Exam Questions NCLEX-PN

National Council Licensure Examination(NCLEX-PN)

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NEW QUESTION 1
- (Topic 1)
Light therapy can be effective for:

A. overcoming weight problems.
B. helping with allergies.
C. use in alternative medical treatments.
D. working with sleep patterns.

Answer: D

Explanation:
Light therapy can be effective in treating problems associated with sleep patterns, stress, moods, jaundice in newborns, and seasonal affective disorders.Nonpharmacological Therapies

NEW QUESTION 2
- (Topic 1)
Broccoli, oranges, dark greens, and dark yellow vegetables can be eaten to:

A. supplement vitamin pills.
B. balance body molecules.
C. cure many diseases.
D. help improve body defenses.

Answer: D

Explanation:
Controversy over what types of food to eat and not eat is still under investigation. Certain foods can help improve body defenses to possibly prevent certain diseases.Nonpharmacological Therapies

NEW QUESTION 3
- (Topic 1)
A client who is immobilized secondary to traction is complaining of constipation. Which of the following medications should the nurse expect to be ordered?

A. Advil
B. Anasaid
C. Clinocil
D. Colace

Answer: D

Explanation:
Colace is a stool softener that acts by pulling more water into the bowel lumen, making the stool soft and easier to evacuate.Basic Care and Comfort

NEW QUESTION 4
- (Topic 1)
Which of the following organs of the digestive system has a primary function of absorption?

A. stomach
B. pancreas
C. small intestine
D. gallbladder

Answer: C

Explanation:
The small intestine has a primary function of absorption. The remaining digestive organs have other primary functions.Physiological Adaptation

NEW QUESTION 5
- (Topic 1)
A client is having a seizure; his blood oxygen saturation drops from 92% to 82%. What should the nurse do first?

A. Open the airway.
B. Administer oxygen.
C. Suction the client.
D. Check for breathing.

Answer: A

Explanation:
The nurse needs to open the airway first when the oxygen saturation drops. The other actions might be appropriate, but the airway must be patent.Reduction of Risk Potential

NEW QUESTION 6

- (Topic 1)
Why must the nurse be careful not to cut through or disrupt any tears, holes, bloodstains, or dirt present on the clothing of a client who has experienced trauma?

A. The clothing is the property of another and must be treated with care.
B. Such care facilitates repair and salvage of the clothing.
C. The clothing of a trauma victim is potential evidence with legal implications.
D. Such care decreases trauma to the family members receiving the clothing.

Answer: C

Explanation:
Trauma in any client, living or dead, has potential legal and/or forensic implications.
Clothing, patterns of stains, and debris are sources of potential evidence and must be preserved. Nurses must be aware of state and local regulations that require mandatory reporting of cases of suspected child and elder abuse, accidental death, and suicide. Each Emergency Department has written policies and procedures to assist nurses and other health care providers in making appropriate reports. Physical evidence is real, tangible, or latent matter that can be visualized, measured, or analyzed. Emergency Department nurses can be called on to collect evidence. Health care facilities have policies governing the collection of forensic evidence. The chain of evidence custody must be followed to ensure the integrity and credibility of the evidence. The chain of evidence custody is the pathway that evidence follows from the time it is collected until is has served its purpose in the legal investigation of an incident.Physiological Adaptation

NEW QUESTION 7
- (Topic 1)
Which is the proper hand position for performing chest vibration?

A. cup the hands
B. use the side of the hands
C. flatten the hands
D. spread the fingers of both hands

Answer: C

Explanation:
The hands are flattened over the area of the body where chest percussion is used to conduct vibration through to the chest and loosen secretions. The other hand positions do not accomplish this task.
Reduction of Risk Potential

NEW QUESTION 8
- (Topic 1)
What interpersonal relief behavior is Ashley using?

A. acting out
B. somatizing
C. withdrawal
D. problem-solving

Answer: B

Explanation:
Somatizing means one experiences an emotional conflict as a physical symptom. Ashley manifests several
physical symptoms associated with severe anxiety. Acting out refers to behaviors such as anger, crying, laughter, and physical or verbal abuse. Withdrawal is a reaction in which psychic energy is withdrawn from the environment and focused on the self in response to anxiety. Problem-solving takes place when anxiety is identified and the unmet need is met.Psychosocial Integrity

NEW QUESTION 9
- (Topic 1)
A diet high in fiber content can help an individual to:

A. lose body weight fast.
B. reduce diabetic ketoacidosis.
C. lower cholesterol.
D. reduce the need for folate.

Answer: C

Explanation:
Fiber-rich foods (such as grains, apples, potatoes, and beans) can help lower cholesterol.
Nonpharmacological Therapies

NEW QUESTION 10
- (Topic 1)
Assessment of a client with a cast should include:

A. capillary refill, warm toes, no discomfort.
B. posterior tibial pulses, warm toes.
C. moist skin essential, pain threshold.
D. discomfort of the metacarpals.

Answer: A

Explanation:

Assessment for adequate circulation is necessary. Signs of impaired circulation include slow capillary refill, cool fingers or toes, and pain.Basic Care and Comfort

NEW QUESTION 10
- (Topic 1)
A client has been taking alprazolam (Xanax) for four years to manage anxiety. The client reports taking 0.5 mg four times a day. Which statement indicates that the client understands the nurse??s teaching about discontinuing the medication?

A. ??I can drink alcohol now that I am decreasing my Xanax.??
B. ??I should not take another Xanax pil
C. Here is what is left of my last prescription.??
D. ??I should take three pills per day next week, then two pills for one week, then one pill for one week.??
E. ??I can expect to be sleepy for several days after stopping the medicine.??

Answer: C

Explanation:
Xanax, like other benzodiazepines, can cause withdrawal symptoms that include agitation, insomnia, hypertension, seizures, and abdominal pain. The drug must be slowly decreased to prevent withdrawal symptoms.
Psychosocial Integrity

NEW QUESTION 13
- (Topic 1)
For which of the following conditions might blood be drawn for uric acid level?

A. asthma
B. gout
C. diverticulitis
D. meningitis

Answer: B

Explanation:
Uric acid levels are indicated for clients with gout.Reduction of Risk Potential

NEW QUESTION 14
- (Topic 1)
A pregnant Asian client who is experiencing morning sickness wants to take ginger to relieve the nausea. Which of the following responses by the nurse is appropriate?

A. ??I will call your physician to see if we can start some ginger.??
B. ??We don??t use home remedies in this clinic.??
C. ??Herbs are not as effective as regular medicines.??
D. ??Just eat some dry crackers instead.??

Answer: A

Explanation:
This statement reveals cultural sensitivity. Ginger is sometimes used to relieve nausea.
The other statements are culturally insensitive and do not show an awareness of herbal pharmacology.
Physiological Adaptation

NEW QUESTION 18
- (Topic 1)
The goals of palliative care include all of the following except:

A. giving clients with life-threatening illnesses the best quality of life possible.
B. taking care of the whole person—body, mind, spirit, heart, and soul.
C. no interventions are needed because the client is near death.
D. support of needs of the family and client.

Answer: C

Explanation:
The goals of palliative care include choices 1, 2, and 4. Choice 3 is not part of palliative care. All aspects of medical, emotional, social, and spiritual needs of the dying client should be focused on until the end of life.Basic Care and Comfort

NEW QUESTION 19
- (Topic 1)
Which condition is associated with inadequate intake of vitamin C?

A. rickets
B. marasmus
C. kwashiorkor
D. scurvy

Answer: D

Explanation:
Scurvy is associated with inadequate intake of vitamin C. The remaining choices refer to other nutritional deficiencies.Health Promotion and Maintenance

NEW QUESTION 22
- (Topic 1)
A client with Kawasaki disease has bilateral congestion of the conjunctivae, dry cracked lips, a strawberry tongue, and edema of the hands and feet followed by desquamation of fingers and toes. Which of the following nursing measures is most appropriate to meet the expected outcome of positive body image?

A. administering immune globulin intravenously
B. assessing the extremities for edema, redness and desquamation every 8 hours
C. explaining progression of the disease to the client and his or her family
D. assessing heart sounds and rhythm

Answer: C

Explanation:
Teaching the client and family about progression of the disease includes explaining when symptoms can be expected to improve and resolve. Knowledge of the course of the disease can help them understand that no permanent disruption in physical appearance will occur that could negatively affect body image. Clients with Kawasaki disease might receive immune globulin intravenously to reduce the incidence of coronary artery lesions and aneurysms. Cardiac effects could be linked to body image, but Choice 3 is the most direct link to body image. The nurse assesses symptoms to assist in evaluation of treatment and progression of the disease.Health Promotion and Maintenance

NEW QUESTION 27
- (Topic 1)
A client with stress incontinence should be advised:

A. to purchase absorbent undergarments.
B. that Kegel exercises might help.
C. that effective surgical treatments are nonexistent.
D. that behavioral therapy is ineffective.

Answer: B

Explanation:
Kegel exercises, tightening and releasing the pelvic floor muscles, might improve stress incontinence. Choice 1 is not an appropriate treatment for stress incontinence. Several effective surgical treatments exist. Lifestyle and dietary modifications can also be helpful.Physiological Adaptation

NEW QUESTION 32
- (Topic 1)
Which is the proper hand position for performing chest percussion?

A. cup the hands
B. use the side of the hands
C. flatten the hands
D. spread the fingers of both hands

Answer: A

Explanation:
The hands are cupped for performing percussion, producing a vibration that helps loosen respiratory secretions. The other hand positions do not accomplish this task.Reduction of Risk Potential

NEW QUESTION 37
- (Topic 1)
Which of the following foods is a complete protein?

A. corn
B. eggs
C. peanuts Dsunflower seeds

Answer: B

Explanation:
Eggs are a complete protein. The remaining options are incomplete proteins.Health Promotion and Maintenance

NEW QUESTION 39
- (Topic 1)
Which of the following medications is a serotonin antagonist that might be used to relieve nausea and vomiting?

A. metoclopramide (Reglan)
B. onedansetron (Zofran)
C. hydroxyzine (Vistaril)
D. prochlorperazine (Compazine)

Answer: B

Explanation:
Zofran is a serotonin antagonist that can be used to relieve nausea and vomiting. The other medications can be used for nausea and vomiting, but they have different mechanisms of action.
Physiological Adaptation

NEW QUESTION 41
- (Topic 1)
A 10-month-old child is brought to the Emergency Department because he is difficult to awaken. The nurse notes bruises on both upper arms. These findings are most consistent with:

A. wearing clothing that is too small for the child.
B. the child being shaken.
C. falling while learning to walk.
D. parents trying to awaken the child.

Answer: B

Explanation:
Children who are shaken are frequently grasped by both upper arms. Symptoms of brain injury associated with shaking include decreased level of consciousness.Psychosocial Integrity

NEW QUESTION 45
- (Topic 1)
Which of the following neurological disorders is characterized by writhing, twisting movements of the face and limbs?

A. epilepsy
B. Parkinson??s
C. muscular sclerosis
D. Huntington??s chorea

Answer: D

Explanation:
Huntington??s chorea is characterized by writhing, twisting movements of the face and limbs.
The remaining options are neurological disorders that do not have such movements as part of their disease process.Reduction of Risk Potential

NEW QUESTION 47
- (Topic 1)
Which of the following nursing actions is most effective when evaluating a kinetic family drawing?

A. telling the child to draw their family doing something
B. offering specific suggestions of what to include in the drawing
C. discouraging the child from talking about the drawing
D. noting the omission of any family members

Answer: D

Explanation:
There are several guidelines for evaluating kinetic family drawings, including Choice 4.
Effective nursing actions include asking the child to explain what each family member is doing, encouraging him or her to tell as much as possible about the drawing, noting physical intimacy or distance, noting placement of family members in the drawing, noting facial expressions of family members and noting if they are facing each other or turned away.
Choice 1 is initial instruction, not evaluation. Only general encouragement should be given to avoid suggesting themes to the child.Health Promotion and Maintenance

NEW QUESTION 50
- (Topic 1)
Which of the following terms refers to soft-tissue injury caused by blunt force?

A. contusion
B. strain
C. sprain
D. dislocation

Answer: A

Explanation:
A contusion is a soft-tissue injury caused by blunt force. It is an injury that does not break the skin, is caused by a blow and is characterized by swelling, discoloration, and pain. The immediate application of cold might limit the development of a contusion. A strain is a muscle pull from overuse, overstretching, or excessive stress.
A sprain is caused by a wrenching or twisting motion. A dislocation is a condition in which the articular surfaces of the bones forming a joint are no longer in anatomic contact.Physiological Adaptation

NEW QUESTION 55
- (Topic 1)
Major competencies for the nurse giving end-oflife care include:

A. demonstrating respect and compassion, and applying knowledge and skills in care of the family and the client.
B. assessing and intervening to support total management of the family and client.
C. setting goals, expectations, and dynamic changes to care for the client.
D. keeping all sad news away from the family and client.

