b. stomach.  
   c. small intestine.  
   d. colon.

80. A 22-year old sexually active male complains of difficulty urinating and purulent discharge from the urethra. Epididymitis and prostatitis are found on examination. The most likely cause is:
   a. Gonorrhea.  
   b. Syphilis.  
   c. Chlamydia.  
   d. Trichomoniasis.

81. A patient with bipolar disorder is prescribed lithium for an episode of acute mania. The therapeutic range of lithium for acute mania is
   a. 0.6 to 1.2 mEq/L  
   b. 1.0 to 1.5 mEq/L  
   c. 1.5 to 2.0 mEq/L  
   d. 2.0 to 3.5 mEq/L.
82. A newly-hired nurse is assisting her team leader, who is preparing to insert an IV catheter. The team leader drops the sterile catheter onto the bed linens and then picks up the contaminated catheter and continues to prepare for insertion. What is the best response?
   a. Wait until the team leader finishes the procedure and ask why she used the contaminated catheter.
   b. Report the team leader’s behavior to a supervisor after the catheter is inserted.
   c. Say nothing to anyone, as the linens were clean.
   d. Immediately say: “The catheter was contaminated when it fell. Would you like me to get another setup or stay with the patient while you get it?”

83. In evaluating nutritional intervention outcomes for a patient with type 1 diabetes mellitus, with a fasting blood sugar of 130 mg/dL three months previously, which lab result most indicates dietary compliance:
   a. Fasting blood sugar of 106 mg/dL.
   b. Hemoglobin A1C of 6.6%.
   c. Hemoglobin A1C of 5.5%.
   d. Fasting blood sugar of 150 mg/dL.

84. A patient who developed acute pulmonary emboli has been treated initially with low-molecular-weight heparin and is to be transitioned to warfarin for at least 6 months to prevent recurrence. How should the warfarin be instituted?
   a. Stop heparin and immediately begin warfarin.
   b. Stop heparin for 48 to 72 hours and then begin warfarin.
   c. Administer both heparin and warfarin for about 5 days.
   d. Administer both heparin and warfarin for 48 to 72 hours.

85. A 33-year old woman developed multiple genital warts in the anogenital area. The warts recently spread to the inside of the vagina. This is a concern, as genital warts increase the woman’s risk of developing:
   a. Infertility.
   b. Gonorrhea.
   c. Syphilis.
   d. Cervical cancer.

86. Which of the following is most likely to lead to medication errors?
   a. Hand block-printing of all orders.
   b. The use of bar coding and scanners.
   c. The use of medical abbreviations.
   d. Computer generated orders.

87. A patient complains of exercise-induced angina, chest pain radiating down the left arm and lasting < 5 minutes. This type of angina is:
   a. Stable.
   b. Unstable.
   c. Coronary artery spasm.
   d. Variant (Prinzmetal’s).
88. One advantage of group instruction over one-on-one instruction is:
   a. It is more cost-effective.
   b. It requires less planning.
   c. It allows more time for questions.
   d. It is more flexible.

89. One of the most common causes of the person-to-person spread of infection in hospitals is:
   a. Crowded conditions.
   b. Poor hand-washing technique.
   c. Inadequate housekeeping.
   d. Antibiotic resistance.

90. Pain Assessment in Advanced Dementia (PAINAD) utilizes:
   a. A face scale with pictures of smiling or crying faces.
   b. A “0” (no pain) to “10” (severe pain) scale.
   c. Monitoring of blood pressure changes.
   d. Observations of non-verbal behavior.

91. The Confusion Assessment Method is a tool that covers 9 factors related to mental status. This tool is used to assess for:
   a. Delirium.
   c. Substance abuse.
   d. Brain injury.

92. A wealthy patient who has been on a unit for two weeks gives a nurse an expensive watch out of gratitude. What is the best nurse response?
   a. "You don’t need to pay for nursing care.”
   b. "Thank you so much! I will treasure this!”
   c. “This is much too expensive for me to accept.”
   d. "I'm sorry. This is so kind of you, but nurses are not allowed to accept gifts from patients.”

93. National guidelines recommend that adults engage in exercises of moderate intensity for:
   a. 20 minutes daily to minimum total of 100 minutes weekly.
   b. 30 minutes daily to minimum of 150 minutes weekly.
   c. 60 minutes daily to minimum of 300 minutes weekly.
   d. 10 minutes daily to minimum of 60 minutes weekly.

94. A problem list focuses on:
   a. A prioritized list of patient problems based on assessment, history, and interview.
   b. All identified patient problems based on assessment, history, and interview.
   c. The patient’s self-reported problems.
   d. A standardized list of problems related to specific diagnoses.
95. The CAGE tool is used to assess people for:
   a. Prescription drug abuse.
   b. Cocaine abuse.
   c. Alcohol abuse.
   d. Gambling addiction.

96. A patient has had a number of intestinal polyps removed during a colonoscopy. Which of the following types of polyps poses the greatest risk for developing into cancer?
   a. Adenomatous
   b. Hyperplastic
   c. Inflammatory
   d. Lymphoid

97. Working for the best interests of the patient despite conflicting personal values and assisting patients to have access to appropriate resources may be defined as:
   a. Moral agency.
   b. Advocacy.
   c. Agency.
   d. Collaboration.

98. Which therapy involves the use of monitoring devices to allow people to control their own physiological responses?
   a. Imagery.
   b. Acupuncture.
   c. Meditation.
   d. Biofeedback.

99. A 30-year old male with paralysis of his legs and hips uses crutches and braces to ambulate. Which crutch gait is most appropriate?
   a. The swing-to gait.
   b. The swing-through gait.
   c. A two-point gait.
   d. A four-point gait.

100. A nurse documents a treatment on the wrong chart. Which is the correct action?
    a. Drawing a line through the entry and writing “Error.”
    b. Leaving the initial entry but indicating below that it was documented on the wrong chart.
    c. Whitening out the entry so it's not legible.
    d. Recopying the entire page, omitting the entry.

101. A cooperative 80-year old patient suffered a stroke and has limited use of her right hand and some forgetfulness. She is very anxious. What type(s) of barriers to self-care would this patient have?
    a. Psychological and cognitive
    b. Physical and cognitive
    c. Physical only.
    d. Psychological, physical, and cognitive.
102. A 23-year old Hmong male has acute appendicitis but refuses to sign the consent form until his grandfather arrives. The probable reason is:
   a. The patient has no insurance.
   b. The patient lives with his grandfather and is dependent on him for support.
   c. The patient is afraid to have surgery without family present.
   d. The grandfather is the eldest male in the family and makes the decisions for the family.

103. Which of the following is a typical characteristic of hyperosmolar syndrome (HHS)?
   a. Serum glucose 300 mg/dL to 800 mg/dL
   b. Normal or slightly elevated ketones
   c. Sudden onset (within hours)
   d. Affects type 1 diabetics

104. A nurse attempts to start an IV line on an elderly patient, but the patient refuses to cooperate. The nurse tells the patient that she will have the nursing assistant hold him down if he doesn’t stop fighting and let her insert the IV. This nurse's response is best characterized as:
   a. Non-therapeutic communication.
   b. Coercion.
   c. Abuse.
   d. Poor judgment.

105. The best approach to solving a problem that involves 3 different departments in the hospital is:
   a. Forming an interdisciplinary team that works together to find a solution.
   b. The administration resolves the problem independently.
   c. Each department proposes a solution to administration.
   d. All three departments have a joint meeting to brainstorm possible solutions.

106. A home health nurse visits an older adult and observes that the patient has little food in the house. The patient states he has run out of money and cannot buy groceries, but he does not want his family and friends to know. Which nurse response is appropriate?
   a. Going to the store and buying a small bag of groceries for the patient.
   b. Referring the patient to the appropriate social service agencies.
   c. Calling the patient’s daughter anyway and telling her that the patient needs assistance.
   d. Asking the next-door neighbor—who has expressed a willingness to help—to provide meals.

107. When positioning a patient after a total hip replacement, it's important to:
   a. Avoid flexing the knee of the affected leg beyond 90 degrees.
   b. Avoid crossing the affected leg over the other leg.
   c. Maintain 90-degree hip flexion while the patient is sitting.
   d. Position the patient in side-lying position with the affected leg at 90-degree flexion.
108. A 56-year-old patient has developed postoperative bleeding, but the patient is a Jehovah’s Witness and had insisted on blood-free surgery with no transfusions. The patient had indicated in writing that he would accept no blood products except fractions permitted by his religious beliefs. Although made aware that his condition may be life-threatening, the patient continues to refuse blood transfusions. However, his wife has confided to the physician and nursing staff that, if the patient loses consciousness, she will authorize the transfusions; and the physician is in agreement. What is the best response?
   a. Refuse to give a transfusion if ordered.
   b. Contact the ethics committee regarding the situation.
   c. Administer the transfusion when ordered.
   d. Tell the patient’s wife that she is violating her husband’s wishes.

109. A patient with myasthenia gravis has been choking frequently (especially with solids and thin liquids), complaining of regurgitation, experiencing esophageal reflux when supine, and losing weight. The patient has probably developed:
   a. Aspiration pneumonia.
   b. Hiatal hernia.
   c. Gastroesophageal reflux disease.
   d. Dysphagia.

110. When preparing written materials for patients, what readability level would be appropriate for a homogeneous adult patient group in an affluent area?
   a. Grade 6 level.
   b. Grade 9 level.
   c. Grade 3 level.
   d. Grade 12 level.

111. A patient who was premedicated 20 minutes ago with a sedative drug prior to a scheduled surgery had not yet signed the consent form. No family is present. Which of the following is the best action?
   a. Notify the surgeon that there is no consent form.
   b. Have the patient sign the consent form.
   c. Obtain a telephone permit from a family member.
   d. Document in the chart that the patient had given verbal consent.

112. A team leader makes decisions independently and strictly enforces all rules. This type of leadership is:
   a. Bureaucratic.
   b. Laissez-faire.
   c. Autocratic.
   d. Democratic.

113. A 50-year-old obese patient with a BMI of 32 and chronic hypercapnia (PaCO₂ of 48 mm Hg) during the daytime is diagnosed with obesity hypoventilation syndrome. The patient most likely has which of the following comorbidities?
   a. Congestive heart failure
   b. Guillain-Barré syndrome
   c. Obstructive sleep apnea
   d. COPD
114. A 38-year old post-operative female is exhibiting signs of pulmonary embolism (tachypnea, tachycardia, cough, fever, rales, anxiety, and hemodynamic instability). Which procedure provides the best diagnostic information?
   b. Electrocardiogram.
   c. Chest x-ray
   d. Spiral CT.

115. A 60-year old female patient is diagnosed as pre-diabetic and insulin resistant with mild kidney disease. Her hemoglobin A1C is 6.5. She is 5 feet 1 inches tall, weighs 220 pounds, and recently quit work because of back pain. Two sisters are diabetic. A typical blood pressure finding would be:
   a. Normal blood pressure.
   b. Hypertension.
   c. Hypotension.
   d. Postural hypotension.

116. A nurse is interviewing a patient who is hearing impaired. Which of the following may well be a significant impediment to communication?
   a. The nurse uses only a normal tone of voice and speaks with short sentences.
   b. The nurse provides assistive devices, such as writing materials.
   c. The nurse is facing the patient at a distance of 5 feet.
   d. The nurse is chewing gum to freshen her breath.

