1. A nurse calls the physician of a client scheduled for a cardiac catheterization because the client has numerous questions regarding the procedure and has requested to speak to the physician. The physician is very upset and arrives at the unit to visit the client after prompting by the nurse. The nurse is outside of the client's room and hears the physician tell the client in a derogatory manner that the nurse" doesn't know anything." Which legal tort has the physician violates?

a. Libel
b. Slander
c. Assault
d. Negligence

2. A nurse is assessing a client who has just been measured and fitted for crutches. The nurse determines that the client's crutches are fitted correctly if:

a. The elbow is at a 30 degrees angle when the hand is on the handgrip
b. The elbow is straight when the hand is on the handgrip
c. The client's axilla is resting on the crutches pad during ambulation
d. The top of the crutch is even with the axilla

3. The first attempt to elevate nursing as a profession by enriching and broadening the preparation of nurses and by educating them in University setting is an idea conceived by:

a. Rosario Delgado
b. Julita V. Sotejo
c. Florence Nightingale
d. Faye Abdellah

4. A nurse is instructing a client how to safely use crutches for ambulating at home. Which measure would the nurse recommend to minimize the risk of falls while ambulating with the crutches?

a. Use grab bars in the bathtub or shower
b. Remove scatter rugs in the home
c. Keep all pets out of the house
d. Use soft-soled slippers when walking with the crutches

5. A client is being discharged and will receive oxygen therapy at home. The nurse is teaching the client and family about oxygen safety measures. Which of the following statements by the client indicates the need for further teaching?

a. "I realize that I should check the oxygen level of the portable tank on a consistent basis."
b. "I will keep my scented candles within 5 feet of my oxygen tank."
c. "I will not sit in front of my wood-burning fireplace with my oxygen on."
d. "I will call the physician if I experience any shortness of breath."

6. The four main concepts common to nursing that appear in each of the current conceptual models are:

a. Person, Nursing , Environment, Medicine
b. Person, Health, Nursing, Support System
c. Person, Health, Psychology, Nursing
d. Person, Environment, Health, Nursing

7. A nurse is taking care of a client on contact isolation. After the nursing care has been performed, on leaving the room, which protective item during client care, would the nurse remove first?

a. Gloves
b. Mask
c. Eye wear(goggles)
d. Gown

8. An older adult woman client with a fractured left tibia has a long leg cast and is using crutches to ambulate. In caring for the client, the nurse assesses for which of the following signs and symptoms that indicate a complication associated with crutch walking?

a. Forearm muscle weakness
b. Left leg discomfort.
c. Triceps muscle spasm
d. Weak biceps brachii

9. A client requests pain medication and the nurse administers an intramuscular (IM) injection. After administration of the injection, the nurse does which of the following first?

a. Recaps the needle
b. Removes the gloves
c. Washes the hands
d. Places the syringe in the puncture-resistant needle box container

10. A nursing manager is reviewing the purpose for applying restraints with the nursing staff. The nurse manager tells the staff that which of the following is not an indication for the use of a restraint?

a. To prevent falls
b. To restrict movement of a limb
c. To prevent the client from pulling out IV lines and catheters
d. To prevent the violent client from injuring self and others

11. A client who is scheduled for gallbladder surgery is mentally impaired and is unable to communicate. In regard to obtaining permission for the surgical procedure, which nursing intervention would be most appropriate?

a. Ensure that the family has signed the informed consent
b. Ensure that the client has signed the informed consent
c. Inform the family about the advance directive process
d. Inform the family about the process of a living will

12. A client diagnosed with tuberculosis (TB) is scheduled to go to the radiology department for a chest x-ray evaluation. Which nursing intervention would be appropriate when preparing to transport the client?

a. Apply a mask to the client
b. Apply a mask and gown to the client
c. Apply a mask, gown, and gloves to the client
d. Notify the x-ray department that the personnel can be sure to wear a mask when the client arrives.

13. A nurse is observing a client using a walker. The nurse determines that the client is using the walker correctly if the client:

a. Puts all four points of the walker flat on the floor, puts weight on the hand pieces, and then walks into it
b. Puts weight on the hand pieces, moves the walker forward, and the walks into it.
c. Puts weight on the hand pieces, slides the walker forward, and then walks into it.
d. Walks into the walker, puts weight on the hand pieces, and then puts all four points of the walker flat on the floor.

