
Question: 1

Mrs. Anderson, an 85-year-old female, was admitted to the unit with a diagnosis of pneumonia. On routine assessment, the nurse observes that the client is demonstrating signs of difficulty breathing. Mrs. Anderson is also complaining of difficulty expelling her secretions. Auscultation of the lung fields reveals bronchial sounds in the left lower lobe. Which of the following nursing interventions is provided to the client first?

- A. Instruct bed rest.
- B. Administer oxygen.
- C. Increase fluid intake per hour.
- D. Administer antibiotics.

Answer: B

Explanation: Administration of oxygen is the first treatment provided to a client with dyspnea due to pneumonia. The client with dyspnea is at risk of becoming hypoxic. As an emergency action, the nurse can administer oxygen without waiting for an order from the physician. Bed rest, increased fluid intake, and antibiotic administration are provided to clients with pneumonia and dyspnea, but they are not the first action of the nurse. These actions do not resolve the immediate need of the client. Antibiotic administration is not a nursing decision and requires a physician's order.

Question: 2

Mr. Campbell, a 25-year-old construction worker, is admitted to a burn unit after a fire in a construction site. Initial assessment reveals burn injuries involving the anterior and posterior aspects of the upper extremities. The injured surfaces are black in color and dry in texture. Tissue with fat exposure and edema are noted. Mr. Campbell reports minimal pain. The nurse assessing Mr. Campbell classifies these integumentary injuries as:

- A. Superficial-thickness burns
- B. Partial-thickness superficial burns
- C. Full-thickness burns
- D. Deep full-thickness burns

Answer: C

Explanation: Mr. Campbell sustained full-thickness burns. Full thickness burns are characterized by deep red, brown or black burned sites, dry injured surfaces, edema, tissue disruption with fat exposure, and minimal or no pain. Superficial- and partial-thickness burns are painful due to partially injured nerve endings. Full- and deep full-thickness burns cause minimal or no pain because the nerve endings are completely damaged. Deep full-thickness burns are characterized by burn injuries to the muscle and bone, absence of edema and blisters, and a black burned area.

Question: 3

Bryan, a 17-year-old high school senior, is rushed to the emergency department after he is found lying unconscious on the floor. Physical assessment reveals cherry-red skin, mucus membranes, and nails. Based on this finding, which of the following is the most likely cause of Bryan's medical condition?

- A. Excessive aspirin ingestion
- B. Hydrocarbon ingestion
- C. Lead poisoning
- D. Carbon monoxide poisoning

Answer: D

Explanation: Bryan is most likely demonstrating a sign of carbon monoxide poisoning. Cherry-red skin, mucus membranes, and nails indicate that the client has been exposed to high levels of carbon monoxide. Excessive aspirin ingestion is manifested by nausea and vomiting. Ingestion of hydrocarbon is characterized by respiratory symptoms. High, toxic levels of lead cause abdominal pain or cramping.

Question: 4

A nurse is assigned to care for Amanda, a 39-year-old lawyer who was recently diagnosed with generalized anxiety disorder. Which of the following statements from Amanda would lead the nurse to suspect that Amanda's anxiety has been a long-standing problem?

- A. "My mother was also diagnosed with general anxiety disorder when she was in her early 40s."
- B. "Adjusting to college life was difficult. I never thought I would even receive a degree."
- C. "I have always solved my problems on my own."
- D. "I've had nightmares since my husband left me a year ago."

Answer: B

Explanation: When a client reveals information about having difficulty adjusting to new stressors between 18 and 24 years, such as in college, a long-standing anxiety problem is suspected. The other items are not indicative of a long-standing GAD. Anxiety may be familial, but the first option does not indicate the duration of the problem. Most clients with GAD would rather solve their problems on their own. Chronic nightmares are a sign of post-traumatic stress disorder.