117. A 50-year old man dying from liver disease is Catholic and asks to take final communion even though it is 2 AM. The nurse should:
   a. Contact the patient’s priest or a priest on call for the institution and ask him to come right away.
   b. Tell the patient that no priest is available.
   c. Ask the patient if he would be willing to see the Protestant chaplain who is on call.
   d. Tell the patient the priest will be called at 7 AM.

118. A nurse gives the wrong medication to a patient. The nurse should:
   a. Immediately inform the patient.
   b. Document the medication given on the patient’s record, indicating that it was a medication error.
   c. Document the medication given only on the incident report.
   d. Document the medication as given on the patient’s record, but indicate it was an error on the incident report only.

119. Which of the following most closely characterizes Selye’s biological theory of stress and aging?
   a. The body is a machine that wears out over time.
   b. The body’s response to stress is characterized by a generalized adaptation syndrome.
   c. All cells and organisms have a programmed life span.
   d. Over time, mutations occur that interfere with body functioning and cause aging.
120. A patient admitted with acute abdominal pain is moaning and curled in the fetal position holding her abdomen. What assessment does the nurse carry out first?
   a. Physical examination of the abdomen
   b. History of onset and duration of abdominal pain
   c. Vital signs
   d. Pain assessment (with pain scale)

121. A 54-year old patient is admitted with symptoms of an ischemic stroke verified by CT. He is being considered for thrombolytic therapy with alteplase tissue-type plasminogen activator (t-PA). Which is a contraindication to thrombolytic therapy?
   a. The patient is 2 hours post-onset of symptoms.
   b. The patient had a mitral valve replacement 1 week previously.
   c. The patient’s blood pressure was 180/90 on admission. It is now 150/90.
   d. The patient had an ischemic stroke 6 months previously.

122. The nurse enters a room of a patient who has advanced macular degeneration and has lost most central vision. Which action is appropriate?
   a. Speaking loudly on entering the room to alert the patient to the nurse’s presence.
   b. Sitting directly in front of the patient while speaking to her.
   c. Announcing his presence in a normal tone of voice and explaining relevant actions and movements.
   d. Speaking to the patient with simple direct vocabulary.

123. A 68-year old female patient has peripheral vascular disease characterized by arterial insufficiency. Which symptom is typical of peripheral arterial disease?
   a. Brownish discoloration about the ankles and the anterior tibial area.
   b. Deep circular painful necrotic ulcers on the toe tips, toe webs, or other pressure areas.
   c. Irregular superficial ulcers on the medial or lateral malleolus and sometimes the anterior tibial area.
   d. Moderate to severe edema.

124. What type of precaution is appropriate under CDC isolation guidelines for a patient with active tuberculosis?
   a. Tier I: Standard precautions
   b. Tier II: Airborne precautions.
   c. Tier II: Droplet precautions.
   d. Tier II: Contact precautions.

125. Which medication order is written correctly?
   a. Maalox 30 cc PO qhs.
   b. Lasix 40.0 mg PO daily.
   c. MS 4.0 mg IV q 4 hr. prn.
   d. Synthroid 0.88 mg PO daily at 0700.

126. The best time for a nurse to establish educational goals for teaching patients is:
   a. Before creating materials and lesson plans.
   b. While creating materials and lesson plans.
   c. After materials and lesson plans are developed.
   d. After presenting the class and determining patient needs.
127. Two months after an ischemic stroke, a patient still has difficulty understanding and producing language in speaking, reading and writing. However, the patient can understand gestures, pictures, and diagrams. This type of aphasia is:
   a. Global.
   b. Transient.
   c. Broca's.
   d. Wernicke's.

128. A 62-year old male patient has a regular pulse >100 with P waves before the QRS complex, but sometimes preceding the T wave. The QRS pattern is of normal shape and duration. The PR interval is 0.12 to 0.20 seconds and P: QRS ratio is 1:1. Given this information, the cardiac diagnosis is:
   a. Sinus bradycardia.
   b. Sinus tachycardia.
   c. Sinus arrhythmia.
   d. Premature atrial contractions.

129. Dietary management of diabetes mellitus, or medical nutrition therapy (MNT), includes:
   a. Calorie-based diet control.
   b. Low protein diet control.
   c. Standardized diet modifications.
   d. Individualized diet modifications.

130. A patient with aspiration pneumonia had been hospitalized and treated for four days with clindamycin before developing abdominal pain with cramping and moderate to severe watery diarrhea. The most likely cause is
   a. allergic response to clindamycin.
   b. Escherichia coli infection.
   c. Clostridium difficile colitis.
   d. viral gastroenteritis.

131. The nurse is interviewing a patient with advanced Parkinson’s disease and dysarthria, but without signs of dementia or hearing impairment. Which interview technique is most appropriate?
   a. Using simple sentences and speaking loudly.
   b. Asking primarily yes/no questions and observing the patient's facial expressions and gestures.
   c. Completing patient's sentences to help the patient communicate more easily.
   d. Directing all questions to family members to spare the patient stress.

132. When considering outcome measures, striving for patient satisfaction is:
   a. A long-term outcome.
   d. A process.
133. Interdisciplinary teams that are most effective have:
   a. <10 members.
   b. 10 – 15 members.
   c. 2 – 4 members.
   d. >15 members.

134. A patient’s laboratory results show the following: TSH of 11.0, T4 of 2.4, and a positive antithyroid microsomal antibodies test. These findings most likely indicate
   a. Hashimoto’s thyroiditis.
   b. euthyroid.
   c. hypothyroidism.
   d. hyperthyroidism.

135. When considering the use of an interpreter for a patient who does not speak English, which consideration is most important?
   a. The interpreter has training in medical vocabulary for both languages.
   b. The interpreter speaks both languages well.
   c. The interpreter knows the patient’s history.
   d. The interpreter is available onsite to translate.

136. A 70-year old female is assessed for nutritional status. Lab results show that her albumin level is 2.4 g/dL, pre-albumin is 4 mg/dL, and transferrin is 90 mg/dL. These results indicate:
   a. Adequate nutrition.
   b. Dehydration.
   c. Severe malnutrition.
   d. Mild to moderate malnutrition.

137. A nurse remembers that she had forgotten to chart a patient’s complaint of disorientation that occurred 5 hours previously. The nurse should now:
   a. Document the information between the lines so it is chronologically in the correct place.
   b. Document in the next space with current date and time but precede the entry with “Late entry” followed by the date and time of the information in parentheses
   c. Document the information in the next space but draw an arrow indicating where it should have been inserted.
   d. Don’t document the information on the chart, but document in an incident report.

138. A patient who is four days postoperative after a bowel resection for cancer was started on oral clear liquids, but has developed nausea, severe abdominal pain, and abdominal distention. The patient vomits bile and fecal material. The nurse is unable to hear bowel sounds. What diagnostic test should the nurse anticipate?
   a. Abdominal x-ray
   b. Abdominal CT
   c. Abdominal MRI
   d. Abdominal ultrasound
139. A 75-year old female patient has been unable to eat after surgery to repair an abdominal aneurysm. She has received total parenteral nutrition (TPN) for four days. What risks are associated with TPN?
   a. Infection and glucose intolerance.
   b. Irritation and aspiration.
   c. Nausea and vomiting.
   d. Skin excoriation

140. As HIV/AIDS progresses, one would expect the CD4 count to:
   a. Increase
   b. Decrease
   c. Remain stable.
   d. Fluctuate.

141. Which of the following professional communication skills are used to facilitate communication with intra- and inter-disciplinary teams?
   a. Interpreting the statements of others to facilitate the flow of ideas.
   b. Reacting and responding to facts rather than feelings.
   c. Providing advice when it appears needed.
   d. Asking questions to challenge other people’s ideas.

142. A 40-year old male patient complains of daytime somnolence, headache, forgetfulness, increased weight, and impotence. His wife states he has been depressed, has had personality changes, and snores loudly with cycles of holding his breath. Which diagnosis is most likely?
   a. Narcolepsy.
   b. Insomnia.
   c. Obstructive sleep apnea.
   d. Hypothyroidism.

143. Which is the most critical skill for a nurse collaborating in an interdisciplinary team?
   a. Patience.
   b. Assertiveness.
   c. Empathy with others.
   d. Willingness to compromise.

144. A 52-year old female with a history of bipolar disease has had a hip replacement, and is at post-operative day one. The patient slept only one or two hours during the night and is now speaking rapidly, throwing her belongings at the nurses, and insisting she is going to leave the hospital against medical advice. The nurse should notify:
   a. The mental health crisis team.
   b. Social services.
   c. The police.
   d. The patient’s husband.
145. Which smoking cessation medication must be monitored carefully because of dangerous side effects?
   a. Nicotine nasal spray.
   b. Bupropion (Zyban®).
   c. Nicotine inhaler.
   d. Varenicline (Chantix®).

146. Following a severe auto accident, a 24-year old patient with a BK amputation is having trouble coping with the change in body image. This is evident by the following sign:
   a. The patient refuses to look at the stump or participate in his own care.
   b. The patient complains of phantom pain.
   c. The patient states he is angry with the other driver.
   d. The patient starts crying when talking about rehabilitation.

147. In the nursing process, evaluation should be done:
   a. During the implementation phase only.
   b. During all phases.
   c. During the assessment phase only.
   d. During the evaluation stage only.

148. Which is a contraindication to organ donation?
   a. Age of 65 years.
   b. History of alcoholism.
   c. Active pancreatic cancer.
   d. Age of 2 years or less.

149. The drop factor of an intravenous drip is:
   a. Equal to the flow rate.
   b. The drops per mL.
   c. The size of the IV tubing.
   d. The size of the IV catheter or needle.

150. What stage is a pressure ulcer with a deep lesion and including involvement of subcutaneous tissue and undermining?
   a. Stage I.
   b. Stage II.
   c. Stage III.
   d. Stage IV.
Answer Explanations

1. A: A cost-benefit analysis uses average cost of a problem (such as wound infections) and the average cost of intervention to demonstrate savings. For example, if a surgical unit averaged 10 surgical site infections annually at an additional average cost of $27,000 each, the total annual cost would be $270,000. If the total cost for interventions, (new staff person, benefits, education, and software) totals $92,000, and the goal is to reduce infections by 50% (0.5 x $270,000 for a total projected savings of $135,000), cost benefit is demonstrated by subtracting the proposed savings from the intervention costs ($135,000 - $92,000) for a savings of $43,000 annually.

2. D: Erickson's psychosocial development model focuses on conflicts at each stage of the lifespan and the virtue that results from finding balance in the conflict. The first 5 stages refer to infancy and childhood and the last 3 stages to adulthood:
   - Intimacy vs isolation (Young adulthood): Love/intimacy or lack of close relationships.
   - Generativity vs stagnation (Middle age): Caring and achievements or stagnation.
   - Ego integrity vs despair (Older adulthood): Acceptance and wisdom or failure to accept changes of aging/despair.

3. B: The patient is experiencing the stage of anger. People grieve individually and may not go through all stages, but most go through at least 2 stages. Kübler-Ross’s 5 stages of grief include:
   - Denial: Refusal to believe, confused, stunned, detached.
   - Anger: Directed inward (self-blame) or outward.
   - Bargaining: If – then thinking. (“If I go to church, then I will heal.”)
   - Depression: Sad, withdrawn.
   - Acceptance: Resolution.