14. A nurse has an order to obtain a 24-hour urine collection of a client with renal disorder. The nurse avoids which of the following to ensure proper collection of the 24-hour specimen?

a. Have the client void at the start time, and place this specimen in the container.

b. Discard the first voiding; save all subsequent voiding during the 24-hour time period.
c. Place the container on ice, or in a refrigerator
d. Have the client void at the end time and place this specimen in the container.

15.A client is receiving total parenteral nutrition (TPN) via central intravenous (IV) line is scheduled to receive an antibiotic by the IV route. Which action by the nurse is appropriate before hanging the antibiotic solution?

a. Ensure a separate IV access for the antibiotic.
b. Turn off the TPN for 30 minutes before administering the antibiotic.
c. Check with the pharmacy to be sure the antibiotic can be hung through the TPN line.
d. Flush the central line with 60 mL of normal saline solution before hanging the antibiotic.

16. A nurse has inserted a nasogastric (NG) tube to the level of the oropharynx and has repositioned the client's head in a flexed forward position. The client has been asked to begin swallowing. The client begins to cough, gag, and choke. Which of the following nursing actions would least likely result in proper tube insertion and promote client relaxation?

a. Continue to advance the tube to the desired distance.
b. Pulling the tube back slightly.
c. Checking the back of the pharynx using a tongue blade and flashlight.
d. Instructing the client to breath slowly.

17. A nurse has an order to obtain a urinalysis from a client with an indwelling urinary catheter. The nurse avoids which of the following, which could contaminate the specimen?
a. Obtaining the specimen from the urinary drainage bag
b. Clamping the tubing of the drainage bag
c. Aspirating a sample from the port on the drainage bag
d. Wiping the port with an alcohol swab before inserting the syringe

18. A nursing assistant is caring for an elderly client with cystitis who has an indwelling urinary catheter. The registered nurse provides directions regarding care and ensures that the nursing assistant:

a. Uses soap and water to cleanse the perineal area
b. Keeps the drainage bag above the level of the bladder
c. Loops the tubing under the client's leg
d. Lets the drainage tubing rest under the leg

19. A nurse is inserting an indwelling urinary catheter into a male client. As the catheter is inserted into the urethra, urine begins to flow into the tubing. At this point, the nurse:

a. Immediately inflates the balloon
b. Withdraws the catheter approximately 1 inch and inflates the balloon
c. Inserts the catheter until resistance is met and inflates the balloon
d. Inserts the catheter 2.5 to 5 cm and inflates the balloon

20. A nurse is caring for a client with cancer. The client tells the nurse that a lawyer will be arriving today to prepare a living will. The client asks the nurse to act as one of the witnesses for the will. The most appropriate nursing action is to:

a. Agree to act as a witness.
b. Refuse to help the client.
c. Inform the client that a nurse caring for the client cannot serve as a witness to a living will.
d. Call the physician.

21. Which of the following signs and symptoms would the nurse expect to find when assessing an Asian patient for postoperative pain following abdominal surgery?

a. Decreased blood pressure and heart rate and shallow respirations
b. Quiet crying
c. Immobility, diaphoresis, and avoidance of deep breathing or coughing
d. Changing position q 2 hours

22. A patient with signs and symptoms of congestive heart failure and leg edema has been placed on diuretic therapy. Which of the following data would best gauge his progress?

a. Fluid intake and output
b. Vital signs
c.Weight
d.Urine specific gravity

23.The correct sequence for assessing the abdomen is:

a. Tympanic percussion, measurement of the abdominal girth and inspection
b. Assessment for distention, tenderness and discoloration around the umbilicus
c. Percussion, palpation and auscultation
d. Auscultation, percussion and palpation

24. Penicillin is classified as an antibiotic with bactericidal action. The term bactericidal indicates that this antibiotic will:

a. Inhibit the growth of a specific bacterium
b. Destroy a specific bacterium
c. Decrease the number of bacteria
d. Increase the number of bacteria

25. A physician asks a nurse to discontinue the feeding tube in a client who is in a chronic vegetative state. The physician tells the nurse that the request was made by the client's spouse and children. The nurse understands the legal basis for carrying out the order and first checks the client's record for documentation of:

a. A court approval to discontinue the treatment.
b. A written order by the physician to remove the tube.
c. Authorization by the family to discontinue the treatment.
d. Approval by the institutional Ethics Committee.