Answer: A

Explanation:
There are many competencies that the nurse must have to care for families and clients at the end of life.
Demonstration of respect and compassion as well as using knowledge and skills in the care of the client and family are major competencies.Basic Care and Comfort

NEW QUESTION 60
- (Topic 1)
Which of the following diseases or conditions is least likely to be associated with increased potential for bleeding?

A. metastatic liver cancer
B. gram-negative septicemia
C. pernicious anemia
D. iron-deficiency anemia

Answer: C

Explanation:
Pernicious anemia results from vitamin B12 deficiency due to lack of intrinsic factor. This can result from inadequate dietary intake, faulty absorption from the GI tract due to a lack of secretion of intrinsic factor normally produced by gastric mucosal cells and certain disorders of the small intestine that impair absorption.
The nurse should instruct the client in the need for lifelong replacement of vitamin B12, as well as the need for folic acid, rest, diet, and support.Physiological Adaptation

NEW QUESTION 63
- (Topic 1)
Which of the following lab values is associated with a decreased risk of cardiovascular disease?

A. high HDL cholesterol
B. low HDL cholesterol
C. low total cholesterol
D. low triglycerides

Answer: A

Explanation:
High HDL cholesterol and low LDL cholesterol are associated with a decreased risk of cardiovascular disease.Reduction of Risk Potential

NEW QUESTION 68
- (Topic 1)
Which of the following is the primary force in sex education in a child??s life?

A. school nurse
B. peers
C. parents
D. media

Answer: C

Explanation:
Parents are the primary force in sex education in a child??s life. The school nurse is involved with formal sex education and counseling. Peers become more important in sex education during adolescence but might lack correct information. The media play a powerful role in what children learn about sex through movies, TV, and video games.Health Promotion and Maintenance

NEW QUESTION 72
- (Topic 1)
Which of the following is likely to increase the risk of sexually transmitted disease?

A. alcohol use
B. certain types of sexual practices
C. oral contraception use
D. all of the above

Answer: D

Explanation:
STDs affect certain groups in groups in greater numbers. Factors associated with risk include being younger than 25 years of age, being a member of a minority group, residing in an urban setting, being impoverished, and using crack cocaine.Physiological Adaptation

NEW QUESTION 77

- (Topic 1)
Which of the following foods might a client with a hypercholesterolemia need to decrease his or her intake of?

A. broiled catfish
B. hamburgers
C. wheat bread
D. fresh apples

Answer: B

Explanation:
Due to the high cholesterol content of red meats, such as hamburger, intake needs to be decreased. The other options do not have high cholesterol content, so they do not need to be decreased.
Reduction of Risk Potential

NEW QUESTION 80
- (Topic 1)
All of the following should be performed when fetal heart monitoring indicates fetal distress except:

A. increase maternal fluids.
B. administer oxygen.
C. decrease maternal fluids.
D. turn the mother.

Answer: C

Explanation:
Decreasing maternal fluids is the only intervention that shouldnotbe performed when fetal distress is indicated.Reduction of Risk Potential

NEW QUESTION 81
- (Topic 2)
The vast majority of deaths resulting from unintentional poisoning occur in:

A. infants.
B. toddlers.
C. teens.
D. adults.

Answer: B

Explanation:
The vast majority of deaths resulting from unintentional poisoning occur in toddlers.Safety and Infection Control

NEW QUESTION 83
- (Topic 2)
Common problems for supervisors include all of the following except:

A. the supervisor facilitates development of staff members.
B. the supervisor micromanages staff members.
C. the supervisor wants to control the style in which a staff member correctly performs a task.
D. the supervisor does not delegate.

Answer: A

Explanation:
Facilitating the development of staff members is an important goal for a supervisor. Micromanagement, intolerance for individual differences in style, and inability to delegate all interfere with team building and overall effectiveness.Coordinated Care

NEW QUESTION 84
- (Topic 2)
A client can receive the mumps, measles, rubella (MMR) vaccine if he or she:

A. is pregnant.
B. is immunocompromised.
C. is allergic to neomycin.
D. has a cold.

Answer: D

Explanation:
A simple cold without fever does not preclude vaccination. Choices 1 and 2 are incorrect because pregnant women and immunocompromised individuals cannot have the MMR vaccine because the rubella component is a live virus and might cause birth defects and/or disease. Choice 3 is incorrect because the American Academy of Pediatrics states, ??Persons who have experienced anaphylactic reactions to topically or systemically administered neomycin should not receive measles vaccine.??Pharmacological Therapies

NEW QUESTION 88
- (Topic 2)
A nurse observes a client sitting alone and talking. When asked, the client reports that he is ??talking to the voices.?? The nurse??s next action should be:

A. touching the client to help him return to reality.
B. leaving the client alone until reality returns.
C. asking the client to describe what is happening.
D. telling the client there are no voices.

Answer: A

Explanation:
Nurses need to inform clients that there is a difference in perceptions and pay attention to the content of hallucinations. The other options are not therapeutic.Psychosocial Integrity

NEW QUESTION 89
- (Topic 2)
A 35-year-old Latin-American client wishes to lose weight to reduce her chances of developing heart disease and diabetes. The client states, ??I do not know how to make my diet work with the kind of foods that my family eats.?? What should the nurse do first to help the client determine a suitable diet for disease prevention?

A. Provide her with copies of the approved dietary guidelines for the American Diabetic Association and the American Heart Association.
B. Ask the client to provide a list of the types of foods she eats to determine how to best meet her needs.
C. Provide a high-protein diet plan for the client.
D. Provide the client with information related to risk factors for heart disease and diabetes.

Answer: B

Explanation:
Assessment is the first step. Assessing what the client eats helps the nurse determine a plan for dietary recommendations based on the ADA and AHA guidelines. Providing the client with a copy of the guidelines is important but is not the first priority. Based on the client??s wish to reduce her chances of heart disease and diabetes, a high-protein diet plan might not be appropriate. Providing information to the client related to risk factors for heart disease and diabetes is important but is not the first step.Health Promotion and Management

NEW QUESTION 93
- (Topic 2)
A client goes to the Emergency Department with acute respiratory distress and the following arterial blood gases (ABGs): pH 7.35, PCO2 40 mmHg, PO2 63mmHg, HCO3 23, and oxygenation saturation (SaO2) 93%. Which of the following represents the best analysis of the etiology of these ABGs?

A. tuberculosis (TB)
B. pneumonia
C. pleural effusion
D. hypoxia

Answer: D

Explanation:
A combined low PO2 and lowSaO2 indicates hypoxia. The pH, PCO2, and HCO3 are normal. ABGs are not necessarily altered in TB or pleural effusion. Depending on the degree of the pneumonia, the PO2 and PCO2 might be low because hypoxia stimulates hyperventilation.Physiological Adaptation

NEW QUESTION 97
- (Topic 2)
The chemotherapeutic DNA alkylating agents such as nitrogen mustards are effective because they:

A. cross-link DNA strands with covalent bonds between alkyl groups on the drug and guanine bases on DNA.
B. have few, if any, side effects.
C. are used to treat multiple types of cancer.
D. are cell-cycle-specific agents.

Answer: A

Explanation:
Alkylating agents are highly reactive chemicals that introduce alkyl radicals into biologically active molecules and thereby prevent their proper functioning, replication, and transcription. Choice 2 is incorrect because alkylating agents have numerous side effects including alopecia, nausea, vomiting, and myelosuppression. Choice 3 is incorrect because nitrogen mustards have a broad spectrum of activity against chronic lymphocytic leukemia, non-Hodgkin??s lymphoma, and breast and ovarian cancer, but they are effective chemotherapeutic agents because of DNA crosslinkage. Choice 4 is incorrect because alkylating agents are non-cell-cycle- specific agents.PharmacologicalTherapies

NEW QUESTION 99
- (Topic 2)
The client??s lab culture report is negative for a suspected infection. A test that can correctly identify those who do not have a given disease is:

A. specific.
B. sensitive.
C. negative culture.
D. marginal finding.

Answer:

A

Explanation:
Testing that identifies clients without a disease is said to be specific, while testing that identifies clients with a disease is said to be sensitive. Safety and Infection Control

NEW QUESTION 102
- (Topic 2)
Which of the following ethnic groups is at highest risk in the United States for pesticide- related injuries?

A. Native American
B. Asian-Pacific
C. Norwegian
D. Hispanic

Answer: D

Explanation:
Because Hispanic people represent a large percentage of migrant workers in the United States, many work in agricultural settings and might be exposed to pesticides, putting them at higher risk than the other groups.Safety and Infection Control

NEW QUESTION 103
- (Topic 2)
The nurse should teach parents of small children that the most common type of first-degree burn is:

A. scalding from hot bath water or spills.
B. contact with hot surfaces such as stoves and fireplaces.
C. contact with flammable liquids or gases resulting in flash burns.
D. sunburn from lack of protection and overexposure.

Answer: D

Explanation:
The most common type of first-degree burn is sunburn, underscoring the need for education regarding the use of sunscreens and avoiding exposure.Safety and Infection Control

NEW QUESTION 106
- (Topic 2)
A nurse observes a client sitting alone and talking. When asked, the client reports that he is ??talking to the voices.?? The nurse??s next action should be:

A. touching the client to help him return to reality.
B. leaving the client alone until reality returns.
C. asking the client to describe what is happening.
D. telling the client there are no voices.

Answer: C

Explanation:
Nurses might observe behavioral cues that can indicate the presence of hallucinations.
Talking about the hallucinations is reassuring and validating to the client who has them. Focusing on the symptoms and asking about the hallucinations helps the client gain control.Psychosocial Integrity

NEW QUESTION 107
- (Topic 2)
The most common cause of injury from a house fire is:

A. explosion.
B. falls from second-story windows.
C. thermal damage to skin and body surfaces.
D. inhalation injury.

Answer: D

Explanation:
Inhalation is the most common cause of injury from a house fire.Accident Prevention

NEW QUESTION 111
- (Topic 2)
A client begins a regimen of chemotherapy. Her platelet counts falls to 98,000. Which action is least likely to increase the risk of hemorrhage?

A. Test all excreta for occult blood.
B. Use a soft toothbrush or foam cleaner for oral hygiene.
C. Implement reverse isolation.
D. Avoid IM injections.

Answer: C

Explanation:
Reverse isolation does not affect the risk of hemorrhage.Physiological Adaptation

NEW QUESTION 112
- (Topic 2)
A 2-year-old child diagnosed with HIV comes to a clinic for immunizations. Which of the following vaccines should the nurse expect to administer in addition to the scheduled vaccines?

A. pneumococcal vaccine
B. hepatitis A vaccine
C. Lyme disease vaccine
D. typhoid vaccine

Answer: A

Explanation:
Pneumococcal vaccine should be administered as a supplemental vaccine. Hepatitis A vaccine is for travelers and individuals with chronic liver disease. The Lyme disease vaccine is for people between the ages of 15 and 70 who are at risk for Lyme disease (transmitted by ticks primarily). The typhoid vaccine is for workers in microbiology laboratories who frequently work with Salmonella typhi.Health Promotion and Maintenance

NEW QUESTION 114
- (Topic 2)
A client has chronic respiratory acidosis caused by end-stage chronic obstructive pulmonary disease (COPD). Oxygen is delivered at 1 L/min per nasal cannula. The nurse teaches the family that the reason for this is to avoid respiratory depression, based on which of the following explanations?

A. COPD clients are stimulated to breathe by hypoxia.
B. COPD clients depend on a low carbon dioxide level.
C. COPD clients tend to retain hydrogen ions if they are given high doses of oxygen.
D. COPD clients thrive on a high oxygen level.

Answer: A

Explanation:
COPD clients are compensating for low oxygen and high carbon dioxide levels. Hypoxia is the main stimulus to breathe in persons with chronic hypercapnia. Increasing the level of oxygen decreases the stimulus to breathe.
Physiological Adaptation

NEW QUESTION 118
- (Topic 2)
Which of the following observations is most important when assessing a client??s breathing?