Question: 5

A 23-year-old female at 35 weeks' gestation comes to the emergency department complaining of severe abdominal pain. Moderate dark vaginal bleeding is noted. Physical assessment findings include increased uterine tone with orthostatic changes in the blood pressure. External fetal monitor reveals fetal distress. Based on these initial findings, the client is most likely diagnosed with which of the following conditions?

- A. Abruptio placenta
- B. Placenta previa
- C. Hydatidiform mole
- D. Ectopic pregnancy

Answer: A

Explanation: The client is most likely diagnosed with abruptio placenta. Placenta previa is characterized by painless, bright red vaginal bleeding. Ectopic pregnancy is a condition in which a fertilized egg implants outside the uterus, usually in the fallopian tube. This condition is usually detected in the first five to ten weeks of pregnancy. Hydatidiform mole is usually detected before the 18th week of pregnancy.

Question: 6

Rachel, a G1P0 female at 30 weeks' gestation, was admitted to the facility due to persistent headaches. On physical assessment, a blood pressure of 180/130 mm Hg was noted. Laboratory tests were conducted, revealing proteinuria of more than 5 grams in a 24-hour collection. History reveals that Rachel was diagnosed with pre-eclampsia. Her physician orders the administration of magnesium sulfate IV to prevent convulsions. The nurse who is tasked with preparing and administering the drug ensures that which of the following medications is readily available as an antidote for magnesium sulfate toxicity?

- A. Naloxone
- B. Calcium gluconate
- C. Protamine sulfate
- D. N-acetylcysteine

Answer: B

Explanation: Calcium gluconate is the antagonist or antidote for magnesium sulfate. Naloxone reverses the action of opioids, such as morphine. Protamine sulfate is the antidote for heparin overdose. N-acetylcysteine is the accepted treatment of acetaminophen overdose.

Question: 7

Which of the following should alert the labour nurse that her client has begun the second stage of labour?

- A. The cervix is thin and fully dilated.
- B. The amniotic membranes have ruptured.
- C. The presenting part is below the ischial spines
- D. The woman tells you she needs to push.

Answer: A

Explanation: Once the cervix is fully dilated and has thinned out, the second stage of labour begins. It will probably be very difficult to feel the edges of the cervix at all at this point.

Question: 8

Andrea, a 23-year-old female, comes to the clinic for her second pre-natal examination. On physical assessment, bluish discoloration of the mucus membranes of the cervix, vagina, and vulva is noted. This probable sign of pregnancy is called:

- A. Goodell's sign
- B. Hegar's sign
- C. Chadwick's sign
- D. Ballottement

Answer: C

Explanation: The client demonstrates the Chadwick's sign, a probable sign occurring about at about six weeks of pregnancy. Goodell's sign is the softening of the cervix. It occurs at the start of the second month. Hegar's sign is the softening and thinning of the lower segment of the uterus. It occurs at about six weeks of pregnancy. Ballottement is the rebounding of the fetus against the examiner's fingers.

Question: 9

Kelly, a nullipara at 34 weeks' gestation, comes to the emergency department saying, "I think I'm about to go into labor." After assessing the client, the nurse alerts the physician for a possible case of pre-term labor. The nurse then initiates nursing interventions that aim to manage pre-term labor. Which of the following findings would be most likely to lead the nurse to suspect pre-term labor?

- A. Irregular uterine contractions; cervical dilatation is absent.
- B. Painful uterine contractions occurring every 10 minutes with cervical dilatation.
- C. Painful uterine contractions occurring every 10 minutes without cervical dilatation.
- D. Irregular contractions every 10 minutes with cervical dilation; effacement has not started.

Answer: B

Explanation: Regular uterine contractions with cervical dilatation before 36 weeks is indicative of pre-term labor. Irregular uterine contractions do not suggest a case of pre-term labor. In nulliparas or women who has not had given birth at more than 20 weeks' gestation, effacement of the cervix usually occurs with dilatation. In multiparas, effacement is often completed before dilatation.