26.A nurse provides medication instructions to a home health care client. To ensure safe administration of medication in the home, the nurse:

a. Demonstrate the proper procedure for taking prescribed medications.
b. Allows the client to verbalize and demonstrate correct administration procedure.
c. Instruct the client that it is OK to double up on medications if a dose has been missed.
d. Conducts pill counts on each home visit.

27.A client is admitted to the hospital for a bowel resection following a diagnosis of a bowel tumor. During the admission assessment, the client tells the nurse that a living will was prepared three years ago. The client asks the nurse if this document is still effective. The most appropriate nursing response is which of the following?

a. "Yes it is."
b. "You will have to ask your lawyer."

c. “It should be reviewed yearly with your physician.”
d. “I have no idea.”

28.A nurse’s note that a postoperative client has not been obtaining relief of pain with prescribed narcotics, but only while a particular licensed practical nurse (LPN) is assigned to the client. The nurse:

a. Reviews the client’s medication administration record and immediately discuss the situation with the nursing supervisor
b. Notifies the physician that the client needs an increase in narcotic dosage
c. Decides to avoid assigning the LPN to the care of clients receiving narcotics
d. Confronts the LPN with the information about the client having pain control problems and asks if the LPN is using the narcotics personally

29.A client’s vital signs have noticeably deteriorated over the past four hours following surgery. A nurse does not recognize the significance of these changes in vital signs and take no action. The client later requires emergency surgery. The nurse could be prosecuted for which of these?

a. Tort
b. Misdemeanor
c. Common law
d. Statutory law

30.A nurse plans to carry out a multidisciplinary research project on the effects of immobility on clients’ stress levels. The nurse understands that which principle is most important when planning this project?

a. Collaboration with other disciplines is essential to the successful practice of nursing.
b. The corporate Nurse Executive should be consulted, because the project will take nursing time.
c. All clients have the right to refuse to participate in research using human subjects.
d. The cooperation of the physicians on staff must be ensured for the project to succeed.

31.A multidisciplinary health care team is planning care for client with hyperparathyroidism. The health care team develops which most important outcome for the client?

a. Describes the administration of aluminum hydroxide gel.
b. Restricts fluids to 1000 mL per day.
c. Walk down the hall for 15 minutes, three times per day.
d. Describes the use of loperamide (Imodium)

32. Stressors cause the release of the mineralocorticoid aldosterone, which regulates sodium absorption and potassium excretion in the renal tubules, resulting in:

a. The need for supplemental potassium
b. The need for a low sodium (500-mg) diet
c. The conservation of water and maintenance of blood volume
d. Increased diuresis

33. The therapeutic effect of incentive spirometry depends on the:

a. Maximum amount of air exhaled
b. Sustained maximum deflation
c. Maximum volume of air remaining after exhaling
d. Sustained maximum inflation

34.The natural sedative in meat and milk products (especially warm milk) that can help induce sleep is:

a. Flurazepam
b. Temazepam
c. Tryptophan
d. Methotrimeprazine

35. One of the main principles of hospice program is that:

a. The family's needs continue after the death of a loved one
b. All persons need palliative care
c. Hospice care must be provided by professional caregivers only
d. Holistic care should not include medical care

36. In the acceptance stage, the terminally ill patient reaches a point where he:

a. Is happy
b. Is neither depressed nor angry about his fate
c. Has many mixed feelings
d. Increased verbal communication with others

37. A nurse administers the morning dose of digoxin (Lanoxin) to the client. When the nurse charts the medication, the nurse discovers that a dose of 0.25 mg was administered rather than the prescribed dose of 0.125 mg. Which nursing action is most appropriate?

a. Administer the additional 0.125 mg
b. Tell the client that the dose administered was not the total amount and administer the additional dose
c. Tell the client that too much medication was administered and an error was made
d. Complete an incident report

38. A registered nurse (RN) is orienting a nursing assistant to the clinical nursing unit. The RN would intervene if the nursing assistant did which of the following during a routine handwashing procedure?

a. Kept hands lower than elbows
b. Used 3 to 5 ml of soap from the dispenser
c. Washed continuously for 10 to 15 seconds
d. Dried from forearm down to fingers

39. A client who is immunosuppressed is being admitted to the hospital and will be placed on neutropenic precautions. The nurse plans to ensure that which of the following does not occur in the care of the client?

a. Placing a mask on the client if the client leaves the room
b. Removing a vase with fresh flowers left by a previous client
c. Admitting the client to a semi private room.
d. Placing a precaution sign on the door to the room.