A. presence of breathing and pulse rate
B. breathing pattern and adequacy of breathing
C. presence of breathing and adequacy of breathing
D. patient position and adequacy of breathing

Answer: C

Explanation:
It is not enough to simply make sure the client is breathing. The client must be breathing adequately. Physiological Adaptation

NEW QUESTION 120
- (Topic 2)
A wrong committed by one person against another (or against the property of another) that might result in a civil trial is:

A. a tort.
B. a crime.
C. a misdemeanor.
D. a felony.

Answer: A

Explanation:
Torts are wrongs committed by one person against another person (or against the property of another), which might result in civil trials. A crime is also defined as a wrong against a person or their property but is considered to be against the public as well. Misdemeanors are crimes that are commonly punishable with fines or imprisonment for less than one year, with both or with parole. A felony is a serious crime punishable by imprisonment in a State or Federal penitentiary for more than one year.Coordinated Care

NEW QUESTION 123
- (Topic 2)
Several passengers aboard an airliner suddenly become weak and suffer breathing difficulty. The diagnosis is likely to be:

A. outbreak of Asian flu.
B. Chemical exposure.
C. bacterial pneumonia.
D. allergic reaction.

Answer: B

Explanation:
The most likely cause of groups of individuals suddenly experiencing similar signs of illness all at once is a chemical exposure.Safety and Infection Control

NEW QUESTION 125
- (Topic 2)
A 45-year-old client with type I diabetes is in need of support services upon discharge from a skilled rehabilitation unit. Which of the following services is an example of a skilled support service?

A. shopping for groceries
B. house cleaning
C. transportation to physician??s visits
D. medication instruction

Answer: D

Explanation:
The only skilled service listed is medication instruction. Grocery shopping, house-cleaning services, and transportation services are all examples of unskilled services offered by volunteer and fee- for-service agencies. Coordinated Care

NEW QUESTION 128
- (Topic 2)
Signs of impaired breathing in infants and children include all of the following except:

A. nasal flaring.
B. grunting.
C. seesaw breathing.
D. quivering lips.

Answer: D

Explanation:
Lip quivering is a distracter. Signs of impaired breathing in infants and children include all the other options.
Physiological Adaptation

NEW QUESTION 130
- (Topic 2)
The nurse is teaching a client about the use of Rifampin for prophylaxis after an exposure to meningitis. What change in bodily functions should the nurse advise the client about?

A. The client??s urine might turn blue.
B. The client remains infectious to others for 48 hours.
C. The client??s contact lenses might be stained orange.
D. The client??s skin might take on a crimson glow.

Answer: C

Explanation:
Rifampin has the unusual effect of turning body fluids an orange color. Soft contact lenses might become permanently stained. Clients should be taught about these side effects to avoid unnecessary concern.Safety and Infection Control

NEW QUESTION 131
- (Topic 2)
A client is diagnosed with HIV. Which of the following are antiviral drug classes used in the treatment of HIV/AIDS?

A. nucleoside reverse transcriptase inhibitors
B. protease inhibitors
C. HIV fusion inhibitors
D. all of the above.

Answer: D

Explanation:
All of the choices are anti-HIV drugs.Safety and Infection Control

NEW QUESTION 132
- (Topic 2)
The intent of the Patient Self Determination Act (PSDA) of 1990 is to:

A. enhance personal control over legal care decisions.
B. encourage medical treatment decision making prior to need.
C. give one federal standard for living wills and durable powers of attorney.
D. emphasize client education.

Answer: B

Explanation:
The purpose of the PSDA is to promote decision-making prior to need. Choices 1, 3 and 4 are incorrect. The focus of the PSDA is individual health care decision-making. A federal standard for advance directives does not exist. Each state has jurisdiction regarding these policies and protocols.Coordinated Care

NEW QUESTION 135
- (Topic 3)
Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board. When the nurse who was not promoted first read the memo and learned that the other nurse had received the promotion, she left the room in tears. This behavior is an example of:

A. conversion.
B. regression.
C. introjection.
D. rationalization.

Answer: B

Explanation:
Crying is a regressive behavior. The ego returned to an earlier, comforting, and less- mature way of behaving in the face of disappointment. Conversion involves the transformation of anxiety into a physical symptom. Introjection involves intense unconscious identification with another person. Rationalization involves the unconscious process of developing acceptable explanations to justify unacceptable ideas, actions, or feelings.Psychosocial Integrity

NEW QUESTION 139
- (Topic 3)
Tuberculosis (mycobacterium) usually effects which system?

A. stomach (GI)
B. heart (cardiac)
C. lungs (respiratory)
D. skin (integumentary)

Answer: C

Explanation:
Mycobacterium tuberculosis is an aerobic bacillus that requires a great deal of oxygen to grow and flourish. It needs highly oxygenated body sites, such as lungs, growing ends of bones, and the brain. The bacillus is airborne.
Physiological Adaptation

NEW QUESTION 143
- (Topic 3)
Which of the following should not be included in the teaching for clients who take oral iron preparations?

A. Mix the liquid iron preparation with antacids to reduce GI distress.
B. Take the iron with meals if GI distress occurs.
C. Liquid forms should be taken with a straw to avoid discoloration of tooth enamel.
D. Oral forms should be taken with juice, not milk.

Answer: A

Explanation:
Iron should not be mixed with antacids.Physiological Adaptation

NEW QUESTION 145
- (Topic 3)
A client newly diagnosed with Diabetes Mellitus needs education. Which of the following statements should the nurse include in this education?

A. ??You can eat anything you want, but no foods with sugar.??
B. ??You need to lose weight, so your diet must be a restricted one.??
C. ??You need a diet and exercise program.??
D. ??You must eliminate all salt, fat, and sugar from your diet.??

Answer: C

Explanation:
A client newly diagnosed with Diabetes Mellitus needs teaching about diet and exercise.
Physiological Adaptation

NEW QUESTION 148
- (Topic 3)
When the nurse is determining the appropriate size of a nasopharyngeal airway to insert, which body part should be measured on the client?

A. corner of the mouth to tragus of the ear
B. corner of the eye to top of the ear
C. tip of the chin to the sternum
D. tip of the nose to the earlobe

Answer: D

Explanation:
A nasopharyngeal airway is measured from the tip of the nose to the earlobe.Reduction of Risk Potential

NEW QUESTION 150
- (Topic 3)
An Rh-negative woman with previous sensitization has delivered an Rh-positive fetus. Which of the following nursing actions should be included in the client??s care plan?

A. emotional support to help the family deal with feelings of guilt about the infant??s condition
B. administration of MICRhoGam to the woman within 72 hours of delivery
C. administration of Rh-immune globulin to the newborn within 1 hour of delivery
D. lab analysis of maternal Direct Coombs?? test

Answer: A

Explanation:
If a woman is sensitized to the Rh factor, it poses a threat to any Rh-positive fetus she delivers. The nurse needs to provide emotional support to help the family deal with the infant??s condition, which might involve a host of conditions that could lead to death or marked neurological damage. RhoGam is never given to a woman already sensitized. If not previously sensitized, MICRhoGam (a smaller dose of Rh immune globulin) is given after an abortion or ectopic pregnancy to prevent sensitization. If not sensitized, RhoGam is given to the woman within 72 hours of delivery. Rh-immune globulin is never given to the newborn. To determine if sensitization has occurred, an Indirect Coombs?? is drawn on the mother to measure the number of Rh- positive antibodies.Health Promotion and Maintenance

NEW QUESTION 154
- (Topic 3)
Accurate documentation of assessment findings regarding pressure ulcers is very important because:

A. the law requires the nurse to document lesions.
B. the hospital requires the nurse to document lesions.
C. the physician requires the nurse to document lesions.
D. the nursing assessment of ulcers is a standard of nursing practice.

Answer: D

Explanation:
Documentation of assessments by the nurse promotes continuity of care and helps prevent further progression of the ulcer.Basic Care and Comfort

NEW QUESTION 156
- (Topic 3)
A contraindication for topical corticosteroid use in a client with atopic dermatitis (eczema) is:

A. parasite infection.
B. viral infection.
C. fungal infection.
D. spirochete infection.

Answer: B

NEW QUESTION 161
- (Topic 3)
Which type of hepatitis is transmitted via the fecal-oral route?

A. A
B. B
C. C
D. D

Answer: A

Explanation:
Type A hepatitis is transmitted via the fecal-oral route. The remaining types have other modes of transmission.
Physiological Adaptation

NEW QUESTION 165
- (Topic 3)
When assessing a client with amytrophic lateral sclerosis (ALS), the nurse should expect which of the following findings?

A. mental confusion
B. muscular weakness
C. sensory loss
D. emotional liability

Answer: B

Explanation:

Clients with ALS have progressive muscular weakness and wasting. However, the mind remains clear and sharp, and there is no sensory loss. There might be periods of grieving, but usually not emotional liability.Reduction of Risk Potential

NEW QUESTION 170
- (Topic 3)
What happens if folic acid is given to treat anemia without determining its underlying cause?

A. Erythropoiesis is inhibited.
B. Excessive levels of folic acid might accumulate, causing toxicity.
C. The symptoms of pernicious anemia might be masked, delaying treatment.
D. Intrinsic factor is destroyed.

Answer: C

Explanation:
Folic acid should not be used if pernicious anemia is suspected because it does not protect the client from
CNS changes common to this type of anemia. Folic acid is usually given with Vitamin B12. Both are part of the Vitamin B complex and are essential for cell growth and division. Folic acid is sometimes used as a rescue drug for cells exposed to some toxic chemotherapeutic agents. The nature of the anemia must be confirmed to ensure that the proper drug regimen is being used.Physiological Adaptation

NEW QUESTION 174
- (Topic 3)
Which of the following lab values is elevated first after a client has a myocardial infarction?

A. LDH
B. troponin
C. CPK
D. SGOT

Answer: B

Explanation:
The troponin level is the first to rise in a client who has had a myocardial infarction, followed by CPK, SGOT, and LDH.Reduction of Risk Potential

NEW QUESTION 177
- (Topic 3)
Which of the following NSAIDS is most commonly used for a brief time for acute pain?

A. Advil
B. Aleve
C. Toradol
D. Bextra

Answer: C

Explanation:
Toradol is an NSAID found to be very effective for brief periods of time for acute pain. It can be given IM,
IV, or PO.Basic Care and Comfort

NEW QUESTION 182
- (Topic 3)
Appropriate nursing strategies to assist a client in maintaining a sense of self include:

A. using the client??s first name when addressing the client.
B. treating the client with dignity.
C. explaining procedures only if the client is attentive.
D. discouraging the use of personal items.

Answer: B

Explanation:
All clients must be treated with dignity. Rather than a strategy, treating clients with dignity is a basic core
value universal to nursing.Psychosocial Integrity

NEW QUESTION 186
- (Topic 3)
Which of the following statements is true about syphilis?

A. The cause and mode of transmission is unclear.
B. There is no known cure for the disease.
C. When the primary lesion heals, the disease is cured.
D. Syphilis can be cured with a course of antibiotic therapy.

Answer: D

Explanation:
Syphilis is an acute and chronic treponemal disease characterized clinically by a primary lesion, a secondary eruption involving skin and mucous membranes, long

periods of latency, and late lesions of skin, bone viscera, the CNS, and the cardiovascular system. The primary lesion (chancre) appears about three weeks after exposure as an indurated, painless ulcer with serous exudate at the site of initial invasion. Invasion of the bloodstream precedes development of the initial lesion, and a firm, nonfluctuant, painless lymph node (bubo) commonly follows.
Infection might occur without a clinically evident chancre; that is, it might be in the rectum or on the cervix. After four–six weeks, even without specific treatment, the chancre begins to involute, and, in approximately one-third of untreated cases, a generalized secondary eruption appears, often accompanied by mild constitutional symptoms.
This symmetrical maculopapular rash involving the palms and soles, with associated lymphadenopathy is classic.
Secondary manifestations resolve spontaneously within weeks to 12 months. Again, about one-third of untreated cases of secondary syphilis become clinically latent for weeks to years. In the early years of latency, infectious lesions of the skin and mucous membranes might recur. Specific treatment includes long- acting penicillin G (benzathine penicillin), 2.4 million units given in a single IM dose on the day that primary, secondary or early latent syphilis is diagnosed. This ensures effective therapy, even if the client fails to return.
Serologic testing is important to ensure adequate therapy. Tests are repeated three and six months after treatment and later as needed.
In HIV-infected clients, testing should be repeated one, two, and three months after treatment, and at three-month intervals thereafter. Any fourfold titer rise indicates the need for retreatment.Physiological Adaptation

NEW QUESTION 189
- (Topic 3)
The nurse should teach a client in the Emergency Department, who has suffered an ankle sprain, to:

A. use cold applications to the sprain during the first 24–48 hours.
B. expect disability to decrease within the first 24 hours of injury.
C. expect pain to decrease within 3 hours after injury.
D. begin progressive passive and active range of motion exercises immediately.