4. C: The most appropriate nursing diagnosis for a person who is able to exercise but remains sedentary is risk of disuse syndrome because the patient is putting himself at risk for the development of circulatory impairment and muscle atrophy. Failure to exercise may also exacerbate his condition. While his health maintenance may be ineffective, it is directly due to of his lack of activity. He does not have impaired physical mobility or activity intolerance that precludes exercise.

5. D: A cost-effective analysis measures the effectiveness of an intervention rather than the monetary savings. For example, annually 2 million nosocomial infections result in 90,000 deaths and an estimated $6.7 billion in additional health costs. From that perspective, decreasing infections should reduce costs, but there are human savings in suffering as well, and it can be difficult to place a dollar value on that. If each infection adds about 12 days to hospitalization, then a reduction of 5 infections (5 x 12 = 60) would result in a cost-effective savings of 60 fewer patient infection days.

6. C: The nurse should arrange for an interpreter. Children should never be used as interpreters as they lack sufficient vocabulary and understanding about health matters and may not interpret correctly. The use of a child interpreter may also be awkward or embarrassing, depending upon the topic being addressed. Other adult family members, such as the wife, should not be asked to answer questions for the patient unless the patient...
is unable to answer questions because of health condition because they may not understand medical terms and may not interpret correctly. Additionally, the patient may have kept information from the family.

7. B. The most important factor in having a patient sign a consent form is the patient’s ability to give informed consent. This means that the patient must have the legal right by age or emancipation and must be able to comprehend. If a patient is cognitively impaired because of dementia, sedation, or condition, this can pose a problem because patients cannot legally give consent if they are unable to understand. If patients don’t speak English, a translator should be provided.

8. C: Kinesthetic learners learn best by handling, doing, and practicing. Thus, they should be allowed to handle supplies and equipment with minimal directions. They benefit most from demonstrating their understanding by performing the procedure. Visual learners learn best by seeing and reading and thus benefit most from written directions, videos, diagrams, pictures, and demonstrations. Auditory learners learn best by listening and talking, so procedures should be thoroughly explained during any demonstrations. Auditory learners also benefit from audiotapes and extra time for questions.

9. A: Root cause analysis (RCA) is a retrospective attempt to determine the cause of an event, such as a death or other sentinel event. RCA involves interviews, observations, and review of medical records. External benchmarking monitors data from outside an institution, such as national rates of infections, and compares them to internal data. Internal trending compares internal rates of one area or population with another. Tracer methodology looks at the continuum of care a patient receives from admission to post-discharge, using a selected patient’s medical record as a guide.

10. B: All departments in a healthcare institution should strive toward a common vision of care. This begins with the organization working collaboratively to create a team approach to serving the patient/family. Achieving a common vision requires inclusion of all levels of staff (both nursing and non-nursing) in consensus building through discussions, in-services, and team meetings. It also includes facilitation that values creativity, a vision statement that incorporates a common vision, and the recognition that a common vision is an organic concept that evolves over time and requires re-evaluation and periodic change.

11. D: The most appropriate nursing diagnosis for an Alzheimer patient who walks away from the hospital and hides in the parking lot is wandering. Acute confusion alone does not account for his behavior. While this patient may have risk-prone health behavior because of his dementia, and impaired memory, this particular type of wandering behavior is typical of Alzheimer patients. The reason patients wander is not clear. They may have been looking for a bathroom and gotten lost or perhaps they were looking for someone. Once lost, they often become frightened and compound the problem by hiding.

12. C: Clinical pathways should be based on evidence-based research, which refers to the use of current research and patient values in practice to establish an idealized plan of care. Research may be the result of large studies of best practices, or it may arise from individual research efforts using observations in practice about the effectiveness of a particular treatment. Evidence-based research requires a commitment to ongoing research and
outcomes evaluation. Evidence-based research requires a thorough understanding of research methods, including internal and external validity.

13. B: The family should be encouraged to stay and talk to the patient, as hearing is usually the last of the senses to fail. Typical physical changes associated with death include:
   - Sensory: Reduced sensations of pain and touch. Decreased vision and hearing
   - Cardiovascular: Tachycardia followed by bradycardia, dysrhythmia, and hypotension.
   - Respiratory: Tachypnea, progressing to Cheyne-Stokes respiration.
   - Muscular: Muscles relax, the jaw sags, and the ability to swallow and talk is lost.
   - Urinary: Output decreases (accompanied by incontinence), and anuria follows.
   - Integumentary: Skin becomes cold, clammy, cyanotic, and waxy. Skin in the coccygeal area often tears.

14. D: Severe dehydration is fluid loss >15% and occurs when total body water decreases but sodium does not. It is characterized by marked hypotension and anuria as well as symptoms associated with lesser dehydration. Mild dehydration (5% loss) is characterized by dizziness, lethargy, reduced skin turgor, dry mucous membranes, and orthostatic hypotension. Moderate dehydration (10% loss) is characterized by confusion, resting hypotension, tachycardia, and oliguria/anuria. Dehydration may result from inadequate fluids, excess water loss, NG suctioning, drugs, diarrhea, vomiting, and fever.

15. A: Functional urinary incontinence can occur when physical (impaired mobility) or mental (confusion, depression) disabilities prevent the person from controlling urination. Stress incontinence is characterized by small amounts of involuntary urinary leakage, often during physical activity. Overflow incontinence is also characterized by small leakages of urine, but it results from pressure on an overly-distended bladder. Urge incontinence involves moderate to large amounts of involuntary urinary leakage and is characterized by a sudden urge to urinate coupled with an inability to hold urine.

16. A. Because the patient sustained a head injury and is at risk for increased intracranial pressure, the patient should have a CT of the brain prior to the procedure so it can be reviewed for signs of a brain shift that may indicate ICP. With increased ICP, when pressure is suddenly relieved by withdrawing of cerebral spinal fluid, the brain structures may herniate through the foramen magnum, compressing the brainstem, which is critical for regulation of cardiac and respiratory function.

17. C: Initially, the physician must certify that a patient who is eligible under Medicare A is terminal with a life expectancy <6 months (two 90-day periods). However, if the patient remains alive, the physician can extend coverage by authorizing continued hospice care every 60 days. The goal is to maintain the patient in the home environment with home health aides, homemakers, durable goods, pain management, case management, counseling, and social worker assistance. Routine intermittent home care must comprise 80% of total care, with in-home continuous care and in-patient hospice care available for short augmenting periods only.

18. B: When asking a patient to describe his/her pain, it is best to use an open-ended type of question that elicits specific information. Questions, such as “Are you having pain?” may easily be answered by a simple “yes” or “no” and thus provide little information. “What kind
of pain are you having?” may be confusing to patients. The pain scale should be used after the patient has described his/her pain and the nurse has explained in detail, with examples, what the pain scale means.

19. C. Phenytoin may cause gingival hyperplasia, so patients should be advised to carefully maintain dental care and to see dentists regularly. Patients may have monthly blood tests initially but once stabilized blood tests are usually done every six months. Patients should be advised to avoid alcohol entirely when taking any anticonvulsant drug. Stopping anticonvulsant drugs abruptly may trigger rebound seizures, so if adverse effects occur, the patient should be advised to immediately contact the physician for guidance in withdrawing the drug if necessary.

20. A: Team members usually observe the leader and determine who controls the meeting and how control is exercised, while beginning to form alliances. Arguing is counterproductive, and following strict rules of discourse may not solve power issues and may be too restrictive for small collaborative groups. Group interactions often become less formal as members develop rapport and are more willing to help and support each other to achieve goals. Rotating leadership roles can lead to a lack of focus as styles may vary widely. The leader is responsible for organizing the group, clarifying methods to achieve work, and the means of working together toward a common goal.

21. B: The Mini-cog test assesses dementia by having patients remember and repeat 3 common objects and draw a clock face indicating a particular time. The MMSE assesses dementia through a series of tests, including remembering the names of 3 common objects, counting backward, naming, providing location, copying shapes, and following directions. The Digit Repetition Test assesses attention by asking the patient to repeat the 2 number, then 3, then 4 and so on. The Confusion Assessment Method is used to assess delirium, not dementia.

22. B. The most appropriate referral for the patient is an occupational therapist who can help the patient develop strategies and skills needed to compensate for poor vision and arthritis and provide information about adaptive equipment that the patient can use to prepare food. The occupational therapist can help the patient establish goals for independent food preparation and help the patient modify tasks. The occupational therapist may also help the patient learn how to better manage her arthritis to minimize symptoms.

23. C: The nurse should first assess the patient’s learning style. Patients often know how they like to learn, or are able to provide enough information for the nurse to determine their learning styles. Audiotapes are appropriate for auditory learners, and pictures and diagrams for visual learners. While auto mechanics are usually good with their hands, the nurse should not assume that the patient has a particular learning style simply because of his profession or occupation.

24. B: The Occupational Safety and Health Association (OSHA) regulates workplace safety, including disposal methods for sharps, such as needles. OSHA requires that standard precautions be used at all times and that staff be trained to use precautions. OSHA requires procedures for post-exposure evaluation and treatment, and the availability of the hepatitis B vaccine for healthcare workers. OSHA regulates occupational exposure to infections, and
establishes standards to prevent the spread of blood-borne pathogens, as well as regulating the fitting and use of respirators.

25. D: Palliative care provides comfort rather than curative treatment, although curative treatment may also relieve pain or symptoms. Thus, there is no clear line between the two. Palliative care is meant to improve the quality of life and to relieve suffering, but it does not include treatments solely intended to prolong life or hasten death. The goals of palliative care are to provide adequate pain management and relief of symptoms (such as nausea or shortness of breath), to provide support for both the patient and caregivers or family, and to ensure that patients and family receive psychosocial, spiritual, and bereavement support.

26. C: The Braden scale is used to assess and predict the risk of a patient developing pressure sores. The Norton Scale is also used to predict pressure sores, and is based on scores in 5 categories (physical, mental, activity, mobility, and incontinence). The Pressure Ulcer Scale for Healing (PUSH) is used to assess improvement or deterioration of existing ulcers based on measurements, exudate, and tissue type. The Diabetic Foot Ulcer Scale assesses the quality of life of those with diabetic foot ulcers.

27. A: The primary purpose of interdisciplinary teams is the sharing of ideas and perspectives to solve problems. Collaboration requires open sharing and respect for the expertise of other professionals. Interdisciplinary teams may include doctors, nurses, and other members of the allied health professions as well. While cost-saving, timesaving, and improved patient satisfaction may (and often do) result from innovative approaches to problem solving, these are secondary benefits from effective interdisciplinary collaboration.

28. A: When a patient is confused and disoriented, the best response is to say what is true. State, “That sound is an ambulance siren,” calmly and without arguing. Saying “No one is screaming” challenges the patient without explanation and may increase confusion. Distracting the patient may be helpful after the explanation, but this should not be the first response. Saying “She has stopped screaming now, so everything’s ok” reinforces the patient’s faulty perception and does nothing to alleviate confusion. Note: A patient confused and disoriented due to transient illness is very different from one suffering with acute delusions or paranoia from chronic mental illness such as schizophrenia. A confused patient needs clarification and re-orientation, while a paranoid and/or delusional patient may become angry or even violent if their perceptions are negated.