40. A client has an order for "enemas until clear" before major bowel surgery. After preparing the equipment and solution, the nurse assists the client into which of the following positions to administer the enema?

a.Left-lateral Sim's position
b.Right-lateral Sim's position
c.Left side-lying with the head of the bed elevated 45 degrees
d. Right side-lying with the head of the bed elevated 45 degrees

41.The nurse has complete tracheostomy care for a client whose tracheostomy tube has a non-disposable inner cannula. The nurse reinserts the inner cannula into the tracheostomy immediately after:

a. Suctioning the client's airway.
b. Rinsing it with sterile water.
c. Tapping it against a sterile surface to dry it
d. Drying it thoroughly with sterile gauze

41.A nurse is caring for a client who has an order for dextroamphetamine (Dextrine) 25mg PO daily. The nurse collaborates with the dietician to limit the amount of which of the following items on the client's dietary trays?

a. Starch
b. Caffeine
c. Protein
d. Fat

43. Before performing a venipuncture to initiate continuous intravenous (IV) therapy, a nurse would:

a. Apply a tourniquet below the chosen vein site.
b. Inspect the IV solution for particles or contamination.
c. Secure a arm board to the joint located above the IV site.
d. Place a cool compress over the vein.

44.Which assessment is most important for the nurse to make before advancing a client from liquid to solid?

a. Food preferences.
b. Appetite.
c. Presence of bowel sounds.
d. Chewing ability.

45.A nurse is preparing to access an implanted vascular port to administer chemotherapy. The nurse:

a. Anchors the port with the dominant hand.
b. Palpates the port to locate the center of the septum.
c. Places a warm pack over the area for several minutes to alleviate possible discomfort.
d. Cleans the area with alcohol working from the outside ward.

46. An elderly woman is brought to the emergency room. On physical assessment, the nurse notes old and new ecchymotic areas on both arms and buttocks. The nurse asks the client how the bruises were sustained. The client, although reluctant, tells the nurse in confidence that her daughter frequently hits her if she gets in the way. Which of the following is the moist appropriate nursing response?

a. "I promise I will not tell anyone but let's see what we can do about this."
b. "I have a legal obligation to report this type of abuse."
c. "Let's talk about ways that will prevent your daughter from hitting you."
d. "This should not be happening, and if it happens again you must call the emergency department."

47. A client tells the home health care nurse of the decision to refuse external cardiac massage. Which of the following is the most appropriate initial nursing actions?

a. Notify the physician of the client's request
b. Document the client's request in the home health nursing care plan
c. Conduct a client conference with the home health care staff to share the client's request
d. Discuss the client's request with the family

48. A nurse manager employs a leadership style in which decisions regarding the management of the nursing unit are made without input from the staff. Type of leadership style that is implemented by this nurse manager is:

a. Autocratic
b. Situational
c. Democratic
d. Laissez-faire

49. A registered nurse (RN) in charge is preparingthe assignments for the day. The RN assigns a nursing assistant to make beds and bathe one of the clients on the unit and assigns another nursing assistant to fill the water pitchers and to serve juice to all the clients. Another RN is assigned to administer all medications. Based on the assignments designed by the RN in charge, which type of nursing care is being implemented?

a. Functional nursing
b. team nursing
c. Exemplary model of nursing
d. Primary nursing

50. Visual acuity may be assessed by using a Snellen chart. If a patient has acuity of 20/40 in both eyes, this means:

a. The patient can see twice as well as normal
b. The patient has double vision
c. The patient has less than normal vision
d. the patient has normal vision

51.The nurse in a well baby clinic is providing safety instructions to a mother of a 1-month-old infant. Which of the following safety instructions is most appropriate at this age?

a. Cover electrical outlets
b. Remove hazardous objects from low places
c. Lock all poisons
d. Never shake the infant's head.

52. A nurse is receiving a client in transfer from the post anesthesia care unit following an above-the-knee amputation. The nurse should take which of the following most important actions when positioning the client at this time?

a. Put the bed in reverse Trendelenburg's position
b. Keep the stump flat with the client lying on operative side
c. Position the stump flat on the bed
d. Elevate the foot of the bed.

53. A nurse manager is planning to implement a change in the method of the documentation system in the nursing unit. Many problems have occurred as a result of the present documentation system and the nurse manager determines that a change is required. The initial step in the process of change for the nurse manager is which of the following?

a. Plan strategies to implement the change
b. Identify potential solutions and strategies for the change process.
c. Set goals and priorities regarding the change process.
D. Identify the inefficiency that needs improvement or correction.