Answer: A

Explanation:
Cold applications are believed to produce vasoconstriction and reduce development of edema. Disability and pain are anticipated to increase during the first 2–3 hours after injury. Progressive passive and active exercises may begin in 2–5 days, according to the physician??s recommendation. A sprain is a traumatic injury to the tendons, muscles, or ligaments around a joint, characterized by pain, swelling, and discoloration of the skin over the joint. The duration and severity of the symptoms vary with the extent of damage to the supporting tissues.
Treatment requires support, rest, and alternating cold and heat. X-ray pictures are often indicated to be certain that no fracture has occurred.Physiological Adaptation

NEW QUESTION 191
- (Topic 3)
A client with a nasogastric (NG) tube begins vomiting. What action should the nurse take?

A. Retape the NG tube.
B. Clamp the NG tube.
C. Remove the NG tube.
D. Check the NG tube placement.

Answer: D

Explanation:
For the client with an NG tube who begins vomiting, the nurse should check the tube placement because it might be displaced, thereby leading to vomiting. The other responses are not appropriate.
Reduction of Risk Potential

NEW QUESTION 192
- (Topic 3)
Hazards of improper splinting include:

A. aggravation of a bone or joint injury.
B. reduced distal circulation.
C. delay in transport of a client with a lifethreatening injury.
D. all of the above.

Answer: D

Explanation:
Hazards of improper splinting include aggravation of a bone or joint injury, reduced distal circulation, and delay in transport of a client with a life-threatening injury.Basic Care and Comfort

NEW QUESTION 196
- (Topic 3)
When caring for a client with a possible diagnosis of placenta previa, which of the following admission procedures should the nurse omit?

A. perineal shave
B. enema
C. urine specimen collection
D. blood specimen collection

Answer: B

Explanation:
An enema could dislodge the placenta and increase bleeding.Physiological Adaptation

NEW QUESTION 199
- (Topic 3)
When working with multicultural populations, the nurse should consider all of the following when planning care for a client with an altered sexuality pattern except:

A. some members of the Hispanic and Native- American cultures are very open when discussing sexuality.
B. some cultures view the postpartum period as a state of impurity.
C. some women in the African-American culture view childbearing as a validation of their femaleness.
D. some Native-American women believe monthly menstruation maintains physical well- being and harmony.

Answer: A

Explanation:
Many cultures (including the Hispanic and Native-American cultures) are sometimes hesitant to discuss sexuality. Some Navajos, Hispanics, and Orthodox Jews view the postpartum period as a state of impurity and might seclude women as long as they are bleeding. The seclusion is usually ended with a ritual bath. Many white teenage girls approve of the prevention of pregnancy, and many African-American teenage girls value pregnancy. Many Native-American women believe in the importance of monthly menstruation to maintain physical wellbeing and harmony.Health Promotion and Maintenance

NEW QUESTION 202
- (Topic 4)
The three universal spiritual needs include all of the following except:

A. meaning and purpose.
B. love and relatedness.
C. forgiveness.
D. God??s permission.

Answer: D

Explanation:
Religious teachings help to present a meaningful philosophy and system of practices within a system of social controls having specific values, norms, and ethics. God is the center of many religions (major), but not all.
Psychosocial Integrity

NEW QUESTION 203
- (Topic 4)
There are many types of torts that can be committed against clients. They include all of the following except:

A. assault.
B. battery.
C. negligence.
D. felony.

Answer: D

Explanation:
Felonies are serious crimes punishable by time in prison. Types of torts are assault, battery, and negligence in addition to slander, invasion of privacy, false imprisonment, and fraud.Coordinated Care

NEW QUESTION 204
- (Topic 4)
Levothyroxine (Synthroid) is the drug of choice for thyroid replacement therapy in clients with hypothyroidism because:

A. it is chemically stable, nonallergenic, and can be administered orally once a day.
B. it is available in a single 25mg tablet, which makes dosing simple.
C. it is not a prodrug.
D. it has a short half-life.

Answer: A

Explanation:
Levothyroxine is safe and effective with virtually no side effects when dosed properly. A single, daily dose is possible because of the long half-life (7 days). Levothyroxine tablets are available in a wide range of concentrations to meet individual client requirements. Levothyroxine (T4) is a prodrug of T3.Pharmacological Therapies

NEW QUESTION 206
- (Topic 4)
Who should receive the hepatitis A vaccine?

A. children who are 18 months of age
B. infants, who should receive the vaccination at birth
C. people who travel to other countries
D. individuals who might come into contact with blood

Answer: C

Explanation:
Hepatitis A is for individuals who travel or persons with chronic liver disease. Infants receive the hepatitis B vaccine at birth. DTaP is administered at 18 months of age. Individuals who come into contact with blood should be immunized against hepatitis B. Health Promotion and Maintenance

NEW QUESTION 209
- (Topic 4)
The nurse uses prioritization to determine all the following except:

A. time allotment for certain tasks.
B. appropriate interventions.
C. treatment procedures.
D. the need for client education.

Answer: C

Explanation:
Treatment procedures are standards of care as defined by the facility or nursing unit. If a treatment is indicated, the nurse is obligated to follow the established procedure to be compliant with practice standards. Established priorities contribute to the determination of time management, appropriate interventions, and the need for client education as a potential intervention.Coordinated Care

NEW QUESTION 213
- (Topic 4)
A client has just returned from surgery where a femoral-popliteal bypass was performed. The nurse has assessed the client and is unable to feel a pulse at either the dorsalis pedis or the posterior tibial sites of the left foot. The foot feels warm and the color is pink. What action should the nurse perform next to prevent ischemia?

A. Notify the physician immediately.
B. Obtain a Doppler device to check for pulses, and notify the physician if they are still absent.
C. Wait 30 minutes and recheck the pulses.
D. Document the finding.

Answer: B

Explanation:
The nurse should immediately obtain a Doppler device and recheck the pulses. The dorsalis pedis and posterior tibial can be difficult to assess and might need to be verified with a Doppler. Because the client just had a surgery in which a complication is arterial insufficiency, the client must be monitored carefully. If the pulses are not found, the nurse should recognize that this is an emergent situation, and the physician must be notified immediately. If the nurse waits 30 minutes before determining if the pulses can be felt, this could compromise the viability of the client??s foot due to ischemia. Documenting the findings is important but must be performed after the nurse locates the dorsalis pedis and posterior tibial pulses or any necessary interventions are made.Health Promotion and Maintenance

NEW QUESTION 216
- (Topic 4)
During a routine health screening, the nurse should talk to the parents of a 1-year-old child about which of the following?

A. the potential hazards of accidents
B. appropriate nutrition now that the child has been weaned from breast-feeding
C. toilet training
D. how to purchase appropriate shoes now that the child is walking

Answer: A

Explanation:
Accidents are the primary source of injury in children and can be life threatening. Appropriate nutrition should have been discussed during the weaning process and while the purchase of appropriate shoes is important, it is not life threatening. One year of age is too early to discuss toilet training.Health Promotion and Maintenance

NEW QUESTION 218
- (Topic 4)
Which of the following factors can impact an individual??s ability to give informed consent?

A. IQ
B. educational level
C. pain medications
D. financial status

Answer: C

Explanation:
Pain medications might alter alertness, thought processes, and reactions. It is recommended that a client be approached for consent at least 4 hours after the last dose of pain medicine to allow minimal impact. Choices 1, 2, and 4 are incorrect. IQ and educational levels might have a bearing on how information is presented through the discussion process, but they do not have a bearing on informed-consent decision-making. Coordinated Care

NEW QUESTION 221
- (Topic 4)
The nurse is teaching a client about sleep and gives background information on normal sleep patterns. Which of the following substances promotes sleep?

A. serotonin
B. cortisone
C. alcohol
D. narcotics

Answer:

A

Explanation:
Serotonin is a substance that is in the body and promotes sleep. Serotonin might play a role in synthesis of a hypnogenic factor that directly causes sleep. Drugs and alcohol can disrupt REM sleep, although they might accelerate the onset of sleep.Basic Care and Comfort

NEW QUESTION 223
- (Topic 4)
A nurse is teaching a group of clients with a diagnosis of Schizophrenia who are nearing discharge from a residential care facility. An essential topic to include is:

A. pathophysiology of the disease and expected symptoms.
B. how to recognize and manage symptoms of relapse.
C. the need to take extra medication when feeling stressed.
D. the importance of contact with follow-up care daily.

Answer: B

Explanation:
Clients are usually aware of the symptoms that indicate relapse is occurring. The client needs to know how to find a safe environment and to seek help. The first two stages of relapse are more difficult to recognize because they do not present symptoms that indicate psychosis. Initially, the client feels anxious and overwhelmed, and might become withdrawn. This is the crucial period to intervene. The client needs to go to a safe environment with someone who is trusted, avoid negative people, and decrease stimuli and stress.Psychosocial Integrity

NEW QUESTION 227
- (Topic 4)
As a type of quality indicator, an example of a structure standard is:

A. a written philosophy.
B. a procedure for a straight catheterization.
C. a protocol for treatment of a client with chest pain.
D. the diagnostic work-up for a client with abdominal pain.

Answer: A

Explanation:
Structure standards define all the conditions needed to operate, direct, and control a system. They do not address client care but rather describe structure with regard to purpose, such as philosophy, objectives, goals, hours of operation, and management responsibility.Coordinated Care

NEW QUESTION 231
- (Topic 4)
Which of the following symptoms is most characteristic of a client with cancer of the lungs?

A. exertional dyspnea
B. persistent changing cough
C. air hunger; dyspnea
D. cough with night sweats

Answer: B

Explanation:
The most common sign of cancer of the lung is a persistent cough that changes. Other signs are dyspnea, bloody sputum, and long-term pulmonary infection. Choice 1 is common with chronic obstructive pulmonary disease (COPD). Choice 3 is common with asthma. Choice 4 is common with tuberculosis.PhysiologicalAdaptation

NEW QUESTION 234
- (Topic 4)
The nurse can best communicate to a client that he or she has been listening by:

A. restating the main feeling or thought the client has expressed.
B. making a judgment about the client??s problem.
C. offering a leading question such as, ??And then what happened???
D. saying, ??I understand what you??re saying.??

Answer: A

Explanation:
Restating allows the client to validate the nurse??s understanding of what has been communicated. It??s an active listening technique. Regarding Choice 2, judgments should be suspended in a nurse-client relationship. Choice 3 is incorrect because leading questions ask for more information rather than showing understanding. Choice 4 communicates understanding, but the client has no way of measuring the understanding.
PsychosocialIntegrity

NEW QUESTION 239
- (Topic 4)
The primary organ for drug elimination is the:

A. skin.
B. lung(s).

C. kidney(s).
D. liver.

Answer: C

Explanation:
Most drugs are excreted in the urine, either as the parent compound or as drug metabolites. Relatively few drugs are excreted in sweat. Some volatile gases are excreted with expiration. The liver primarily metabolizes drugs. Some of them are excreted in bile, especially those with a molecular weight above 300.PharmacologicalTherapies

NEW QUESTION 242
- (Topic 4)
The nurse suspects an elderly client has been the victim of abuse. The client denies abuse and declines assistance. The nurse??s next action should be to:

A. do nothing; the client has the right to refuse treatment.
B. report the incident to the police.
C. arrange an appointment with the client??s next of kin.
D. educate the client about available services.

Answer: D

Explanation:
Although clients do have the right to refuse treatment, the nurse should remain nonjudgmental and inform the client of available services. Frequently elders are not aware of existing programs.Psychosocial Integrity

NEW QUESTION 245
- (Topic 4)
A stool culture reveals Shigella. What corollary should the nurse recognize regarding this bacterial infection?

A. People who have been in contact with the client need to be tested.
B. Shigella is an airborne infection.
C. Shigella is a bacteria sometimes found in stagnant water.
D. The nurse should wear a one-way breathing apparatus when giving client care.

Answer: C

Explanation:
Shigella is a bacteria sometimes found in stagnant water. Transmission of Shigella is typically oral-fecal, so good hand washing and the use of gloves are the best means of prevention when caring for a client with Shigella. The bacteria can be found in food and water contaminated by fecal material. Incidences of Shigella are reportable in many states. Safety and Infection Control

NEW QUESTION 250
- (Topic 4)
Which of the following clients require airborne precautions?

A. a client with fever, chills, vomiting, and diarrhea
B. a client suspected of varicella (chickenpox)
C. a client with abdominal pain and purpura
D. a client diagnosed with AIDS

Answer: B

Explanation:
Chickenpox (varicella) is an acute, infectious, airborne illness that requires others in direct contact to wear a respirator mask.Safety and Infection Control

NEW QUESTION 254
- (Topic 4)
What is the reason for a contract between nurse and client?