29. A: This patient is exhibiting dependence in response to stress. Typical psychological responses to stress include:
   - Dependence: The patient has an inability to make decisions, requires constant reassurance, and calls nurses/families frequently.
   - Depression: The patient is withdrawn and sad, fails to take treatments and/or misses appointments, and may be at risk for suicide.
   - Anger: The patient is belligerent, uncooperative, and blames others.
   - Confusion: The patient is forgetful, disoriented, and bewildered.
   - Passivity: The patient defers to others, feeling he/she has no control.

30. D: All staff members are responsible for identifying performance improvement projects. Performance improvement must be a continuous process. Continuous Quality Improvement (CQI) is a management philosophy that emphasizes the effectiveness of an
organization and the systems and processes within that organization, rather than focusing on specific individuals. Total Quality Management (TQM) is a management philosophy that espouses a commitment to meeting the needs of the customers (patients and staff) at all levels within an organization. Both management philosophies recognize that change can be made in small steps and should involve staff at all levels.

31. A: The American Geriatrics Society’s “Guideline for the Prevention of Falls in Older Persons” includes an assessment of falls, gait and balance and makes a number of recommendations for preventing falls, including visual remediation (e.g., glasses, if needed, etc.), exercises for strength and balance, review and possible reduction in medications that cause dizziness or instability, modification of home environment, use of an assistive device, supportive footwear, and control of cardiovascular conditions that might cause dizziness/syncope and thereby precipitate falls.

32. A: Healthy People 2020 outlines 12 leading health indicators and national objectives to improve health and reduce the risks of disease in order to improve life expectancy and quality of life. Leading health indicators are: 1) access to health services, 2) clinical preventive services, 3) environmental quality, 4) injury and violence, 5) maternal, infant, and child health, 6) mental health, 7) nutrition, physical activity, and obesity, 8) oral health, and 9) reproductive and sexual health, 10) social determinants, 11) substance abuse, 12) tobacco. Additionally Healthy People 2020 includes 42 focus areas that relate to the 12 leading health indicators.

33. D: The Agency for Healthcare Research and Quality (AHRQ) of the US Department of Health and Human Services provides research and funding for the development of evidence-based practice guidelines. The AHRQ has sponsored the development of surveys for assessment of patient safety and is actively involved in outcomes research. The AHRQ research centers specialize in research related to patient safety, quality improvement, outcomes, assessment of clinical practices and technology, healthcare delivery systems, primary and preventive care, and health care costs.

34. C: Referring the single mother to a social worker is the most appropriate, as social workers have the expertise required to assist a patient to apply for social services, including programs such as Temporary Assistance for Needy Families (TANF) and food stamps. The social worker may be able to help the patient avoid homelessness by assisting her to apply for subsidized or low-cost housing. While the patient may benefit from a referral to a mental health clinic, this will not solve the immediate underlying problem of food and shelter.

35. A: Hyperkalemia often occurs with renal disease and is characterized by ventricular arrhythmia, weakness with ascending paralysis and hyperreflexia, diarrhea, and confusion. Hypokalemia is characterized by weakness, lethargy, nausea and vomiting, paresthesias, dysrhythmias (PVCs, flattened T waves), muscle cramps with hyporeflexia, hypotension, and tetany. Hypocalcemia is characterized by tetany, tingling, seizures, altered mental status, and ventricular tachycardia. Hypercalcemia is characterized by increasing muscle weakness with hypotonicity, constipation, anorexia, nausea and vomiting, and bradycardia.
36. C: Adult learners tend to be practical and goal-oriented, so they tend to remain organized and keep their educational goals in mind while learning. Other characteristics include:

- Self-directed: Adults prefer active involvement and responsibility.
- Knowledgeable: Adults can relate new material to information with which they are familiar by life experience or education.
- Relevancy-oriented: Adults like to know how they will use information.
- Motivated: Adults like to see evidence of their own achievement, such as gaining a certificate.

37. D: The Instrumental Activities of Daily Living (IADL) tool assesses financial ability (ability to pay bills, budget, and keep track of finances), telephone use, shopping, food preparation, housekeeping, laundry, transportation availability (ability to drive or use public transportation), and medications (ability to manage prescriptions and take medications). The Barthel Index of Activities of Daily Living assesses 10 categories, usually including bathing, toileting, ascending or descending stairs, feeding, mobility, personal grooming, urinary and fecal control, transferring, and ambulatory/wheelchair status.

38. A: A patient with cancer and mild pain (Level 1) should begin treatment with acetaminophen or aspirin followed by NSAIDs. Patients should always start with the medication with the fewest side effects (acetaminophen/aspirin) and then move to stronger medications as necessary. NSAIDs should be used if acetaminophen or aspirin doesn’t relieve pain. As patients move up the pain ladder to mild-moderate pain (Level 2) codeine (hydrocodone, tramadol, or oxycodone) with adjuvants will be added, and, finally, with moderate-severe pain (Level 3), opioids (such as fentanyl, morphine and oxycodone), are used to control pain.

39. C. Providing sensitive information to patients or family members should be done slowly rather than quickly so that they have time to digest the information. The nurse should ask if they have questions and should avoid technical jargon and consider psychosocial implications and cultural differences. It’s important to respond to people’s feelings and discuss follow-up. The nurse should exercise patience, understanding that people respond to bad news in very different ways, including both anger and silence.

40. B: The best time to initiate conflict resolution is when conflict first emerges, but before open conflict and hardening of positions. Resolution steps include:

- Allowing both parties to present their side without bias.
- Encouraging cooperation through negotiation and compromise.
- Maintaining focus and avoiding arguments.
- Evaluating the need for renegotiation, a formal resolution process, or a 3rd party mediator.
- Utilizing humor and empathy to diffuse tension.
- Summarizing and outlining key arguments.
- Avoiding forced resolution if possible.

41. A: Signs of inhaled cocaine use include nasal irritation and nosebleeds, and signs of smoked cocaine include lip burns and a cough. Constricted pupils, headaches, and abdominal pain are also common. Most abused drugs have similar symptoms. However, heroin users would have needle tracks and would not have nasal irritation. Marijuana users
may exhibit tachycardia and cough from lung irritation (similar to tobacco smokers), but usually do not develop nasal irritation or nose bleeds. Methadone abuse can cause constricted pupils and abdominal pain, but does not cause nasal symptoms.

42. B. The best strategy when coaching another nurse is usually to provide positive feedback, stressing the nurse’s correct actions rather than focusing on errors because the latter may increase the graduate nurse’s anxiety and result in more errors. The nurse may use questioning to help the graduate nurse recognized problem areas. The nurse should provide a demonstration and encourage the graduate nurse to ask questions. The primary objective should be to help the learner gain both confidence and skills.

43. A: Viral infections generally do not cause a rise in white blood cell count (WBC) as is found with bacterial infections. With viral infection the WBC is often 4000 or lower, though sometimes accompanied by an increase in lymphocytes. A normal WBC value is 4800 to 10,000. Anything over 10,000 is indicative of an acute bacterial infection, and a value of 30,000 or more is indicative of a severe infection. An increase in the WBC count is usually related to an increase in one type of white cells, as recorded in the “differential”, which provides the percentages of each type of white blood cell present in the blood.

44. B: Acute pain in response to illness or injury often responds well to opioids. Chronic back pain responds less well to opioids and more relief may be gained by exercise, corticosteroids, or complementary therapy (massage, acupuncture, TENS). Psychogenic pain is difficult to treat but opioids are not appropriate. Phantom pain after amputation can be severe and is sometimes treated with opioids, but tricyclic antidepressants and anticonvulsants are often more effective and have fewer side effects. Other treatments, such as TENS or acupuncture, may be effective.

45. A: In this case, averting the eyes is probably a sign of respect toward the nurse. In many Asian cultures, it is considered disrespectful to look someone in the eyes, and the eyes are often averted downward to show respect. Although what is generally true for a group is not always true for an individual, the fact that the woman seems relaxed rather than anxious and is forthcoming with her responses suggests that she is not fearful, depressed, or dishonest.

46. A. These symptoms are consistent with hypoparathyroidism, which can occur from manipulation of the parathyroids during thyroidectomy or inadvertent removal of all or some. Hypoparathyroidism results in hypocalcemia, which causes the numbness, tingling, muscle cramps, twitching, anxiety, and fatigue. Patients usually receive IV calcium gluconate initially and then oral calcium and vitamin D for one to two months, after which an attempt is made to wean the patient from oral calcium. Patients who are unable to wean from oral calcium within 6 months usually must continue to take calcium.

47. B: “You are shaking and seem worried” acknowledges what is true and evident and leaves an opening for the patient to discuss his feelings if he desires. “What’s wrong?” requires a direct response that the patient may not feel like giving. “Do you want me to call your family” does not deal with the patient’s anxiety and is an escape for the nurse. “You don’t need to worry. Everything will be all right” is a platitude that has little meaning and may not, in fact, be true. Of additional note, it is usually wise to first confer with the intervening physician, if possible, to become better informed regarding the presenting
issue. This can aid in avoiding pitfalls and unnecessary conflicts, and in more meaningfully supporting the patient.

48. C: The nurse who delegates remains accountable for patient outcomes and for supervision of the person to whom the task was delegated. The scope of nursing includes delegation of tasks to unlicensed assistants, along with ensuring those personnel have adequate training and knowledge. Delegation can be used to manage the workload and to provide adequate and safe care. Delegation should be done in a manner that reduces liability by providing adequate communication.

49. B: This profile of increased clotting times and reduced fibrinogen, antithrombin and platelets is found with disseminated intravascular coagulation (DIC), which is a secondary disorder (i.e., triggered by another). DIC causes both coagulation and hemorrhage through a complex series of events. It includes trauma of a nature that causes tissue factor (transmembrane glycoprotein) to enter the circulation and bind with coagulation factors, triggering the coagulation cascade. This cascade stimulates thrombin to convert fibrinogen to fibrin, causing aggregation and destruction of platelets and forming clots that can be disseminated throughout the intravascular system.

50. D: Transcutaneous electrical nerve stimulation (TENS) is appropriate treatment for a woman with chronic low back pain. TENS is contraindicated for those with pacemakers, as TENS can interfere with pacemaker function. TENS should not be used on the anterior neck and should be used on the head only with careful physician supervision. TENS should not be used by those who have dementia, as they may become confused and fail to use the equipment properly.

51. D. Initial output from an ileostomy may be copious, as much as 1500 to 2000 mL per day, so the ileostomy appliance may need emptying every 3 to 4 hours (although the appliance itself is usually left in place for several days). Ileostomy output usually stabilizes at 500 to 1000 mL daily, although some high-output ileostomies may consistently have outputs of about 2000 mL daily. The consistency of the output (thin to pasty) varies according to many factors, including diet.

52. C: In this case, cultural sensitivity should take precedence over gender equality, and the nurse should reassure the patient and make arrangements for a female nurse to provide the dressing change. This Saudi patient comes from a culture that strictly segregates males and females, and this surgery and follow-up care may threaten her religious and cultural beliefs, her sense of sexuality, and her body image. Further, because they care for both males and females, nurses are not always held in high esteem. Thus, the males in her family may be very upset that the patient allowed a male to change her dressings, adding significantly to her stress.