54. A nurse has received the client assignment for the day and is organizing the required tasks. Which of the following will not be a component of the plan for time management?

a. Prioritizing client needs and daily tasks
b. Providing time for unexpected tasks
c. Gathering supplies before beginning a tasks
d. Documenting task completion at the end of the day.

55. A nurse enters the client's room and finds the client lying on the floor. Following assessment of the client, the nurse calls the nursing supervisor and the physician to inform them of the occurrence. The nursing supervisor instructs the nurse to complete an incident report. The nurse understands that incident reports allow the analysis of adverse client events by:

a. Evaluating quality care and the client
b. Determining the effectiveness of nursing intervention in relation to the client
c. Providing a method of reporting injuries to local, state, and federal agencies
d. Providing clients with necessary stabilizing treatments

56. A nurse observes that the client received pain medication 1 hour ago from another nurse, but that the client still has severe pain. The nurse has previously observed this same occurrence. The nurse practice act requires the observing nurse to do which of the following?

a. Talk with the nurse who gave the medication
b. Report the information to a nursing supervisor
c. Call the impaired nurse organization
d. Report the information to the police

57. a patient has intravenous fluids infusing in the right arm. When takinga blood pressure on this patient, the nurse would:

a. Take the blood pressure in the right arm.
b. Take the blood pressure in the left arm.
c. Use the smallest possible cuff
d. report inability to take the blood pressure

58. A client is 2 days post operative. The vital signs are: BP - 120/70, HR - 110, RR - 26, and Temperature - 100.4 degrees Fahrenheit (38 degrees Celsius). The client suddenly becomes profoundly short of breath, skin color is gray. Which assessment would have alerted the nurse first to the client's change in condition?

a. Heart rate
b. Respiratory rate
c. Blood pressure
d. Temperature

59. Constipation is one of the most frequent complaints of elders. When assessing this problem, which action should be the nurse's priority?

a. Add a thickening agent to the fluids
b. Obtain a health and dietary history
c. Refer to a provider for a physical examination
d. Measure height and weight

60. While caring for a client, the nurse notes a pulsating mass in the client's periumbilical area. Which of the following assessments is appropriate for the nurse to perform?

a. Measure the length of the mass
b. Auscultate the mass
c. Percuss the mass
d. Palpate the mass

61. A client being treated for hypertension returns to the community clinic for follow up. The client says, "I know these pills are important, but I just can't take these water pills anymore. I drive a truck for a living, and I can't be stopping every 20 minutes to go to the bathroom." Which of these is the **best** nursing diagnosis?

a.Noncompliance related to medication side effects
b.Knowledge deficit related to misunderstanding of disease state
c.Defensive coping related to chronic illness
d.Altered health maintenance related to occupation

62. A client with congestive heart failure is newly admitted to home health care. The nurse discovers that the client has not been following the prescribed diet. What would be the most appropriate nursing action?

a. Discharge the client from home health care related to noncompliance
b. Notify the health care provider of the client's failure to follow prescribed diet
c. Discuss diet with the client to learn the reasons for not following the diet
d. Make a referral to Meals-on-Wheels

63. A client is admitted to the rehabilitation unit following a CVA and mild dysphagia. The **most** appropriate intervention for this client is:

a. Position client in upright position while eating
b. Place client on a clear liquid diet
c. Tilt head back to facilitate swallowing reflex
d. Offer finger foods such as crackers or pretzels

64. A client has altered renal function and is being treated at home. The nurse recognizes that the most accurate indicator of fluid balance during the weekly visits is

a. difference in the intake and output
b. changes in the mucous membranes
c. skin turgor
d. weekly weight

65. One of the ethical obligations of nursing is accountability. Accountability means that the staff nurse is responsible for:

a.The behavior of clients who are noncompliant
b.The consequences of his or her actions, even mistakes in judgment
c.The behavior of other staff members who are negligent in their nursing care
d.The consequences of an administrative decision to decrease nursing staff

66. An RN has been assigned for six clients for the 12-hour shift. The RN is responsible for every aspect of planning, giving, and evaluating their care during the shift. When leaving at 7:00 am, the nurse will pass this same responsibility to the incoming nurse. This illustrates nursing care delivered via the:

a. Case method
b. Functional method
c. Team method
d. Primary nursing method

67. The nurse has been asked to witness an informed consent for surgery. The nurse understands that he or she is witnessing is that the:

a. Informed consent took place
b. Client signed the consent form
c. Client was fully informed about the procedure.
d. Family consented to the procedure.