A. Contracts state the roles the participants take.
B. Contracts are indicative of the feeling tone established between participants.
C. Contracts are binding and prevent either party from ending the relationship prematurely.
D. Contracts spell out the participation and responsibilities of both parties.

Answer: D

Explanation:
A contract emphasizes that the nurse works with the client, rather than doing something for the client.Working withsuggests that each party is expected to participate and share responsibility for outcomes. Contracts do not,however, stipulate roles or feeling tone, nor is premature termination expressly forbidden.Psychosocial Integrity

NEW QUESTION 256
- (Topic 4)
The nurse acts as an advocate for the nursing profession by performing all of the following activities except:

A. encouraging political involvement by nurses with their legislators.

B. acting as a first-aid provider for a children??s athletic team.
C. precepting newly licensed nurses in the work situation.
D. encouraging as many persons to become nurses as possible.

Answer: D

Explanation:
The nurse acts as an advocate for the nursing profession by encouraging appropriate persons to become nurses, by being a positive role model and mentor, and by communicating the needs of nurses in the most professional manner possible, to those making the laws.Coordinated Care

NEW QUESTION 260
- (Topic 4)
The nurse is working with families who have been displaced by a fire in an apartment complex. What is the priority intervention during the initial assessment?

A. Provide a liaison to meet housing needs.
B. Attentively listen when clients describe their feelings.
C. Offer nurturing support for clients who are confused by the events.
D. Provide structure for clients exhibiting moderate to severe anxiety.

Answer: A

Explanation:
After physical needs of housing, clothing and food are met, the nurse should focus on assisting clients to manage the psychological effects of loss.Psychosocial Integrity

NEW QUESTION 263
- (Topic 4)
Nursing care for a client undergoing chemotherapy includes assessment for signs of bone marrow depression. Which finding accounts for some of the symptoms related to bone marrow depression?

A. erythrocytosis
B. leukocytosis
C. polycythemia
D. thrombocytopenia

Answer: D

Explanation:
Thrombocytopenia is an abnormal decrease in the number platelets, which results in bleeding tendencies. Erythrocytosis is an abnormal increase in the number of circulating red blood cells. Leukocytosis is an increase in the number of white blood cells in the blood. Polycythemia is also an excess of red blood cells and is a synonym for erythrocytosis. With chemotherapy there is a decrease in red and white blood cells, not an increase.
Physiological Adaptation

NEW QUESTION 265
- (Topic 4)
One day postoperative, the client complains of dyspnea, and his respiratory rate (RR) is 35, slightly labored, and there are no breath sounds in the lower-right base. The nurse should suspect:

A. cor pulmonale.
B. atelectasis.
C. pulmonary embolus.
D. cardiac tamponade.

Answer: B

Explanation:
The first three symptoms could be indicative of any of the conditions. The distinguishing symptom is the lack of breath sounds in the lower-right base, which is assessed when a portion of the lung has collapsed.Physiological Adaptation

NEW QUESTION 269
- (Topic 4)
The nurse??s first action upon discovery of an electrical fire should be which of the following?

A. Disconnect the electrical power if it can be performed safely.
B. Smother the source with an object such as a blanket.
C. Saturate the source with water or other readily available liquid.
D. Activate the fire alarm immediately.

Answer: A

Explanation:
If it is safe to do so, the nurse should disconnect electrical devices from the power source.
Smothering with a blanket is not indicated in an electrical fire and might serve to fuel the fire,just as water or other liquids might incite an explosion or flames. The fire alarm should be activated promptly, and this should be the next action after disconnecting the electrically powered equipment.Safety and Infection Control

NEW QUESTION 270
- (Topic 4)

A client??s central venous access device (CVAD) becomes infected. Why might the physician order antibiotics to be given through the line rather than through a peripheral IV line?

A. to prevent infiltration of the peripheral line
B. to reduce the pain and discomfort associated with antibiotic administration in a small vein
C. to lessen the chance of an allergic reaction to the antibiotic
D. to attempt to eliminate microorganisms in the catheter and prevent having to remove it

Answer: D

Explanation:
Microorganisms that infect CVADs are often coagulase-negative staphylococci, which can be eliminated by antibiotic administration through the catheter. If unsuccessful in eliminating the microorganism, the CVAD must be removed. CVAD use lessens the need for peripheral IV lines and thus the risk of infiltration. In this case, however, the antibiotics are given to eradicate microorganisms from the CVAD. CVAD use has the effect described in Choice 2, but in this case, the antibiotics are given through the CVAD to eliminate the infective agent. The route does not prevent an allergic reaction.Pharmacological Therapies

NEW QUESTION 273
- (Topic 4)
Hearing screening of prematurely born infants is an effective means of identifying disease and is an example of:

A. primary prevention.
B. secondary prevention.
C. tertiary prevention.
D. disability prevention.

Answer: B

Explanation:
The three levels of prevention address disease and disability across all phases, from absence of disease and at risk for disease, to preventing further impairment. Hearing impairment associatedwith prematurity cannot be prevented by screening, but identifying the infants with hearing loss might prevent sequelae and further impairment by allowing early intervention.Safety and Infection Control

NEW QUESTION 277
- (Topic 4)
A day care center has asked the nurse to provide education for parents regarding safety in the home. What type of preventive care does this represent?

A. primary
B. secondary
C. tertiary
D. health promotion

Answer: A

Explanation:
Primary prevention involves activities that are utilized to promote wellness or prevent illness or injury. There are many dangers in the home for small children. Providing education regarding the need for safety measures to prevent injury in the home is considered primary prevention. Secondary prevention involves early detection of a disease or illness and quick intervention to aid the client in maintenance of the disease or injury. Tertiary prevention involves the reduction of a disability and the promotion of the highest level of functioning for a client in relation to his or her disease or injury. Health promotion is any activity that increases a client??s health and wellness.Health Promotion and Maintenance

NEW QUESTION 281
- (Topic 5)
All of the following are clinical manifestations indicating male climacteric except:

A. hot flashes.
B. loss of reproductive ability.
C. headaches.
D. heart palpitations.

Answer: B

Explanation:
The likelihood of fathering children does decrease with aging and decreased testosterone production, but men do not lose their ability to reproduce during the climacteric. Many men do not experience any physical symptoms of climacteric but some men do report hot flashes, headaches, and heart palpitations, among other symptoms.Health Promotion and Maintenance

NEW QUESTION 283
- (Topic 5)
When teaching a woman about possible side effects of hormone replacement therapy, the nurse should include information about all of the following except:

A. Hypoglycemia in diabetic women.
B. The possible return of monthly menses when taking combination hormones.
C. Increased risk of gallbladder disease.
D. Increased risk of breast, cervical, and ovarian cancer with long-term use.

Answer: A

Explanation:

When taking estrogen, there is an increased risk of diabetes or hyperglycemia due to lowered glucose tolerance. It is true that monthly menses might return when taking combination hormones. The progestin is responsible for this. There is also a risk of gallbladder disease. It is also true that there is an increased risk of breast, cervical, and ovarian cancer with long-term hormone replacement therapy.Health Promotion and Maintenance

NEW QUESTION 288
- (Topic 5)
Which of the following statements by a client indicates adequate preparation for magnetic resonance imaging?

A. ??I can leave my metal jewelry on during the test.??
B. ??I need to wear earplugs during the test.??
C. ??I can have the test even though I have a pacemaker.??
D. ??I can have the test even though I have an artificial hip.??

Answer: B

Explanation:
Due to the loud noises from the scanner moving to obtain images, earplugs need to be worn. No metal objects are allowed, including jewelry, pacemakers, and artificial joints. Reduction of Risk Potential

NEW QUESTION 291
- (Topic 5)
When a middle-age woman says to the nurse, ??I??m really worried about menopause. When my mom went through it, she got really depressed.?? The nurse??s best response is:

A. ??It is a myth that women get depressed because of menopause.??
B. ??Menopause is a normal developmental process.??
C. ??It sounds like you are worried that you might become depressed during menopause.??
D. ??When women experience depression during menopause it is usually because of social stresses.??

Answer: C

Explanation:
Choice 3 not only acknowledges the client??s fear but invites more disclosure and discussion. Reflective listening is very therapeutic and in this case acknowledges the woman??s unspoken fear that she might become depressed like her mother. When her fears have been acknowledged and she feels that the nurse understands, she will be more open to the teaching or interventions to follow. It is a myth that menopause causes depression, but to say that to this client does not acknowledge the fear she shared with the nurse and gives the impression the nurse doesn??t care about her concern. It closes down communication. It is also true that menopause is a normal developmental process. This can certainly be used in teaching but not to address her immediate concern; the client might feel the nurse doesn??t think her concern is appropriate because menopause is normal. If women experience depression during menopause, it is usually due to social stresses such as loss of loved ones, loss of roles, caregiver demands, and physical problems. Choice 4 is true but is a nontherapeutic response in this situation.Health Promotion and Maintenance

NEW QUESTION 295
- (Topic 5)
The nurse can promote relief of muscle pain, spasms, and tension by:

A. having the client continue his activities as usual.
B. immobilizing the client.
C. applying heat, cold, pressure, or vibration to the painful area.
D. giving as much pain medication as needed to ease the muscle.

Answer: C

Explanation:
Superficial heat and cold, massage, pressure, or vibration can be applied to alleviate pain associated with muscle tension, pain, or spasms.Nonpharmacological Therapies

NEW QUESTION 299
- (Topic 5)
All of the following are causes of vaginal bleeding in late pregnancy except:

A. placenta previa.
B. eclampsia.
C. abruptio placentae.
D. uterine rupture.

Answer: B

Explanation:
Eclampsia is a disorder of pregnancy characterized by hypertension, proteinuria, and edema. This condition can cause seizure and/or coma. Choices 1 and 3 are abnormal conditions that can cause bleeding, particularly in the third trimester. Choice 4 is a major obstetrical emergency that can cause bleeding internally and externally.Safety and Infection Control

NEW QUESTION 304
- (Topic 5)
Which type of exercises might be prescribed to strengthen the pelvic floor muscles of a client with urinary incontinence?

A. Kegel
B. resistance

C. passive
D. stretching

Answer: A

Explanation:
Kegel exercises might be prescribed to strengthen the pelvic floor muscles of a client with urinary incontinence.Physiological Adaptation

NEW QUESTION 305
- (Topic 5)
A nurse is caring for a client with an elevated cortisol level. The nurse can expect the client to exhibit symptoms of:

A. urinary excess.
B. hyperpituitarism.
C. urinary deficit.
D. hyperthyroidism.

Answer: C

Explanation:
High levels of cortisol can produce sodium and fluid retention and potassium deficit, thus creating urinary deficit.Physiological Adaptation

NEW QUESTION 309
- (Topic 5)
Support systems during the grieving process include all of the following except:

A. a despondent friend.
B. a nurse.
C. a social worker.
D. a family member.

Answer: A

Explanation:
A despondent friend, even though this could be a support to the grieving person, is in a state of despondency. Therefore, he or she might not do well with a grieving friend. Psychosocial Integrity

NEW QUESTION 314
- (Topic 5)
When a client who is 25 years of age asks the nurse when she should seek fertility counseling, the best response by the nurse is:

A. ??Fertility counseling should be sought when you have been unable to conceive after 1 year of unprotected intercourse.??
B. ??Fertility couseling should be sought when you have not been able to conceive after 6–9 months of unprotected intercourse.??
C. ??The average time it takes someone your age to conceive is 512 months, so if you haven??t conceived by then, we can refer you.??
D. ??We can give you some guidance now on how to increase your chances of conceiving and then refer you if it doesn??t happen within a year.??

Answer: D

Explanation:
The guidelines for a fertility workup are to refer after the couple has not conceived after one year of unprotected intercourse. So, Choice 1 is technically correct, but it doesn??t consider the immediate need for the couple to have some counseling. Choice 4 is the best answer because it gives the couple guidance now and the referral at the appropriate time. If the woman is over the age of 35, an earlier referral, at six to nine months of unprotected intercourse, is appropriate. It is true that the average time it takes a 25-year-old woman to conceive is 5.3 months, but that does not address the concern the client is expressing. Choice 4 is still the most caring and correctanswer. Couples conceive within the first month of unprotected intercourse 20% of the time.Health Promotion and Maintenance

NEW QUESTION 317
- (Topic 5)
All of the following clients are in need of an emergency assessment except:

A. a bleeding client who has an injury from falling debris.
B. an unresponsive client.
C. a client with an old injury.
D. a pregnant woman with imminent delivery.

Answer: C

Explanation:
The client with an old injury does not need an emergency assessment because this is not a life-threatening or new situation or condition.Safety and Infection Control

NEW QUESTION 318
- (Topic 5)
Which of the following is not a function of parathyroid hormone?