53. A: These symptoms are typical of a stroke in the right hemisphere. A left hemispheric stroke results in right-sided paresis and visual field defect. Depression and impulsive behavior are commonly sequelae. Patients often have visio-spatial, math, and language difficulties that can include aphasia and difficulty with reading and writing. Patients may have short-term memory loss and difficulty learning new material. Brain stem stroke impairs cardiac and respiratory function and often results in death. Cerebellum strokes result in ataxia, nausea, vomiting, headaches, and dizziness or vertigo.
54. D: The “5 rights of delegation” include:
   - Right task: The nurse determines an appropriate task to delegate for a specific patient.
   - Right circumstance: The nurse has considered all relevant information to determine appropriateness of delegation.
   - Right Person: The nurse chooses the right person based on education and skills to perform the task.
   - Right direction: The nurse provides a clear description of the task, purpose, limits, and expected outcomes.
   - Right supervision: The nurse must supervise, intervene as needed, and evaluate performance.

55. A: Depressed respiratory rate, hypotension, and pinpoint pupils are signs of morphine overdose and should be treated with naloxone (Narcan®) intravenously, as it is an opiate antidote. Flumazenil is an antidote for benzodiazepines. Charcoal may be used for an oral overdose of morphine if little time has passed since ingestion but will not have an effect on morphine that was administered intravenously. N-acetylcysteine is the antidote for overdose of acetaminophen and will have no effect on a morphine overdose.

56. B: These symptoms are typical of metabolic alkalosis: Elevated serum pH, PCO2 that is relatively normal (if compensated) or increased (if uncompensated), and a urine pH that is >6 (if compensated). The patient is dizzy, confused, and is exhibiting tremors, seizures, tingling, tachycardia, arrhythmias. Metabolic alkalosis occurs with decreased strong acid or increased base, with compensatory CO2 retention by the lungs associated with hypoventilation. Metabolic alkalosis is usually caused by excessive vomiting, gastric suctioning, diuretics, potassium deficit, excessive mineralocorticoids, and/or excessive NaHCO3 intake.

57. D: A patient who requires vigorous and continuous external stimuli to arouse and who exhibits withdrawal as a motor response is categorized as stuporous. When stimulation fails to elicit a voluntary response, then the patient is comatose, the most severe category. Less severe categories range from alert (responds to minimal external stimulus), confused (disoriented with impaired judgment and decreased attention span), delirious (disoriented and having hallucinations), lethargic (drowsiness), to obtunded (indifferent to external stimuli and minimally responsive).

58. B: The patient remains at high risk for suicide because of her choice of self-injury (knives and guns increase risk) and the fact that she has had previous suicide attempts. Additionally, the method used is more aggressive and less impulsive, and thus her intent may well have escalated. She also has little or no social support. The fact that the patient states she is no longer depressed is less important than the outward signs of depression, such as a flat affect, as patients are not always truthful when they are suicidal. Finally, the risk of suicide often increases when depression first begins to lift (as it induces greater emotional engagement and potentially a renewed impetus toward suicide). Consequently, this patient is at high risk for suicide and should be hospitalized.

59. D: The suction catheter should be inserted into the tracheostomy without suction, and then intermittent suction used only during withdrawal. The tracheostomy should be
secured with ties about the neck. Regular suction of the tracheostomy is needed, especially initially, to remove secretions. The suction catheter should be 50% the size of the tracheostomy tube to allow ventilation during suctioning. Vacuum pressure is 80-100 mm Hg, and the catheter should only be inserted <0.5 cm beyond the tube to avoid tissue damage.

60. C: Posting exit routes from each area of the hospital is the responsibility of the Disaster-Preparedness Committee, which is charged with ensuring the institution can respond quickly and effectively to natural disasters, such as hurricanes or floods, and other disasters, such as terrorist attacks, fires, or pandemics. The Disaster-Preparedness Committee should establish phone trees for rapid contacts upon news of a disaster, and should ensure that fire suppressant equipment is readily available and in working order. This committee is not responsible for plant services or infection control issues.

61. D: Both the patient’s verbal and non-verbal responses may be of equal importance. Patients may look away or become tense if they are not telling the truth or don’t want to answer. Thus, information elicited during an interview should include not only the patient’s factual responses but also attitudes and concerns. Nurses should ask open-ended information questions rather than yes/no questions, and should follow-up with clarifying questions. Providing a list of options and rephrasing a patient’s statement may encourage the patient to provide more information.

62. B. The elemental diet contains no complete or partial protein, only essential and non-essential amino acids. Most calories are derived from glucose, which is a simple sugar. Vitamins and minerals are also generally added to the formula and a small amount, less than 1%, of fat. Patients are usually allowed no other foods while on the elemental diet. Some patients are able to drink the formula but others require a feeding tube because they cannot tolerate the taste.

63. D: Behavior modification and compliance rates are the best determinants of the effectiveness of patient education. Patients may be satisfied, may understand, and may be able to provide a demonstration, but if they don’t utilize what they have learned the education has not been effective for that patient. Behavior modification involves thorough observation and measurement, identifying behavior that needs to be changed and then planning and instituting interventions. Compliance rates should be determined by observation at necessary intervals and on multiple occasions.

64. C: An autologous blood patch (15 – 20 mL) is injected epidurally near the subarachnoid puncture site to plug the puncture hole in the dura. Post-dural puncture headache (frontal and/or occipital) results from loss of cerebrospinal fluid through the puncture hole, resulting in displacement of the brain posteriorly and stress on supporting structures. Headache onset is usually 12 to 48 hours after the puncture, but may be delayed for weeks or months. Conservative treatment includes bed rest, fluid, and caffeine.

65. B: The right to pain control is part of the Patients’ Bill of Rights. Affordable healthcare and access to latest medical technology are not included. The right to sue is not directly included, but patients are entitled to a procedure for registering complaints or grievances. Other provisions include respect for patient, informed consent, advance directives, and end of life care, privacy and confidentiality, protection from abuse and neglect, protection
during research, appraisal of outcomes, appeal procedures, an organizational code of ethical behaviors, and procedures for donating and procuring organs/tissues.

66. C: An environmental assessment includes not only specific rooms in the home but also general needs and includes evaluations of:
   - Environmental hazards: Piles of paper or junk, loose carpets, cluttered pathways.
   - Lighting: Adequate for reading in all rooms and stairways.
   - Heat and air-conditioning: Adequate to control heat and cold.
   - Sanitation: Rotting food, infestations of cockroaches or rodents
   - Animal care: Pets should have access to food, water, toileting, and veterinary care.
   - Smoke/chemicals in the environment: Second-hand smoke or cleaning chemicals.

67. C. The nurse should delegate those tasks with the lowest priority and to the staff member that is the lowest in the hierarchy of nursing but still has the skills and knowledge to carry out the tasks. The delegator remains responsible for the task and so must provide information to the UAP, describe the course of action needed, identify any parameters that require the nurse’s intervention, identify variables, and then monitor and supervise the task and obtain feedback. UAP may carry out such tasks as bathing, turning, taking vital signs, monitoring intake and output, ambulating, transferring, and toileting.

68. D: Gay and lesbians are as vulnerable to domestic abuse as heterosexuals (many studies indicate greater abuse rates, up to 18 times higher), but this is often overlooked by healthcare providers. Partners who commit abuse often stay with the patient to ensure that the victim does not report the abuse, and abused males are particularly unlikely to report. The inconsistencies in this report are also cause for alarm. This patient has injuries consistent with domestic abuse:
   - Facial and head injuries, including ruptured eardrum, suggests blows to the head.
   - Bilateral injuries of both arms suggest defensive wounds.
   - Bruising on the back suggests the patient was kicked while curled into a defensive posture.

69. C: Collaborating with the patient to find a solution to a problem is an example of effective therapeutic communication. The other responses are non-therapeutic and can serve to block effective communication. “Everyone gets upset at times” devalues the patient’s feelings. “You should stop arguing with the nurses” is a negative, confrontational judgment that may anger the patient more and does not deal with the real issue. “You should be happy that the wound is healing” provides unwanted advice and ignores the patient’s concerns.

70. A: The patient with meningioma was provided a list of possible treatment options, as required by the guidelines for informed consent. Fine needle aspiration is not the only option for diagnosis of breast cancer and has a high rate of false negatives. While gallbladder surgery is relatively safe, patients should be realistically appraised of the specific risks rather than being given blanket statements. A patient with 4th stage pancreatic cancer has a very low chance of survival even with treatment, and thus should be provided information about the risks and benefits of both having treatment and foregoing treatment.
71. B: The primary reason for completing continuing education courses is to remain current in the field of nursing. It is every nurse’s responsibility to be informed and aware of advances and changes in practice. Many states require continuing education for licensure, and some institutions require continuing education as a condition for continued employment. Taking courses to meet requirements for a salary increase is a personal reason that does not obviate a nurse’s professional responsibility for learning.

72. D: The best solution for this man’s urge incontinence is to provide a urinal for him to use during the daytime, as he is aware of the need to urinate but is unable to make it to the bathroom in time. Leaving the man in his room would isolate him. Foley catheters are no longer recommended for long-term use to control incontinence because of the danger of infection. Adult diapers would not resolve the problem and would require frequent changing to prevent skin breakdown.

73. A: Pneumococcal polysaccharide-23 (single dose), influenza (annual), and herpes zoster (single dose) immunizations are recommended for all adults >60 to 65. Hepatitis B is recommended for older adults with end-stage renal disease (including those receiving dialysis), chronic liver disease, or HIV/AIDS and those in correctional facilities or substance abuse facilities. Hepatitis A is recommended for those at risk because of lifestyle (males having sex with males or substance abusers) or medical condition (liver disease). International travelers may receive a hepatitis A and/or B vaccine depending on their destination. There is no hepatitis C vaccine.

74. C: This type of neglect (malnutrition, no dentures, unkempt and dirty clothing) is probably an example of passive neglect. The patient’s wife is also elderly and frail, and caring for an Alzheimer’s patient is very difficult as he may be uncooperative. Active neglect is more intentional, and abuse (physical, financial, sexual, emotional) is more serious. The patient does not have injuries consistent with physical abuse and does not appear frightened of his wife (which might suggest physical or emotional abuse). Poverty may be an issue, but is probably not the cause of this neglect.

75. B: Prior to an MRI, a 65-year old woman with renal disease should have a creatinine test. Some institutions also require an eGFR. All current MRI contrast materials contain gadolinium, which has been implicated in the development of a fatal renal disorder in those with end-stage renal disease. For these patients, alternative imaging, such as CT, should be done. If this is not possible, then the patient may need dialysis after completion of the MRI to rapidly remove the gadolinium, which is normally excreted through the kidneys.

76. D: Multiple organ dysfunction syndrome (MODS) is the most common cause of sepsis-related death. It is a progression from an infection that results in bacteremia, septicemia, sepsis, severe sepsis, septic shock, and finally MODS as the infection overwhelms the body’s defenses. Cardiac function becomes depressed. Acute respiratory distress syndrome may occur, with renal failure following acute tubular necrosis or cortical necrosis. Thrombocytopenia occurs in 30% of cases and may result in disseminated intravascular coagulation (DIC). Liver and bowel necrosis may also occur.

77. A: The wrist strap restraint restricts the patient’s movement. Restraints can only be used if other methods to protect the patient have failed. The physician must order the restraint, and the patient must be evaluated face-to-face within one hour by the ordering
physician or an NP, PA, or RN trained in restraint requirements. An initial order is 4 hours for an adult. After another evaluation, the order can be renewed for a total limit of 24 hours. The patient must be monitored at intervals established by the institution. Restraints required for medical treatment, however, such as wrist boards or traction, or standard half side rails (2 rails) are exempt – although 4 rails are considered a restraint.