Question: 10

A nurse auscultates the heart of Anne, a 21-year-old female. Anne seeks a consultation for dizziness and easy fatigability. During assessment, the nurse identifies a mid-to-late systolic click followed with mid-to-late systolic murmur at the cardiac apex. The murmur gets louder when Anne stands up. Based on these findings, Anne is most likely considered for which of the following cardiac problems?

- A. Aortic stenosis
- B. Mitral valve prolapse
- C. Pulmonic stenosis
- D. Mitral regurgitation

Answer: B

Explanation: The client is most likely considered for mitral valve prolapse. Mitral valve prolapse is a cardiac condition in which the valve found between the left atrium and left ventricle does not shut down as it should, causing a backflow of blood. Aortic stenosis is manifested by crescendo-decrescendo systolic murmur. Pulmonic stenosis causes wide splitting of the second heart sound. Mitral regurgitation is manifested by high-pitched holosystolic murmur with the first heart sound and extending to the second heart sound.

Question: 11

A client who complains of moderate to severe joint pain and stiffness is diagnosed with rheumatoid arthritis. The nurse caring for the client reviews the client's record and notes which of the following as the most consistent diagnostic finding of rheumatoid arthritis?

- A. Low sedimentation rate
- B. Synovial tissue biopsy showing absence of inflammation
- C. Greater than 80 IU/mL rheumatoid factor
- D. Normal C-reactive protein levels

Answer: C

Explanation: A rheumatoid factor greater than 80 IU/mL is the most consistent diagnostic finding of rheumatoid arthritis. About 80% of individuals with rheumatoid arthritis are positive for rheumatoid factor. The sedimentation rate and C-reactive protein levels are usually above the normal range. Synovial tissue biopsy shows inflammation.

Question: 12

A client is rushed to the emergency department after demonstrating signs of acute myocardial infarction. History reveals that the chest pain has not been resolved by sublingual nitroglycerin. The client is started on tissue plasminogen activator by infusion. The nurse caring for the client frequently assesses which of the following parameters?

- A. Serum potassium levels

- B. Oxygen saturation
- C. Pulse rate
- D. Visual acuity

Answer: C

Explanation: The nurse assesses for the client's pulse rate. Tissue plasminogen activator dissolves existing clots, increasing the client's risk for excessive bleeding. Internal hemorrhage increases the pulse rate and decreases the blood pressure. Other signs of bleeding include shortness of breath, blood in urine or stool, back pain or abdominal pain, neurological changes, and painful joint movement.

Question: 13

A client complaining of joint pain is diagnosed with osteoarthritis, a progressive degeneration of a joint as a result of wear-and-tear. The nurse expects to note which of the following findings in the client's record?

- A. Joint symptoms in symmetrical pattern
- B. Hand deformities
- C. Joint pain that intensifies after inactivity
- D. Joint pain that diminishes after rest

Answer: D

Explanation: Osteoarthritis is manifested with joint pain that diminishes after rest. Joint symptoms intensify after activity. The most commonly affected joints are the weight-bearing joints, such as the knee and hips. Osteoarthritic joint symptoms do not occur in symmetrical pattern; this is commonly seen in individuals with rheumatoid arthritis. Hand deformities are noted in rheumatoid arthritis cases.

Question: 14

Wanda comes to the emergency department complaining of substernal chest pain that radiates to the neck and left arm. A 12-lead electrocardiogram is attached to Wanda to evaluate the function of the heart. A nurse examines the tracing, which suggests myocardial ischemia. Which of the following electrocardiogram changes is most likely noted by the nurse?

- A. Formation of Q wave
- B. Depression of ST segment
- C. Widened QRS complex
- D. Tall T wave

Answer: B

Explanation: Depression of ST segment is consistent with myocardial ischemia. Formation of Q wave is usually in acute myocardial infarction. Widened QRS complex is a common electrocardiogram finding in clients with bundle branch block. Tall T wave is usually noted in clients with hyperkalemia.