A. moving calcium from bones to the bloodstream
B. promoting renal tubular reabsorption of phosphorus
C. promoting renal tubular reabsorption of calcium

D. enhancing renal production of vitamin D metabolites

Answer: B

Explanation:
Parathyroid hormone depresses renal tubular reabsorption of phosphorus. All of the other choices are functions of parathyroid hormone.Reduction of Risk Potential

NEW QUESTION 323
- (Topic 5)
A client who recently lost 50 pounds just received news that she is pregnant. A possible nursing diagnosis is:

A. Actual Chronic Low Self-Esteem (related to obesity).
B. Potential Chronic Low Self-Esteem (related to obesity).
C. Actual Situational Low Self-Esteem (related to fear of weight regain and pregnancy).
D. Potential Situational Low Self-Esteem (related to fear of weight regain and pregnancy).

Answer: D

Explanation:
If there are indications of a body image disturbance, the nursing care plan should include body disturbances, related to a functional or physical problem. The disturbance might be an anticipated one—that is, weight gain and pregnancy. Stressors can include a change in physical appearance, sexuality concerns, or an unrealistic ideal self.
Psychosocial Integrity

NEW QUESTION 327
- (Topic 5)
Client room environments should include:

A. a made bed, fresh water, thermostat regulation, and clean floors in all occupied client areas.
B. a made bed, comfort and safety, a clutter-free area, hygiene articles nearby.
C. accident prevention, comfort, a room (including furniture) that has been cleaned with chloroseptic wash, a bed that is made every other day.
D. odor control (by spraying the room with deodorizers), closet storage of all client objects, a clean roo
E. (Gloves should be worn when cleaning.)

Answer: B

Explanation:
Preparing a client??s room environment should include making the client??s bed, ensuring comfort and safety at all times, keeping the area free of clutter, and keeping the client??s hygiene articles nearby. All procedures should be explained before they are performed, and the client should assist with personal arrangement of articles.Basic Care and Comfort

NEW QUESTION 332
- (Topic 5)
During the work phase of the nurse-client relationship, the client says to her primary nurse, ??You think that I could walk if I wanted to, don??t you??? What is the best response by the nurse?

A. ??Yes, if you really wanted to, you could.??
B. ??Tell me why you??re concerned about what I think.??
C. ??Do you think you could walk if you wanted to???
D. ??I think you??re unable to walk now, whatever the cause.??

Answer: D

Explanation:
This response answers the question honestly and nonjudgmentally and helps to preserve the client??s selfesteem.
Choice 1 is an open and candid response but diminishes the client??s self-esteem. Choice 2 doesn??t answer the client??s question and is not helpful. Choice 3 increases the client??s anxiety because her inability to walk might be directly related to an unconscious psychological conflict that has not been resolved.Psychosocial Integrity

NEW QUESTION 335
- (Topic 5)
The nurse should utilize data about which of the following to provide information about the nutritional status of a client being evaluated for malnutrition?

A. triceps skinfold measurement
B. fasting blood glucose level
C. hemoglobin A1c level
D. serum lipid profile results

Answer: A

Explanation:
Objective anthropometric measurements such as triceps skinfold and mid-arm circumference (MAC), along with weight, are usually used to diagnose malnutrition. While all the other choicesrepresent tests that might provide useful information, they also might be affected by variables other than malnutrition.Physiological Adaptation

NEW QUESTION 338

- (Topic 5)
Pain tolerance in an elderly client with cancer should:

A. Stay the same.
B. Decrease.
C. Increase.
D. Cancer should have no effect on pain tolerance for an elderly client.

Answer: B

Explanation:
There is potential for a lowered pain tolerance to exist with diminished adaptative capacity.
Basic Care and Comfort

NEW QUESTION 341
- (Topic 5)
A spinal change occurring with pregnancy that alters mobility is:

A. scoliosis.
B. kyphosis.
C. lordosis.
D. ankylosing spondylitis.

Answer: C

Explanation:
The spinal change occurring with pregnancy is lordosis. This occurs due to the weight of the enlarging uterus and the affect of gravity.Basic Care and Comfort

NEW QUESTION 344
- (Topic 5)
A client with urinary tract calculi needs to avoid which of the following foods?

A. lettuce
B. cheese
C. apples
D. broccoli

Answer: B

Explanation:
The client with urinary tract calculi needs to avoid cheese, which has high calcium content.
The other foods do not.Physiological Adaptation

NEW QUESTION 347
- (Topic 5)
A client expresses anxiety about having magnetic resonance imaging performed. Which of the following is an appropriate response by the nurse?

A. ??You can receive a sedative to help you relax during the test.??
B. ??There is absolutely nothing to worry about.??
C. ??There is no discomfort with this test, so don??t be anxious.??
D. ??The test won??t last long, so you can handle it.??

Answer: A

Explanation:
This statement reassures the client that there is a solution for relief of his anxiety. The other responses minimize the client??s feelings.Reduction of Risk Potential

NEW QUESTION 348
- (Topic 5)
An 80-year-old aphasic CVA client had abdominal surgery 2 days ago. Which of the following puts this client at the highest risk for inadequate pain management?

A. inability to turn, cough, and breathe deeply
B. inability to communicate pain
C. inability to ambulate freely
D. inability to use a bedside commode

Answer: B

Explanation:
The client cannot speak to alert the nurse to his pain state. The nurse needs to provide alternate methods of communication with the client.Basic Care and Comfort

NEW QUESTION 349
- (Topic 6)
The Token Economy is a type of therapy that focuses on:

A. play therapy.
B. behavior modification.

C. milieu therapy.
D. associative.

Answer: B

Explanation:
Behavior modification gives positive feedback and rewards for appropriate behavior. Behavior modification requires negative behavior if it??s not destructive or life threatening. Psychosocial Integrity

NEW QUESTION 354
- (Topic 6)
A nurse is assessing a patient in the rehab unit at shift change. The patient has suffered a TBI 3 weeks ago. Which of the following is the most distinguishing characteristic of a neurological disturbance?

A. LOC (level of consciousness)
B. Short term memory
C. + Babinski sign
D. + Clonus sign

Answer: A

Explanation:
LOC is the most critical indicator of impaired neurological capabilities.

NEW QUESTION 358
- (Topic 6)
A mother that has never breast-feed a child before is having trouble getting the baby to latch on to the breast. The baby has lost 3% of its?? birth weight within the first 2 days of life. The best statement is:

A. The baby will eventually take to the breast.
B. I can fix up a bottle if you want to try that.
C. A small amount of weight loss in the first few days is normal.
D. I can get the charge nurse to come and talk to you about breast-feeding.

Answer: C

Explanation:
5-10% of birth weight loss following birth is normal for the first few days of life.

NEW QUESTION 362
- (Topic 6)
If your patient is acutely psychotic, which of the following independent nursing interventions would not be appropriate?

A. Conveying calmness with one on one interaction
B. Recognizing and dealing with your own feelings to prevent escalation of thepatient??s anxiety level
C. Encourage client participation in group therapy
D. Listen and identify causes of their behavior

Answer: C

Explanation:
Acutely psychotic patients will disrupt group activities.

NEW QUESTION 363
- (Topic 6)
Which direction given to the nursing assistant is most likely to accomplish the task of getting a urine specimen delivered to the lab immediately after collection?

A. ??Make it a stat delivery.??
B. ??Please do it as soon as you can after break.??
C. ??This client is delirious, and we??re worried about a urinary sepsis.??
D. ??Take this client to the bathroom now and collect a urine specimen from this voidin
E. Take the specimen to the lab immediately.??

Answer: D

Explanation:
Effective delegation depends on clear, concise direction that leaves no room for question or interpretation on the part of the one being delegated to. Nursing assistants have a limited understanding of medical conditions and terminology, and should not be relied on to prioritize such tasks.Coordinated Care

NEW QUESTION 368
- (Topic 6)
The nurse assesses a client for physiological risk factors for falls. The nurse should conclude that the client is not at risk if which of the following is discovered?

A. history of dizziness
B. need for wheelchair due to reduced mobility
C. weakness and fatigue noted when climbing stairs
D. intact recent and remote memory

Answer: D

Explanation:
Intact recent and remote memory indicates that a client is not at risk for falls. Risk for falls can occur in elder clients, and the nurse should assess each client for the possibility of falls and take appropriate actions.Safety andInfection Control

NEW QUESTION 370
- (Topic 6)
An nurse is instructing a patient on the order of sensations with the application of an ice water bath for a swollen right ankle. Which of the following is the correct order of sensations experienced with an ice water bath?

A. cold, burning, aching, and numbness
B. burning, aching, cold, and numbness
C. aching, cold, burning and numbness
D. cold, aching, burning and numbness

Answer: A

Explanation:
CBAN, cold, burn, ache, numbness

NEW QUESTION 373
- (Topic 6)
A nurse is assessing a 18 year-old female who has recently suffered a TBI. The nurse notes a slower pulse and impaired respiration. The nurse should report these findings immediately to the physician, due to the possibility the patient is experiencing which of the following conditions?

A. Increased intracranial pressure
B. Increased function of cranial nerve X
C. Sympathetic response to activity
D. Meningitis

Answer: A

Explanation:
The patient is at high risk of developing increased intracranial pressure (ICP).

NEW QUESTION 377
- (Topic 6)
A client was involved in a motor vehicle accident in which the seat belt was not worn. The client is exhibiting crepitus, decreased breath sounds on the left, complains of shortness of breath, and has a respiratory rate of 34/min. Which of the following assessment findings should concern the nurse the most?

A. temperature of 102?? F and a productive cough
B. arterial blood gases (ABGs) with a PaO2 of 92 and PaCO2 of 40 mmHg
C. trachea deviating to the right
D. barrel-chested appearance

Answer: C

Explanation:
A mediastinal shift is indicative of a tension pneumothorax along with theother symptoms in the question.Because the individual was involved in an MVA, assessment is targeted at acute traumatic injuries to the lungs, heart, or chest wall rather than other conditions indicated in the other choices. Choice 1 is common with pneumonia. Values in Choice 2 are not alarming. Choice 4 is typical of someone with chronic obstructive pulmonary disease (COPD). A tensionpneumothorax is a dangerous complication and a medical emergency where entering air cannot escape by the same route and pressure within the pleural cavity increases, resulting in complete collapse of the lung. A mediastinal shift to the unaffected side and a downward displacement of the diaphragm can be observed. Physiological Adaptation

NEW QUESTION 382
- (Topic 6)
A nurse at outpatient clinic is returning phone calls that have been made to the clinic. Which of the following calls should have the highest priority for medical intervention?

A. A home health patient reports, ??I am starting to have breakdown of my heels.??
B. A patient that received an upper extremity cast yesterday reports, ??I can??t feel my fingers in my right hand today.??
C. A young female reports, ??I think I sprained my ankle about 2 weeks ago.??
D. A middle-aged patient reports, ??My knee is still hurting from the TKR.??

Answer: B

Explanation:
The patient experiencing neurovascular changes should have the highest priority. Pain following a TKR is normal, and breakdown over the heels is a gradual process. Moreover, a subacute ankle sprain is almost never a medical emergency.

NEW QUESTION 383
- (Topic 6)
The home health nurse has made a visit to an 85-year-old female client??s home who has recently had surgery to replace her left knee. The client has been discharged from a rehab facility and has been able to walk on her own. The nurse assesses the need for teaching related to fall prevention. What should the nurse include in this teaching plan?

A. The client should remove all scatter rugs from the floor and minimize clutter.
B. The client should not get up and move around the house.
C. The client does not need to install a raised toilet and grab bar because she is able to walk on her own.
D. The client should wear a robe and socks while walking in the house.

Answer: A

Explanation:
Rugs and clutter are a primary cause of falls in the home and should be eliminated if possible to decrease the risk of a fall. The elderly and those with gait issues are at an increased risk for a fall at home. The client should have a raised toilet seat and grab bars available in the bathroom to aid in movement in this potential slippery area of the home. Some clients find it difficult to rise up and down from the toilet and to get in and out of the shower. These items are all important in maintaining safety in the home. The client should not limit her movement within the home unless ordered by the physician. This decreases the ability of the client to perform activities of daily living and hinders the client??s return to a normal lifestyle after surgery. The client should notwear baggy clothing such as long robes, and the client should not wear socks on slippery floors. These items can cause the client to trip, slip, or fall.Health Promotion and Maintenance

NEW QUESTION 388
- (Topic 6)
The nurse is teaching a client about communicable diseases and explains that a portal of entry is:

A. a vector.
B. a source, like contaminated water.
C. food.
D. the respiratory system.

Answer: D

Explanation:
The path by which a microorganism enters the body is the portal of entry. A vector is a carrier of disease, a source (like bad water or food) can be a reservoir of disease.Safety and Infection Control

NEW QUESTION 392
- (Topic 6)
While repositioning a comatose client, the nurse senses a tingling sensation as she lowers the bed. What action should she take?