78. B: The learner outcome for teaching a patient about insulin reaction should relate directly to that goal:  List and describe the symptoms of insulin reaction. While all of the other things (different types of insulin, foods high in carbohydrates, and the difference between Type 2 and Type 2 diabetes) are important, they don’t relate to the topic and should not be the learner outcome for this activity. In some cases, one class or session may cover multiple topics with multiple outcomes, but a patient may be overwhelmed by too much information.

79. D. About three-quarters of patients who have hematochezia (bright to dark red bloody stools) have bleeding from the colon, although if there is significant upper GI bleeding, the blood may remain essentially undigested through the bowels, indicating further testing to isolate the site of bleeding. Melena and hematemesis generally occur with bleeding in the upper GI system. Emesis of frank blood usually means that bleeding is ongoing, while coffee-ground emesis usually means that bleeding is slower (because it is mixed with gastric fluids).

80. A: Difficulty urinating, purulent discharge, epididymitis, and prostatitis are classic symptoms of gonorrhea in the male. Females are often asymptomatic but may have abdominal pain, cystitis, or mucopurulent cervicitis, which can lead to pelvic inflammatory disease and chronic pain if left untreated. Women and homosexual males may also present with rectal infections. Untreated gonorrhea may become a systemic infection with petechial or purpuric skin lesions, arthralgias, fever, malaise, and septic arthritis. Treatment is with antibiotics, such as Cefixime 400 mg orally in one dose.

81. B. The therapeutic range of lithium for acute episodes of mania is 1.0 to 1.5 mEq/L while the therapeutic range for maintenance is lower at 0.6 to 1.2 mEq/L. Lithium has a very narrow therapeutic range and must be monitored at least monthly because, if levels are too high, severe life-threatening adverse effects may occur. Levels ranging from 1.5 to 2.0 are associated with mild toxicity, 2.0 to 3.5 with moderate toxicity, and greater than 3.5 with severe toxicity.

82. D: As an advocate for the patient, the nurse must prevent possible injury to a patient: “The catheter was contaminated when it fell,” states the problem. “Would you like me to get another setup or stay with the patient?” suggests a solution without assigning blame. A contaminated catheter could cause a serious infection. Reporting the team leader’s behavior to the supervisor, while appropriate, does not protect the patient. Saying nothing may (but is not guaranteed to) protect either nurse from possible secondary repercussions (i.e., subsequent infection) but it is also negligent and unprofessional conduct.

83. C: Hemoglobin A1C of 5.5% most indicates dietary compliance. Hemoglobin A1C comprises hemoglobin A with a glucose molecule because hemoglobin holds onto excess blood glucose, so it shows the average blood glucose levels over a 3-month period and is used primarily to monitor long-term diabetic therapy:  Normal value: <6% and elevation
>7%. Fasting blood sugar (FBS) results can vary widely and show only a current serum level. Thus, a person who stays on a diet for only a few days and fasts before the test may show a near-normal FBS for a short period, even though the patient is frequently non-compliant. Normal FBS: 70-99 mg/dL.

84. C. Patients must be treated with heparin (generally LMWH) prior to transitioning to warfarin and the heparin continued for the first 5 to 7 days because warfarin can result in increased coagulation for a few days until the warfarin can interfere with production of vitamin-K dependent coagulation factors. The warfarin dose should be adjusted to maintain an INR in the 2.5 to 3.5 range (normal 0.9 to 1.1) to reduce the risk of bleeding.

85. D: Genital warts, caused by the human papillomavirus (HPV), increase a woman's chance of developing cervical cancer because the virus induces changes in the cervical mucosa. There are about 40 different HPVs that are sexually transmitted. Over 99% of cervical cancer is caused by HPV and 70% is caused by HPVs 16 and 18. The HPV vaccine, Gardasil®, protects against HPVs 6, 11, 16, and 18, but does not convey protection if a female is already infected, so the initial dose is recommended between ages of 11-12 years.

86. C: The use of medical abbreviations is one of the leading causes of medication errors. While institutions usually have an approved list of abbreviations, sometimes these lists are overly extensive. In many cases abbreviations and symptoms should be avoided altogether, or at least restricted to a limited list. Illegible handwriting also leads to errors, so orders should be block-printed or computer generated. Institutions should establish protocols for medication administration, such as double identification of each patient, and should provide lists of similarly-named medications.

87. A: These are classic symptoms of stable angina. Unstable angina (pre-infarction), a medical emergency, is a progression of coronary artery disease. Pain may increase and last >5 minutes. Coronary artery spasm can cause angina pain and ischemia and is sometimes related to cocaine use. Variant (Prinzmetal's) angina is also related to coronary artery spasm but symptoms are more predictable. It is usually cyclical, occurring at rest and at the same time each day, and is characterized by elevation of ST segments. It may be associated with substance abuse.

88. A: Group instruction is more cost effective than one-on-one instruction because a number of patients/family can be served at one time. Group presentations are usually more rigidly scripted and scheduled for a particular time period, so family and patients have less control. Questions may be more limited, but group instruction also allows patients/families with similar concerns to interact. Group instruction is particularly useful for general types of instruction, such as managing diet or other lifestyle issues.

89. B: Inadequate or poor hand-washing technique is one of the most common causes of the person-to-person spread of infection in hospitals. Hands should be washed before and after every patient contact or when removing gloves. Hand-washing should be done under running water with plain soap, scrubbing the hands, nails, and wrists thoroughly, and turning the faucet off by using the elbow, upper arm, or paper towel. Alcohol-based rubs used for hand disinfection (at least 15 seconds) are effective against Staphylococcus aureus but are not effective against Clostridium difficile.
90. D: Pain Assessment in Advanced Dementia (PAINAD) scale utilizes careful observation of non-verbal behavior to evaluate pain, noting changes in:

- Respirations: Rapid, labored, with short periods of hyperventilation or Cheyne-Stokes.
- Vocalization: Negative or absent speech, moaning, and crying out as pain increases.
- Facial expression: Sad, frightened, frowning, grimacing.
- Body language: Tense, fidgeting, pacing, clenching fists, and lying in a fetal position as pain increases.
- Consolability: Less easily distractible or consolable as pain increases.

91. A: The Confusion Assessment Method is used to assess the development of delirium and is intended for use by those without psychiatric training. The assessment tool covers 9 factors:

- Onset: Acute changes in mental status.
- Attention: Inattentive, stable, or fluctuating.
- Thinking: Disorganized, rambling, switching topics, illogical.
- Level of consciousness: Altered (ranging from alert to coma).
- Orientation: Time, place, person.
- Memory: Impaired.
- Perceptual disturbances: Hallucinations, illusions.
- Psychomotor abnormalities: Agitations or retardation.
- Sleep-wake cycle: Awake at night, sleepy in the daytime.

92. D: Small tokens of appreciation, such as candy or flowers that can be shared among staff are usually acceptable as gifts from patients (depending on facility policy), but almost any other gifts (clothes, jewelry, watches, etc.) should be politely declined with an explanation: “I’m sorry. This is so kind of you, but nurses are not allowed to accept gifts from patients.” Patients often offer gifts, and some patients, especially those who are older or cognitively impaired, may be easily manipulated into giving away valuables or money.

93. B: National guidelines recommend that adults exercise 30 minutes daily to a minimum of 150 minutes weekly with moderate intensity exercises (walking, bicycling, gardening) or 20 minutes of vigorous intensity exercises (running, aerobics, heavy physical work) to a minimum of 60 minutes a week. In addition, adults should engage in strengthening exercises (pushups, sit-ups, weight-lifting) at least twice weekly. Exercise sessions should be at least 10 minutes long to achieve health benefits.

94. A: A problem list focuses on a prioritized list of patient problems based on assessment data, history, and interview. Trying to deal with all patient problems without prioritizing them to determine which are the most critical can result in ineffective care. Patients are not always aware of their own needs regarding health care or intervention, and standardized lists of problems may be used as a guide but will not always match the individual’s circumstances.
95. C: The CAGE tool is used as a quick assessment tool to determine if people are drinking excessively or have become problem drinkers:
   - C – Cutting down: Do you think about trying to cut down on drinking?
   - A – Annoyed at criticism: Are people starting to criticize your drinking?
   - G – Guilty feeling: Do you feel guilty or try to hide your drinking?
   - E – Eye opener: do you increasingly need a drink earlier in the day?

96. A. Adenomatous polyps are precancerous; and, if found and removed during a colonoscopy, patients are generally advised to have repeat colonoscopies every 2 to 3 years instead of every 5 to 10 years. While all polyps are abnormal, most, such as the common hyperplastic polyps, are non-neoplastic, but most colorectal cancers arise from adenomatous polyps, which result in DNA changes in the tissue of the colon. The risk of developing adenomatous polyps increases after age 50.

97. B: Advocacy is working for the best interests of the patient despite conflicting personal and assisting patients to have access to appropriate resources. Moral agency is the ability to recognize needs and a willingness take action to influence the wholesome outcome of a conflict or decision. Agency is a general willingness to act arising from openness and the recognition of involved issues. Collaboration is working together to achieve better results.

98. D: Biofeedback uses monitoring devices to allow people to control their own physiological responses. People use information (feedback) from ECG, EMG, EEG, galvanic skin response, pulse, BP, and temperature to differentiate between the abnormal and the desired state. People with hypertension will use the feedback about their BP to help them lower it by relaxing, deep breathing, or other activities. The monitoring devices show when their efforts are effective. Biofeedback may be used to control heart rate, BP, pain, incontinence, and muscle strength.

99. A: The swing-to gait, in which the crutches are advanced together and the body swings to meet the crutches, is most appropriate for a patient with paralysis of the lower extremities. A swing-through gait swings the body past the crutches and requires better balance and coordination. A two-point gait (with the right crutch and left foot advancing together and vice versa) requires partial weight bearing on each foot. A three-point gait alternates between weight bearing on two crutches and an unaffected limb. A four-point gait requires weight bearing on both legs and moves each foot and crutch independently (i.e., left crutch and right foot, followed by right crutch and left foot, and so on.

100. A: Once an entry is made, it must be left in place and remain legible. The correct procedure is to draw a single line through the incorrect entry and write “Error” after the entry. It is never appropriate to whiteout an entry or otherwise render it illegible. Hand entries should always be made with blue or black permanent ink, and no erasable pen or pencil should be used for any documentation on a patient’s permanent record. Recopying a page to omit an error is not acceptable.
101. D: The barriers to self care that this patient faces after the stroke are psychological, physical, and cognitive:

- **Psychological:** She is very anxious, and this may interfere with her ability to manage her own care.
- **Physical:** The stroke has left her with motor impairment that may prevent her from carrying out necessary daily activities or procedures.
- **Cognitive:** This patient is forgetful, so she may require repeated instructions, prompts, and reminders to adequately manage her own care.

102. D: The Hmong culture is patriarchal and the eldest male makes the decisions. More traditional families may shun Western medicine and rely on healers, but Christian Hmong and others who are less traditional may rely on Western medicine or some combination. Hmong believe that illness occurs when the spirit, soul, and body are out of balance. They believe people have multiple souls and sickness occurs when one or more soul is lost or taken by other spirits. These souls must be reclaimed by a healer for healing to occur.