Question: 15

Evelyn, a 72-year-old female, was admitted to the facility due to myocardial infarction. On routine assessment, the nurse caring for Evelyn notes bilateral pitting edema in the lower extremities. Indentation is 4 millimeters. Which of the following is the most appropriate action of the nurse?

- A. Inform the client that she should limit her intake of sodium to 1 gram a day.
- B. Recommend diuretic administration at bedtime.
- C. Review the client's fluid intake and output for the last 48 hours.
- D. Inform the client that she should limit her fluid intake to 1,500 mL per day.

Answer: C

Explanation: The most appropriate action of the nurse is to review the client's fluid intake and output for the last 48 hours. The client's edema is graded 2, which is not severe. Fluid intake and sodium restriction are initiated with severe edema. Diuretics are administered in the morning to avoid nocturia.

Question: 16

Jane is a 54-year-old female who was recently diagnosed with pulmonary edema. Furosemide, given through intravenous route, is ordered to the client. The nurse caring for the client reviews Jane's chart and finds out that she is also ordered to take digoxin. Which of the following is the priority action of the nurse?

- A. Check the client's most recent potassium level.
- B. Check the client's pulse rate.
- C. Contact the physician and verify the order.
- D. Check the client's creatinine levels.

Answer: A

Explanation: The nurse should check for the client's most recent potassium level. A client on furosemide therapy has an increased risk for hypokalemia. The risk of developing digoxin toxicity increases with hypokalemia. Insufficient potassium levels in the blood can also increase the client's risk for ventricular dysrhythmias. The physician is contacted if the client's serum potassium level is not within the normal range.

Question: 17

A client who has a history of diabetes mellitus type 2, angina, and myocardial infarction is diagnosed with left-sided heart failure. The nurse assessing the client identifies all of the following as symptoms of left-sided heart failure EXCEPT:

- A. Orthopnea
- B. Presence of crackles on auscultation
- C. Enlargement of the liver
- D. Cough with frothy sputum

Answer: C

Explanation: Enlargement of the liver, also known as hepatomegaly, is a sign of right-sided heart failure. Signs of left ventricular failure, such as orthopnea, cough with frothy sputum, and orthopnea, are related to the pulmonary system. Signs of right ventricular failure are seen in the systemic circulation.

Question: 18

A client is admitted to the facility due to right-sided heart failure. The nurse notes that the client demonstrates distention of the jugular vein. The nurse places the head of the bed in which of the following positions to obtain the most accurate jugular venous pressure reading?

- A. Raised to 45degrees
- B. Raised to 90degrees
- C. Raised between 15 and 30degrees
- D. Raised between 45 and 90degrees

Answer: C

Explanation: The head of bed is raised between 15 and 30degrees to obtain the most accurate jugular venous pressure reading. When the head of bed is raised higher than 30degrees, the veins are less discernible above the clavicle. When the head of bed is lower than 15degrees, increased pressure is not detectable.

Question: 19

A female client complains of vaginal burning and itching. Vaginal discharge with a cottage-cheese-like appearance is reported. History reveals that the client is on antibiotic therapy. The nurse suspects that the client is experiencing which of the following vaginal infections?

- A. Gonorrhea
- B. Bacterial vaginosis
- C. Trichomoniasis
- D. Candidiasis

Answer: D

Explanation: Candidiasis is manifested by vaginal itching and burning and vaginal discharge with a cottage-cheese-like appearance. The infection is caused by the opportunistic fungus *Candida albicans*. Candidiasis occurs when the vaginal environment is altered. Antibiotics and corticosteroids decrease the host's defenses. Gonorrhea is manifested by vaginal discharge that is purulent in appearance. Bacterial vaginosis causes thin and grayish white vaginal discharge with a fishy odor. Trichomoniasis is manifested by greenish or grayish and frothy vaginal