A. Unplug the bed??s power source.
B. Remove the client from the bed immediately.
C. Notify the biomedical department at once.
D. Turn off the oxygen.

Answer: A

Explanation:
Shutting off the bed??s electricity should be the initial step. The nurse should not touch the client until the bed is checked for faulty grounding. An electrician should assess the equipment. Oxygen should be discontinued until the equipment is cleared.Safety and Infection Control

NEW QUESTION 394
- (Topic 6)
A client who has a known history of cardiac problems and is still smoking enters the clinic complaining of sudden onset of sharp, stabbing pain that intensifies with a deep breath. The pain is occurring on only one side and can be isolated upon general assessment. The nurse concludes that this description is most likely caused by:

A. pleurisy.
B. pleural effusion.
C. atelectasis.
D. tuberculosis.

Answer: A

Explanation:
Pleurisy is an inflammation of the pleura and is often accompanied by abrupt onset of pain. Symptoms of pleurisy are abrupt pain that is usually unilateral and localized to a specific portion of the chest. The pain is sharp, stabbing, and might radiate to the neck or shoulder. Pressure changes caused by breathing, movement, or coughing intensify the pain. Other symptoms might include fever, cough (dry, hacking), localized tenderness, diminished breath sounds, tachypnea, and pleural friction rub.Physiological Adaptation

NEW QUESTION 399
- (Topic 6)
If a client is suffering from thyroid storm, the PN can expect to find on assessment:

A. tachycardia and hyperthermia.
B. bradycardia and hypothermia.
C. a large goiter.
D. a calm, quiet client.

Answer: A

Explanation:
In thyroid storm, there is too much thyroxine, causing the client to go faster. Atrial fibrillation and palpitations are also frequently seen. Choices 2, 3, and 4 are associated withhypo thyroidism.Physiological Adaptation

NEW QUESTION 401
- (Topic 6)
After the client discusses her relationship with her father, the nurse says, ??Tell me whether I am understanding your relationship with your father. You feel dominated and controlled by him??? This is an example of:

A. verbalizing the implied.
B. seeking consensual validation.
C. encouraging evaluation.
D. suggesting collaboration.

Answer: B

Explanation:
Consensual validation is a technique used to check one??s understanding of what the client has said. Consensual validation is the process by which people come to agreement about the meaning and significance of specific symbols. Through this experience, individuals develop the ability to relate effectively.Psychosocial Integrity

NEW QUESTION 403
- (Topic 6)
Which intervention should the nurse take first to assist a woman who states that she feels incompetent as the mother of a teenage daughter?

A. Recommend that she discipline her daughter more strictly and consistently.
B. Make a list of things her husband can do to help her improve.
C. Assist the mother to identify what she believes is preventing her success and what she can do to improve.
D. Explore with the mother what the daughter can do to improve her behavior.

Answer: C

Explanation:
The intervention priority with a mother who feels incompetent to parent a teenage daughter is to assist the mother to identify what she feels her crisis events are and to help her develop better coping skills and improve her mothering skills. With a teenager, the growth and development parameters have to be concentrated on self as well as acquiring an added event. Choices 1, 2, and 4 do not directly address the mother??s feelings of inadequacy.Psychosocial Integrity

NEW QUESTION 407
- (Topic 6)
A nurse is teaching a client about self-administration of Haldol 15 mg po hs. For which side effect/s must the client seek medical attention?

A. SOB and fatigue
B. restlessness and muscle spasms
C. dry mouth
D. diarrhea

Answer: B

Explanation:
Muscle spasms and restlessness are side effects of Haldol

NEW QUESTION 409
- (Topic 6)
Appropriate care for a client with neutropenia includes:

A. plenty of fresh fruits and vegetables.
B. a semi-private room.
C. wearing a mask when out of the room.
D. routine hand washing.

Answer: C

Explanation:
When a client is neutropenic (one type of white blood cell), they lack the ability to fight off infection. The mask is to prevent exposure to any upper-respiratory infections. Fresh fruits, vegetables, and flowers can contain pathogens that might infect the neutropenic client. All foods must be thoroughly cooked and plants/flowers are not allowed. A neutropenic client needs a private room and carefully screened visitors—no one is to enter the room withany symptoms of an illness (runny nose, sneezing, nausea, and so on). Meticulous, frequent hand washing is called for.Physiological Adaptation

NEW QUESTION 411
- (Topic 6)
A client admitted to the medical nursing unit has classic symptoms of tuberculosis (TB) and tests positive on the purified protein derivative (PPD) skin test. Several months later, the nurse who cared for the client also tests positive on an annual TB skin test for work. The most likely course of treatment if the chest X-ray (CXR) is negative is to:

A. repeat a TB skin test in six months.
B. treat the nurse with an anti-infective agent for six months.
C. monitor for signs and symptoms within the next year.
D. follow up in one year at the next annual physical with CXR only.

Answer: B

Explanation:
Exposure with a positive TB skin test usually requires six months of prophylactic treatment unless contraindicated. The TB skin test should not be repeated; the results will always be positive. A CXR is usually not required annually in the event that the skin test was positive. TB is a type of pneumonia caused by the acid-fast bacillus, mycobacterium tuberculosis, and is contracted by airborne droplets that enter the lungs and multiply in the pulmonary alveoli. Nursing Assessment: (1) Assessment includes symptom analysis of type and progression of symptoms; color, consistency, and amount of sputum; knowledge of the disease; weight pattern; vital signs; description of any pain; palpable lymph nodes; breath sounds; and activity tolerance. (2) Diagnostic tests:a) CXR (shows dense lesions in the upper lobes, enlarged lymph nodes, and formation of large cavities); b) CBC (presence of leukocytosis); c) Fiberoptic bronchoscopy and bronchial washing (for obtaining culture specimens); d) Tuberculin skin test (positive at 5 to 9 mm for clients with abnormal CXR or HIV; positive at 10 to 15 mm for clients with high-risk factors such as intravenous [IV] drug use; residence in a long-term facility, high-incidence country; positive at 15 mm for all other people); e) Three early-morning sputum collections for acid-fast staining, culture and sensitivity positive for M. tuberculosis. Results can take up to 10 days.Physiological Adaptation

NEW QUESTION 413
- (Topic 6)
A nurse teaching a patient with COPD pulmonary exercises should do which of the following?

A. Teach pursed-lip breathing techniques.
B. Encourage repetitive heavy lifting exercises that will increase strength.
C. Limit exercises based on respiratory acidosis.
D. Take breaks every 10-20 minutes with exercises.

Answer: A

Explanation:
Purse lip breathing will help decrease the volume of air expelled by increased bronchial airways.

NEW QUESTION 418
- (Topic 6)
A client receives a cervical intracavity radium implant as part of her therapy. A common side effect of a cervical implant is:

A. creamy, pink-tinged vaginal drainage.
B. stomatitis.
C. constipation.
D. xerostomia.

Answer: A

Explanation:
Creamy, pink-tinged vaginal drainage persists for 1 to 2 months after removal of a cervical implant. Diarrhea, not constipation, is usually a side effect of cervical implants. Stomatitis and xerostomia are local side effects of radiation to the mouth.Physiological Adaptation

NEW QUESTION 420
- (Topic 6)
The physician wants to know if a client is tolerating his total parenteral nutrition. Which of the following laboratory tests is likely to be ordered?

A. triglyceride level
B. liver function tests
C. a glucose tolerance test
D. a complete blood count

Answer: B

Explanation:
The liver is the primary organ for digestion. Liver function tests measure the blood level of enzymes produced by the liver: prothrombin time/partial prothrombin time, serum glutamic oxaloacetic and pyruvic transaminases, gamma glutamyl transpeptidase, albumin, and alkalinephosphatase. Choice 1 measures the body??s ability to clear triglycerides, the primary component of fats. Failure to clear triglycerides from the bloodstream indicates a problem with storage or the ingestion of too much fat. Choice 3 measures the blood glucose at intervals after a glucose-rich solution is ingested; it is used for diagnosing diabetes. Choice 4 is used to evaluate blood components.Pharmacological Therapies

NEW QUESTION 421
- (Topic 6)
The nurse is developing a care plan for a client with severe anxiety. An appropriate outcome for the client is that within 4 days the client should:

A. Have decreased anxiety.
B. Talk to the nurse for 10 minutes.
C. Sit quietly for 30 minutes.
D. Develop an adaptive coping mechanism.

Answer: B

Explanation:
Outcome criteria need to be specific, measurable, and realistic. Talking for 10 minutes meets all of these
conditions. It is not realistic to expect a severely anxious client to sit quietly for 30 minutes.
The other statements are vague and not measurable.Psychosocial Integrity

NEW QUESTION 424
- (Topic 6)
While admitting a client to an acute-care psychiatric unit, the nurse asks about substance abuse based on knowledge that:

A. psychiatric illness is more prevalent in addicted populations.
B. people with psychiatric disorders are more prone to substance abuse.
C. substance disorders are easily detected and diagnosed in acute-care psychiatric settings.
D. undetected substance problems have no real effect on treatment of psychiatric disorders.

Answer: B

Explanation:
The failure to address substance abuse among clients with psychiatric disorders interferes with treatment effectiveness and contributes to relapse. Misdiagnosis of a psychiatric disorder, suboptimal pharmacological treatment, neglect of appropriate interventions, or an inappropriate referral might also occur.PsychosocialIntegrity

NEW QUESTION 426
- (Topic 6)
A client has experienced a CVA with right hemiparesis and is ready for discharge from the hospital to a long-term care facility for rehab. To provide optimal continuity of care, the nurse should do all of the following except:

A. document current functional status.
B. have the physician phone a report to the receiving facility.
C. copy appropriate parts of the medical record for transport to the receiving facility.
D. phone a report to the facility.

Answer: B

Explanation:
It is the nurse??s responsibility to communicate the client??s condition and care plan to the receiving facility to support continuity of care. Documentation of the client??s baseline functional status is important for the receiving facility to work with in further goal setting. A copy of select portions of the medical record (according to facility policy) is another form of communication and supports continuity. A physician might be asked to be involved if there are specific medical needs or orders that she believe are important, but is generally not involved.Coordinated Care

NEW QUESTION 430
- (Topic 6)
Which of the following is one of the main goals for Healthy People 2010?

A. reduction of health care costs
B. elimination of health disparities
C. investigation of substance abuse
D. determination of an acceptable morbidity rate

Answer: B

Explanation:
Healthy People 2010has as its main goal elimination of health disparities among the U.S. population.Healthy People 2010is a set of health objectives for the nation to achieve over the first decade of the twenty-first centuryand was developed by the Surgeon General??s office. Earlier editions of this report,Healthy PeopleandHealthy People 2000: National Health Promotion and Disease Prevention Objectivesestablished national health objectivesand served as the basis for the development of state and community plans. Health Promotion and Maintenance

NEW QUESTION 431
- (Topic 6)
A nursing advocate is one who:

A. makes decisions for others.
B. encourages persons to make decisions for themselves and acts with or on behalf of the person to support those decisions.
C. manages the care of others.
D. is the legal representative for a person.

Answer: B

Explanation:
Nurse advocates work with clients to provide information and assistance is decision- making. The decisions and care that occur from these decisions are based on the right of the client to self-determination and the work of the nurse advocate supports this right. Coordinated Care

NEW QUESTION 432
- (Topic 6)
A client reports that someone is in the room and trying to kill him. The nurse??s best response is:

A. ??No one is in your roo
B. Let??s get you more medicine.??
C. ??I do not see anyone, but you seem to be very frightened.??
D. ??No one can hurt you here.??
E. ??Just tell the person to go away.??

Answer: B

Explanation:
It is important to acknowledges the client??s fear. The other responses deny the client??s perceptions.
Psychosocial Integrity

NEW QUESTION 436
- (Topic 6)
A nurse doing a home health visit consults with a male patient that has a diagnosis of CAD and COPD. The patient is currently taking Ventolin, Azmacort, Aspirin, and Theophylline. The patient complains of upset stomach, nausea and feeling uncomfortable. The nurse should:

A. Contact the patient??s physician immediately
B. Recommend the patient position himself in right sidelying.
C. Recommend the patient schedule a doctor??s visit the next day.
D. Recommend a hold on the drug-Azmacort

Answer: A

Explanation:
Consult the physician immediately, due to the fact that theophylline toxicity may be occurring.