103. B. With hyperosmolar syndrome, unlike DKA, ketones are normal or only slightly elevated. HHS is characterized by higher serum glucose (600 to 2000 mg/dL) than DKA. Onset is usually slow, occurring over a period of days or weeks. HHS occurs only with type 2 diabetes and most often in older adults with recent illness or therapeutic procedures. The pH usually remains normal unless severe lactic acidosis develops from dehydration. Dehydration is usually severe and may result in neurological impairment.

104. B: Threatening to force a patient to undergo a treatment is a form of coercion. Nurses can easily intimidate patients into having procedures or treatments they don’t want. Regardless of age, patients have the right to choose and refuse treatment. Forcing a patient to do something against his or her will borders on abuse and can sometimes degenerate into actual abuse if physical coercion is involved. If patients are cognitively impaired, other family members may be designated to make decisions, but every effort should be made to gain cooperation.

105. A: The best approach to solving a problem that involves 3 different departments is to form an interdisciplinary team of representative participants to work together and find a solution. This allows all parties to have a voice and to work toward compromise, while avoiding the confusion caused by too many competing interests. If administration makes a decision independently, or picks one of the proposed solutions over another, all or many staff members may feel their voices weren’t heard. Trying to gather all members of 3 departments together for brainstorming is usually impractical, and an unnecessary use of employee time and resources.

106. B: Making referrals to the appropriate social services agencies is the appropriate response. Older patients often have many needs, but buying groceries is a sign of overinvestment in a patient’s life, will not solve the problem in the long run. It can also establish a relationship of dependency. Calling the daughter or discussing the matter with a neighbor would be a violation of the patient’s right to privacy and should be done only with patient’s permission.

107. B: The patient has been told to avoid crossing the affected leg over the other leg since this position could dislocate the implant. Although there is no reason to flex the knee on the
affected leg more than 90 degrees, doing so would not adversely impact the hip joint. An abduction pillow should be used between the legs while the patient is in bed or turned on the side. Ninety-degree flexion of the affected hip should be avoided in both the sitting and lying position. The patient should be cautioned to avoid bending over to pull on shoes or socks. The toilet seat should be raised, and chairs should have cushions or platforms to raise the seats.

108. B. While usually a spouse can authorize medical care for a patient who is unconscious, this treatment may save the patient’s life but may also result in a violation of his religious beliefs and his filing a malpractice suit against the hospital, the physician, and the nurse because the patient made his wishes clear when he was alert and of sound mind. As soon as the issue arises, the nurse should contact the ethics committee as the committee can provide guidance to all the parties involved, including the moral and legal implications of different actions.

109. D: Dysphagia may develop as the result of stroke, neuromuscular disease (Parkinson’s disease, myasthenia gravis, MS, ALS), drugs (phenothiazines), achalasia, and esophageal strictures, diverticulum, or cancer. Dysphagia is a common cause of aspiration pneumonia. A diagnosis is made through presenting symptoms, barium swallow testing, and endoscopy. Management includes treating the underlying cause, sitting upright to eat, avoiding eating prior to lying down, chewing foods carefully, sipping water, thickening thin liquids, limiting bite sizes (in part by using smaller utensils), doing strengthening exercises, and taking medications to relax the esophagus.

110. A: The best readability level is grade 6. The average American reads effectively at the 6th to 8th grade level (regardless of education achieved), and research shows that even people with much higher reading skills learn medical and health information most effectively when the material is presented at the 6th to 8th grade readability level. A grade 3 level would be too simplified for most native speakers of English, but might be appropriate for immigrant populations with limited English.

111. A. The nurse must immediately notify the physician that there is no consent form. Patients who are under the influence of alcohol or have received premedication for surgery are not considered competent to give consent for surgery. In order to give consent, adults must be at least 18 years old and have the ability to understand consequences. Telephone consent (with witnesses listening) is generally used only for emergency situations in which the patient is unable to give consent.

112. C: Autocratic leaders make decisions independently and strictly enforce rules. Bureaucratic leaders follow organizational rules exactly and expect others to do so, as well. Laissez-faire leaders exert little direct control and allow others to make decisions with little interference. Participatory leaders present a potential decision and make a final decision based on input from team members. Consultative leaders present a decision and welcome input, but rarely change their decisions. Democratic leaders present a problem and ask the team to arrive at a solution, although these leaders make the final decision.

113. C. Approximately 9 out of 10 patients with obesity hypoventilation syndrome (BMI greater than 30 and hypoventilation) also have obstructive sleep apnea because the added weight on the chest results in hypoventilation and restricted airflow on the upper airways.
Patients diagnosed with obesity hypoventilation syndrome should be referred to a sleep lab for polysomnography. Treatment includes weight loss and treatment of OSA as indicated. Some patients benefit from respiratory stimulants, such as theophylline.

114. D: Spiral (helical) CT provides a definitive diagnosis for pulmonary embolism. Blood gases provide supporting information (hypoxemia, hypocarbia, and respiratory alkalosis). A chest x-ray may be used to rule out other disorders, but is not adequate for a definitive diagnosis as an x-ray may indicate a false negative. Electrocardiogram may show typical cardiac abnormalities (tachycardia) but it is not sufficient for diagnosis. Angiography also provides a definitive diagnosis, but is more invasive and is associated with more complications.

115. B: This patient is at risk for hypertension (resulting from a change in cardiac output, peripheral resistance, or both) for a variety of reasons:

- Obesity results in hyperinsulinism that increases peripheral resistance through structural hypertrophy.
- Genetic abnormalities may increase peripheral resistance.
- Stress triggers overactivity of the sympathetic nervous system, increasing contractility and/or renin-angiotensin excess, resulting in increased constriction and resistance.
- Insufficient nephrons result in sodium retention and decreased filtration, causing increased fluid volume and preload.

116. D: Many hearing-impaired patients use some degree of lip-reading, so the nurse should not chew, smoke, or eat while speaking to the patient. The nurse should face the patient at a distance of 2 to 6 feet, use a normal tone of voice and short sentences, and provide assistive devices as necessary, including writing materials and TDD phone/relay service. If patients are deaf and know sign language, interpreters should be used for important communication, and the nurse should face the patient during the communication, not the interpreter.

117. A: The nurse should attend to the spiritual needs of the patient by calling a priest even though the hour is not convenient. A Protestant chaplain cannot perform specific rituals that are important to Catholics, and the patient may not survive or be able to receive communion if the call is delayed. Catholic rituals include:

- Sacrament of the Anointing of the Sick: This replaces the last rites (Extreme Unction) and is a bedside blessing.
- Viaticum: This is essentially the “last” Holy Communion and is called the “food for the journey.”

118. D: While procedures vary somewhat, generally the nurse should document the medication given on the patient’s record as well as the time the physician was notified and any medical orders to prevent or treat adverse effects, but specifically indicate that it was an actual error on the incident report only. Patients are not informed of an error by the nurse involved and, in many cases, are never informed at all. This is an ethical issue that has legal and moral implications. Some healthcare facilities are now utilizing an open policy in which patients are informed, but more often this is not the case.
119. B: Selye’s biological theory of stress and aging states that stress is a body response to demands requiring positive or negative adaptation, characterized by the “generalized adaptation syndrome,” which includes 3 stages:

- **Alarm**: Fight or flight response.
- **Resistance**: The body mobilizes to resist a threat, focusing on those organs most involved in an adaptive response.
- **Exhaustion**: As the body is weakened and overwhelmed, organs/systems begin to deteriorate (hypertrophy/atrophy) and can no longer cope with stress, resulting in stress-related illnesses and eventual death.

120. C. Because acute abdominal pain may be associated with GI bleeding, the nurse should first take vital signs to assess for signs of hypovolemia, such as hypotension and tachycardia, which may require emergent action. Then, the nurse should progress to a physical examination of the abdomen, noting distention, bowel sounds, guarding, and any other abnormality while obtaining a history about the onset and duration of pain and the degree of pain (with appropriate pain scale).

121. B: Contraindications to thrombolytic therapy include hemorrhagic stroke, recent surgery, or bleeding. While, ideally, thrombolytic therapy should be administered within 90 minutes of the onset of symptoms, it may be given within 6 hours. History of any type of stroke within 2 months, AVM, or aneurysm precludes thrombolytic therapy. Severe hypertension (>210/130) that is uncontrolled by medications or that occurs with retinal-vascular disease is also a contraindication. Relative contraindications, such as >75 years of age, pregnancy, pericarditis, and endocarditis, should be evaluated on individual basis.

122. C: The nurse should announce his presence in a normal tone of voice, explaining actions and movements. Visual impairment is unrelated to hearing or intelligence, so speaking loudly or using simple sentences is not necessary. If the central field of vision is impaired, the patient may have better peripheral vision, so the nurse should ask the patient which position is best, and then position himself to the patient’s advantage. Braille materials, enlarged text, or manipulatives may also be helpful.

123. B: Peripheral arterial insufficiency is characterized by deep, circular painful necrotic ulcers on the toe tips, toe webs, or other pressure areas, intermittent to constant pain, rubor on dependency and pallor on foot elevation, shiny, pale, skin with loss of hair, thick and ridged nails, weak or absent pulses, and minimal edema. Peripheral venous insufficiency is characterized by irregular superficial ulcers on the lateral malleolus and sometimes on anterior tibial area, aching and cramping pain, pulses present, brownish discoloration about the ankles and anterior tibial area, and moderate to severe edema.

124. B: Tier II, airborne precaution, is appropriate for a patient with active tuberculosis, measles, or varicella. The patient is placed in a private room with negative airflow and a closed door. Staff must use respiratory precautions (masks). Tier II, droplet precautions (private room and masks if within 3 feet of the patient) is used with viral influenza, pertussis, Neisseria meningitides, streptococcal pharyngitis or pneumonia and mumps. Tier II, contact precautions (private room or cohorting and a protective gown for close contact) is used for infections spread by person-to-person contact. Tier I, standard precautions (protection from blood and body fluids) is used for all patients.
125. D: Synthroid 0.88 mg PO daily at 0700 is correct because the medication is spelled out, the decimal has a leading zero, PO is clearly written, and “daily” is used instead of “qd,” which can be misinterpreted as QID if the nurse uses periods (i.e., “q.d.”). Additionally, a 24-hour (military) time designation is used. “Maalox 30 cc” should be “Maalox 30 mL” because “cc” may be misread as “U” for unit. Instead of “qhs,” which can be misread as “qhr,” “nightly” should be used. “Lasix 40.0 mg” should be “Lasix 40 mg” because the trailing zero may cause someone to read the order as “400 mg.” “MS” could be misread as magnesium sulfate.

126. A: The nurse should establish educational goals before beginning to develop materials and lesson plans. This is important because all objectives should be directed specifically at the educational goals and expected learner outcomes. Planning should always precede production, or the nurse can waste considerable time preparing materials and lesson plans that are not effective, or that wander off of the topic and confuse the learners. As each educational goal is identified, the nurse should then plan how to specifically achieve that particular goal through the educational process.