NEW QUESTION 441
- (Topic 6)
The nurse supporting a family who has just experienced a sudden and unexpected death needs to know:

A. that survivors have greater emotional turmoil and shock than when death is expected.
B. that survivors have less emotional turmoil and shock than when death is expected.
C. that survivors have the same emotional turmoil and shock as when death is expected.
D. that survivors have little emotional turmoil and shock because they were not there.

Answer: A

Explanation:
Sudden death produces greater emotional turmoil and shock in survivors thandoes a gradual, expected death.Survivors do not have time to engage in anticipatory grief. The most disturbing and unbalancing feature of sudden death is its unexpectedness. Psychosocial Integrity

NEW QUESTION 443
- (Topic 6)
A client needs to rapidly achieve a therapeutic plasma drug concentration of a medication. Rather than wait for steady state to be achieved, the physician might order:

A. a maintenance dose.
B. a loading dose.
C. a medication with no first-pass effect.
D. the medication to be given intravenously.

Answer: B

Explanation:
A loading or priming dose rapidly establishes a therapeutic plasma drug level. It can be calculated by multiplying the volume of distribution by the desired plasma drug concentration. A maintenance dose maintains a therapeutic level after the loading dose. It takes five drug half-lives to achieve steady state if no loading dose is given. Choice 3 is similar to a maintenance dose. Intravenous administration provides excellent drug bioavailability, but one dose will not achieve a therapeutic plasma level.Pharmacological Therapies

NEW QUESTION 444
- (Topic 6)
A client receiving preoperative instructions asks questions repeatedly about when to stop eating the night before the procedure. The nurse tries torefocus the client. The nurse notes that the client is frequently startled by noises in the hall. Assessment reveals rapid speech, trembling hands, tachypnea, tachycardia, and elevated blood pressure. The client admits to feeling nervous and having trouble sleeping. Based on the assessment, the nurse documents that the client has:

A. mild anxiety.
B. moderate anxiety.
C. severe anxiety.
D. a panic attack.

Answer: C

Explanation:
In severe anxiety, a client focuses on small or scattered details. The person is unable to solve problems. With mild anxiety, stimuli are readily perceived and processed, and the ability to learn and solve problems is enhanced. Moderate anxiety narrows the perceptual field, but the client notices things brought to his attention. During a panic attack, the person is disorganized and might be hyperactive or unable to speak or act.Psychosocial Integrity

NEW QUESTION 449
- (Topic 6)
Issues addressed in ethics committees include all of the following except:

A. nonpayment of bills.
B. euthanasia.
C. starting or stopping treatment.
D. use of feeding tubes.

Answer: A

Explanation:

Ethics committees do not deal with financial matters of payment. Euthanasia, starting or stopping treatment, and use of feeding tubes to maintain nutritional status are topics within the ethical scope of the committee??s function.Coordinated Care

NEW QUESTION 453
- (Topic 6)
Which of the following medications is not considered a neuromuscular blocker?

A. Anectine
B. Pavulon
C. Pitressin
D. Mivacron

Answer: C

Explanation:
Pitressin is a hormone replacement medication.

NEW QUESTION 456
- (Topic 6)
A client diagnosed with Borderline Personality Disorder frequently attempts to burn herself. The best intervention to facilitate behavior change is:

A. constantly observing the client to prevent self-harm.
B. enlisting the client in defining and describing harmful behaviors.
C. checking on the client every 15 minutes to ensure she is not engaging in harmful behavior.
D. removing all items from the environment that the client could use to harm herself.

Answer: B

Explanation:
The challenge when intervening with clients who might harm themselves is to maintain client safety while facilitating behavior change. Enlisting the client to identify the triggers for self-harm makes the client an active participant in treatment. Nurses are less judgmental when they understand the source of the behavior and can be sensitive to client feelings. Psychosocial Integrity

NEW QUESTION 460
- (Topic 6)
A mother has just given birth to a baby who died soon after. The mother has been crying and states, ??I can??t believe this has happened to me. I did everything right during this pregnancy.?? How should the nurse respond to this mother?

A. Tell her she did nothing wrong; it was God??s will.
B. Tell her she can have another baby.
C. Tell her that her behavior is not going to solve anything.
D. Tell her nothing and let her mourn this loss in the manner she chooses.

Answer: D

Explanation:
Perinatal loss is a great tragedy for the parents. A bereaved mother must resolve the crisis of perinatal loss in addition to the crisis of pregnancy. Such a loss is described as losing part of one??s self—loss of self-worth. The perinatal grief response must involve attachment and detachment as a part of the mourning process.Psychosocial Integrity

NEW QUESTION 463
- (Topic 6)
A nurse is returning phone calls in a pediatric clinic. Which of the following reports most requires the nurse??s immediate attention and phone call?

A. A 8 year-old boy has been vomiting and appears to have slower movements and has a history of an atrio-ventricular shunt placement.
B. A 10 year-old girl feels a dull pain in her abdomen after doing sit-ups in gym class.
C. A 7 year-old boy has been having a low fever and headache for the past 3 days that has history of an anterior knee wound.
D. A 7 year-old girl that had a cast on her right ankle is complaining of itching.

Answer: A

Explanation:
The shunt may be blocked and require immediate medical attention.

NEW QUESTION 467
- (Topic 6)
A fifty-five year-old man suffered a left frontal lobe CVA. The patient??s family is not present in the room. Which of the following should the nurse watch most closely for?

A. Changes in emotion and behavior
B. Monitor loss of hearing
C. Observe appetite and vision deficits
D. Changes in facial muscle control

Answer: A

Explanation:

The frontal lobe is responsible for behavior and emotions.

NEW QUESTION 472
- (Topic 6)
The factor that most determines drug distribution is:

A. vascular perfusion of the tissue or organ.
B. salt form.
C. drug interactions.
D. steady state.

Answer: A

Explanation:
Drugs are distributed via the circulatory system. Adequate perfusion is necessary for distribution of a drug.Choices 2, 3, and 4 are not as dependent on adequate perfusion. Pharmacological Therapies

NEW QUESTION 475
- (Topic 6)
A patient has recently been prescribed Lidocaine Hydrochloride. Which of the following symptoms may occur with over dosage?

A. Memory loss and lack of appetite
B. Confusion and fatigue
C. Heightened reflexes
D. Tinnitus and spasticity

Answer: B

Explanation:
Lidocaine Hydrochloride can cause fatigue and confusion if an over dosage occurs.

NEW QUESTION 476
- (Topic 6)
A patient is scheduled for electro-convulsive therapy treatment scheduled in the morning. What must the evening nurse do to provide the client ECT treatment possible?

A. Patient signs an informed consent form
B. Patient is given morning medications
C. Patient gets a good night??s sleep
D. Patient has a good breakfast

Answer: A

Explanation:
An informed consent is required prior to surgery.

NEW QUESTION 481
- (Topic 6)
If a client has chronic renal failure, which of the following sexual complications is the client at risk of developing?

A. retrograde ejaculation
B. decreased plasma testosterone
C. hypertrophy of testicles
D. state of euphoria

Answer: B

Explanation:
Untreated chronic renal failure causes decreased testosterone levels, atrophy of testicles, and decreased spermatogenesis. Retrograde ejaculation is not a complication of chronic renal failure. It is a complication of transurethral resection of the prostate. In chronic renal failure, the testicles atrophy; they do not hypertrophy. Chronic renal failure produces a state of depression, not euphoria.Health Promotion and Maintenance

NEW QUESTION 483
- (Topic 6)
A client with a spinal cord injury is preparing to return home from the rehabilitation unit. Which of the following statements by a family member indicates a need for further teaching regarding autonomic dysreflexia?

A. ??I should raise him to a sitting position.??
B. ??I should check for a fecal impaction.??
C. ??I should look for a kink in the urinary catheter tubing.??
D. ??I should see whether symptoms worsen.??

Answer: D

Explanation:
If the client develops signs or symptoms of autonomic dysreflexia, they need to be addressed immediately. If the family member is not able to relieve them, a health care provider needs to be notified immediately. The remaining choices are correct; they are all ways to relieve autonomic dysreflexia.Reduction of Risk

Potential

NEW QUESTION 485
- (Topic 6)
The acts enacted by states to provide immunity from liability to persons who provide emergency care at an accident scene are called:

A. Good Samaritan laws.
B. HIPAA.
C. Patient Self-Determination Act (PSDA).
D. OBRA.

Answer: A

Explanation:
The Good Samaritan laws protect providers of care in an emergency situation. HIPAA??s focus is confidentiality of information and right to privacy. The PSDA concerns a client??s autonomous decision-making. OBRA was passed in the late 1980s to promote nursing home reform due to quality issues.Coordinated Care

NEW QUESTION 486
- (Topic 6)
A nurse is caring for a patient who has recently been diagnosed with fibromyalgia and COPD. Which of the following tasks should the nurse delegate to a nursing assistant?

A. Transferring the patient to the shower.
B. Ambulating the patient for the first time.
C. Taking the patient??s breath sounds
D. Educating the patient on monitoring fatigue

Answer: A

Explanation:
Nursing assistants should be competent on all transfers.

NEW QUESTION 487
- (Topic 6)
The nurse working with elderly clients should keep in mind that falls are most likely to happen to elderly who are:

A. in their 80s.
B. living at home.
C. hospitalized.
D. living on only Social Security income.

Answer: C

Explanation:
Elder people are particularly prone to falling and incurring serious injury, especially in new situations and environments (such as the hospital).Safety and Infection Control

NEW QUESTION 492
- (Topic 6)
A patient asks a nurse the following question. Exposure to TB can be identified best with which of the following procedures? Which of the following tests is the most definitive of TB?

A. Chest x-ray
B. Mantoux test
C. Breath sounds examination
D. Sputum culture for gram-negative bacteria

Answer: B

Explanation:
The Mantoux is the most accurate test to determine the presence of TB.

NEW QUESTION 493
- (Topic 6)
A patient has recently been prescribed Zidovudine (Retrovir). The patient has AIDS. Which of the following side effects should the patient specifically watch out for?

A. Weakness and SOB
B. Fever and anemia
C. Hypertension and SOB
D. Fever and hypertension

Answer: B

Explanation:
Anemia and fever are associated with Zidovudine??s side effects.

NEW QUESTION 498
- (Topic 6)
The mother of a newborn child is very upset. The child has a cleft lip and palate. The type of crisis this mother is experiencing is:

A. reactive.
B. maturational.
C. situational.
D. adventitious.

Answer: C

Explanation:
The arrival of the imperfect child that the mother had not envisioned places the mother in a situational crisis.
Choice 1 is not an option. Choice 2 is an identified specific time period in normal development when anxiety and stress increase. Choice 4 is a crisis that occurs outside the person??s control so that the person has a disruption in social norms.Psychosocial Integrity

NEW QUESTION 502
- (Topic 6)
A 24 year-old man has been admitted to the hospital due to work-related back injury. The patient??s wife would like to see the patient??s chart. The nurse should:

A. Provide the chart to the patient??s wife following verbal approval by the patient.
B. Provide the chart to the patient??s wife after consulting with the patient??s physician.
C. Get written approval from the patient prior to providing the wife with chart information and call the MD about the patient??s request.
D. Tell the patient?? wife, a copy of the patient??s medical record is on-file with medical records.

Answer: C

Explanation:
Some facilities require the physician to be notified about a patient??s request and written permission from the husband is required for the wife to view the chart.

NEW QUESTION 506
- (Topic 6)
A nursing care plan for a client with sleep problems has been implemented. All of the following should be expected outcomes except:

A. the client reports no episodes of awakening during the night.
B. the client falls asleep within 1 hour of going to bed.
C. the client reports satisfaction with his amount of sleep.
D. the client rates sleep as an 8 or more on the visual analog scale.

Answer: B

Explanation:
An expected outcome is that the client falls asleep shortly after going to bed. The stages of sleep are defined by 4 stages. By stage 3 or 4 (within a short period of time—usually 1 hour) the client is considered to be in the deep part of sleep.Basic Care and Comfort

NEW QUESTION 507
- (Topic 6)
The nurse notices that a family is waiting at the nursing station desk for its loved one to be brought to the unit for admission during a change-of-shift report. The nurse should:

A. request that the family wait for its loved one in the client??s room and wait to resume the report until the family has left the desk area.
B. request that a nursing assistant bring coffee for the family while it waits at the desk and continue with the report.
C. request that the family have a seat in the station rather than stand while awaiting its loved one.
D. request that the family wait for its loved one in the Emergency Department waiting room.

Answer: A

Explanation:
To protect the privacy of clients and the confidentiality of the information shared in a change-of-shift report, the family should be asked to wait in the client??s room, and the report should be resumed only after it can no longer hear what is said.Coordinated Care

NEW QUESTION 508
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