127. A: Aphasia is the loss of ability to use and/or understand written or spoken because of damage to speech centers in the brain. Global aphasia is characterized by difficulty understanding and producing language, although patients may still understand gestures, pictures, and diagrams. Transient aphasia is short lasting, often related to transient ischemic episodes. Broca’s aphasia (also known as “expressive aphasia”) is characterized by difficulty producing verbal (and, usually, written) language, even though the ability to understand others remains intact. Wernicke’s aphasia (also known as “receptive aphasia”) is characterized by difficulty understanding (i.e., receiving) verbal (and, usually, written) language even while retaining the ability to understand gestures and produce language. Global aphasia is when Broca’s and Wernicke’s aphasias are combined.

128. B: Sinus tachycardia is characterized by pulse >100. The rapid pulse rate decreases diastolic filling time and reduces cardiac output. The result is hypotension and pulmonary edema. Bradycardia is characterized by pulse <60. Sinus arrhythmia is characterized by cyclic changes in pulse during respirations, and is common in children and young adults. However, it may also occur with vagal stimulation from suctioning, vomiting, or defecating. Premature atrial contractions are essentially extra beats caused by an errant electrical impulse to the atrium before the sinus node impulse, resulting in an irregular pulse.

129. D: Dietary management of diabetes mellitus, medical nutrition therapy (MNT), includes individualized diet modifications. Typically, the type of food consumed is more important than the calories themselves, and a normal protein intake is recommended. Diets may be low fat and low carbohydrate. Saturated fats should be restricted to <7% of total calories and carbohydrates monitored through the use of carbohydrate counting or exchanges. Sugar alcohols and non-nutritive sweeteners (aspartame, Splenda®) may be used. Alcohol intake should be limited to 1 drink daily for females and 2 for males.

130. C. While nausea, vomiting, and diarrhea are common adverse effects associated with clindamycin, moderate to severe watery diarrhea and abdominal pain and cramping are suggestive of C. difficile infection, which is frequently associated with hospitalization and antibiotic therapy, with clindamycin a common cause. Treatment includes stopping the antibiotic and treating with metronidazole or vancomycin, depending on the severity of the
colitis. Patients should be monitored carefully because *C. difficile* infections recur in about one-quarter of patients.

131. B: Because the Parkinson's patient with dysarthria has difficulty speaking, the nurse should ask primarily yes/no rather than open-ended information questions (e.g., who, what, when, where, how, why) and should observe the patient's facial expressions and gestures used in "augmentative and alternative communication" (AAC). The patient has no dementia or hearing impairment, so age-appropriate sentences and normal tone of voice should be used. The nurse should not rush the patient, finish sentences, or direct questions at family rather than the patient. Assistive materials (such as computer programs) may be used.

132. A: Striving for patient satisfaction is a long-term outcome. Process is important, but both short-term and long-term outcome measures should be established based upon clinical efficacy, rather than patient satisfaction (e.g., patients may not always appreciate essential treatments and interventions). Short-term outcomes show results directly related to process and allow modification of the process, but long-term outcomes (such as patient satisfaction) often relate to general quality of care and may be used retrospectively to evaluate the process or plan for future care. Three types of outcome measures should be identified: clinical, patient functioning, and patient satisfaction.

133. A: Interdisciplinary teams with <10 members are most effective. Very small teams (2-4) may not be sufficiently representative. Large teams are difficult to lead and keep focused. Team members should have complementary skills and should be allowed a reasonable degree of autonomy in producing action plans. They should also have flexibility in working together. Team members are collectively accountable, rather than individually accountable.

134. A. The TSH is elevated (normal value 0.4) while the T4 is decreased (normal value 5 to 13.5), indicating hypothyroidism. However, the anti-thyroid microsomal antibodies test is positive, and this indicates that the hypothyroidism is associated with Hashimoto's thyroiditis, which is an autoimmune disorder in which antibodies attack the thyroid gland, causing the thyroid gland to enlarge and interfering with thyroid function so that the thyroid cannot produce thyroid hormone. TSH levels increase as the pituitary gland tries to stimulate production in response to falling T4.

135. A: The interpreter should have training in medical vocabulary for both languages. Just speaking the languages well does not mean that the translator will adequately interpret specialized vocabulary. It is not necessary for the interpreter to know the patient’s history, as the interpreter’s job is only to interpret what is said, not add to it or augment it based on prior knowledge. While onsite interpreters are ideal, interpretation can be provided through a speakerphone at a distance.
136. C: The patient is suffering from severe malnutrition, based on these laboratory findings. Value ranges and interpretations include:

- **Albumin**: Normal 3.5 to 5.5 g/dL. Severe deficiency <2.5 g/dL. Albumin is more sensitive to long-term protein deficiencies than short term.
- **Pre-albumin**: Normal 16 to 40 mg/dL. Severe deficiency <5 mg/dL. Pre-albumin responds quickly to changes in nutritional status related to protein intake.
- **Transferrin**: Normal 200 to 400 mg/dL. Severe deficiency <100 mg/dL. Transferrin levels decrease rapidly with protein deficiency but may be affected by many different things, such as liver disease and iron deficiency.

137. B: The correct information should be documented in the next space with the current date and time: “10-09-08, 1400. Late entry (10-09-08, 1100) Patient states he does not know where he is or the date.” The nurse must never alter the record by inserting information out of place or between lines and should not use arrows to indicate correct chronological placement. This omission did not result in a medical error and thus does not need to be reported in an incident report.

138. A. These symptoms (vomiting, distention, lack of peristalsis) are consistent with a paralytic ileus, so the most likely diagnostic test is an abdominal x-ray, which should show the distended gas-filled bowel. Because the patient’s symptoms include vomiting of fecal material, the most likely initial treatment is insertion of an NG tube to suction for decompression. When the patient’s condition stabilizes, small enteral feedings may be given to stimulate motility. In some cases, the patient may need parenteral nutrition.

139. A: Both infection from the IV catheter and glucose intolerance are common side effects of total parenteral nutrition (TPN). A re-feeding syndrome, which can be fatal, can be triggered by an excessive carbohydrate load in malnourished patients. Vitamin and essential fatty acid deficiencies may occur, so nutrition must be monitored carefully. Enteral feeding poses the risk of irritation from NG, ND, or NJ tubes, and skin excoriation from gastrostomy and jejunostomy tubes. The risk for aspiration is high with nasal tubes. Nausea, vomiting, and diarrhea may also occur, especially if the infusion rate is excessive.

140. B: As HIV/AIDS progresses, the CD4 count decreases as the immune system of the body is impaired. Some fluctuation in CD4 count is normal, so often a series of tests are taken and the results are averaged. Institution of anti-retroviral treatment should cause the CD4 count to increase or stabilize. Current CDC guidelines diagnose AIDS when the CD4 count is <200 cells/mm³ whether or not other symptoms are present. The CD4 count is usually ordered in combination with a viral load count, which measures the amount of HIV present in the blood.

141. B: Reacting and responding to facts instead of feelings to avoid confrontations and diffuse anger. Professional communication skills to facilitate team communication also include:

- Avoiding interpreting others statements, interrupting, giving unsolicited advice, or jumping to conclusions - all of which may interfere with the free flow of ideas.
- Listening actively and asking questions for clarification rather than challenging other people’s ideas.
- Clarifying information or opinions to help avoid misunderstandings.
- Communicating openly and respecting others’ opinions.
142. C: These symptoms are typical of obstructive sleep apnea. Diagnosis is per polysomnography and evaluation of O2 saturation during sleep. ECG may indicate bradydysrhythmia during apnea and tachydysrhythmia during respiration. Erythrocytosis is common. Narcolepsy is characterized by brief sudden episodes of falling asleep, loss of muscle tone, and sleep paralysis. Insomnia has milder symptoms. Patients complain of inadequate sleep or waking up and being unable to go back to sleep. Hypothyroidism can cause similar symptoms to obstructive sleep apnea and should be ruled out with thyroid function tests.

143. D: While all of these characteristics are important for team members, central to collaboration is the willingness to compromise. In addition, members must be able to communicate effectively, which encompasses assertiveness, patience, and empathy. Teams should identify specific challenges and problems and then focus on the task of reaching a solution. Collaboration is needed in order to move nursing goals forward. Nurses must take an active role in gathering date for evidence-based practice to support the role of nursing in health care. They must also share this information with other nurses and health professionals.

144. A: The nurse should call the mental health crisis team. Crisis teams are comprised of mental health professionals. The teams are usually available to non-psychiatric units in order to evaluate the mental status of a patient. In this case, the patient is probably experiencing an exacerbation of her bipolar disease because of the stress related to surgery and could irreparably damage her surgical repair. The crisis team will determine whether the patient is a danger to herself or others, identify any treatment necessary to stabilize the mania the patient appears to be experiencing, and will decide whether she should remain hospitalized for further treatment.

145. D: Varenicline use must be carefully monitored as it can cause mood or behavioral changes, seizures, psychiatric manifestations, and suicidal thoughts. Varenicline is one of the most lethal drugs in terms of injury and death associated with a drug. Other prescription medications include nicotine inhalers, nicotine nasal sprays, and bupropion (Zyban®). Bupropion can cause insomnia and dry mouth. OTC smoking cessation medications include nicotine gum, the nicotine patch, and nicotine lozenges. These can cause local irritation, primarily.

146. A: The patient’s refusal to look at the amputation stump or participate in his own care suggests he is having trouble coping with the change in body image. Phantom pain is common after an amputation. Grief at the loss of a limb and some lability in emotions is normal. The other driver is a logical target for anger. Rehabilitation plans may easily become overwhelming for someone who is still coming to terms with new limitations, so crying is probably a normal response.
147. B: While evaluation is a separate phase of the nursing process, it does not take place chronologically. Evaluation is critical, so evaluation and re-evaluation should be done at all phases:

- Assessment: Collecting data, history, and completing a physical exam.
- Diagnosis: Analyzing data, determining needs and problems, and applying a nursing diagnosis.
- Planning: Setting priorities, setting goals and expected outcomes, and planning interventions and strategies of care.
- Implementation: Applying interventions/treatments.
- Evaluation: Reassessing and auditing.

148. C: Actively spreading cancer, systemic infection, and positive HIV status/AIDS are absolute contraindications for organ donation, but age (young or old) is not in itself a contraindication, as the organs will be examined for suitability. Cancer in and of itself may not be an absolute contraindication—for example, primary brain cancer that has not spread beyond the brainstem is not a contraindication for donation. A history of alcoholism does not necessarily exclude a donor, depending upon the extent of alcohol abuse and any physical damage related to alcohol use.

149. B: The drop factor of an intravenous infusion specifically refers to drops per mL, although the drop factor also relates to the size of the IV tubing that is used. The drop factor is marked on the packaging for the IV tubing. Drop factors are standardized: 10, 15, and 20 gtts/mL (where “gtts” refers to drops). Mini-drip setups, often used for pediatric patients, have drop factors of 60 gtts/mL. This high drop factor helps to minimize the danger of fluid overload in these small patients. Flow rate is calculated by multiplying the volume by the drop factor and dividing the result by the time in minutes.

150. C: This is a stage III pressure ulcer:

- Stage I: Intact skin with erythema (non-blanching), edema and/or induration.
- Stage II: Shallow abrasion or blister-like appearance with partial thickness skin loss.
- Stage III: Deep lesion with full-thickness skin loss and sometimes with involvement of subcutaneous tissue, usually with surrounding “undermining” (progression of the ulcer beyond the visible wound edge, extending under the skin).
- Stage IV: Deep lesion that may include damage to muscles, bones, tendons, and/or joints with undermining and/or sinus tracts about lesion.