68. A 7-week-old is admitted with a 2-week history of vomiting and weight loss. Tentative diagnosis is pyloric stenosis. While doing the admission assessment, in what order should the nurse assess the infant's abdomen?

a. Auscultate, inspect, palpate, percuss.
b. Palpate, percuss, inspect, auscultate.
c. Inspect, auscultate, percuss, palpate.
d. Percuss, palpate, auscultate, inspect.

69. A client is scheduled for cardioversion to treat sustained atrial fibrillation. The nursing priority before the procedure would be to:

a. Auscultate the heart sounds.
b. Administer medication for sedation.
c. Give the prescribed analgesic.
d. Start an antibiotic IV per order.

70. To monitor a client's fluid volume more closely, a central venous pressure (CVP) line has been inserted via the right subclavian vein. The nurse needs to know that CVP assesses the pressure in:

a. The left atrium
b. The right atrium
c. The left ventricle
d. The right ventricle.

71. The nursing priority to look for in assessing a client with right ventricular failure is the presence of:

a. Fluid retention and distended neck veins.
b. Weight gain and bradycardia.
c. Confusion and apathy.
d. Chest pain and elevated temperature.

72. A client is to have a breast biopsy and possible mastectomy. Before going to see this client the morning of surgery, the nurse who is assigned to assist her in the final preparation for surgery should first:

a. Prepare the preoperative medication.
b. Check to be sure the operative permit has been assigned.
c. Check to see if the operative laboratory reports have been placed in the chart.
d. Check the diet orders to be sure the clients has been placed on NPO list.

73. Which is not true about informed consent?

a.Obtaining consent is the responsibility of the physician.
b.A nurse may accept responsibility for witnessing a consent form.
c.A physician subjects himself or herself to liability of the physician withholds any facts that are necessary to for the basis of an intelligent consent.
d.If a nurse witnesses a consent for surgery, the nurse is, in effect, indicating that the client is “informed.”

74. In preparing preop injections for a 3 year old, which size needle would the nurse be most correct in selecting to administer IM injection?

a. 25 G 5/8 inch
b. 21G, 1 inch
c. 18 G, 1 inch
d. 18 G, 1 ½ inch

75. Mr. L. is homeless and has gangrene on his foot. The physician has recommended hospitalization andsurgery. Mr. L. has refused. The nurse knows which of the following is true? The client

a. Cannot be hospitalized against his will.
b. Can be restrained if one physician declares him incompetent
c. Cannot choose which treatment to refuse.
d. May sign against medical advice (AMA).

76. Ms. R. has been medicated for her surgery. The operating room (OR) nurse, when going through the client's chart, realizes that the consent form has not been signed. Which of the following is the best action for the nurse to take?

a. Tell the physician that the consent form is not signed.
b. Assume it is emergency surgery and the consent is implied.
c. Get the consent form and have the client sign it.
d. Have a family member sign the consent form.

77. Mr. T. is a client on your medical-surgical unit. His cousin is a physician and wants to see the chart. Which of the following is the best response for the nurse to take?

a. Tell the cousin that the request cannot be granted.
b. Hand the cousin the client's chart to review.
c. Call the attending physician and have the doctor speak with the cousin.
d. Ask Mr. T. to sign an authorization, and have someone review the chart with the cousin.

78. Ms. L. is admitted to the floor. She is in the terminal stages of AIDS. During the admission assessment, the nurse would ask her if she had which of the following except?

a.An organ donation card.
b.Healthcare proxy.
c.Living will
d.Durable power of attorney for health care

79. The nurse enters a room and finds a fire. Which is the best initial action?

a.Activate the fire alarm or call the operator, depending on the institution's system.
b.Get a fire extinguisher and put out the fire.
c.Evacuate any people in the room, beginning with the most ambulatory and ending with the least mobile.

d.Close all the windows and doors, and turn off any oxygen or electrical appliances.

80. Ms. R. has had both wrists restrained because she is agitated and pulls out her IV lines. Which of the following would the nurse observe if Ms. R. is not suffering any ill effects from the restraints? That

a. Ms. R.'s capillary refill is less than two seconds.
b. She has difficulty moving her fingers and making a fist.
c. Her skin is reddened where the mitts were tied around her wrist.
d. The client complains of numbness and tingling in her hand.

81. When a patient you are admitting to the unit asks you why you are doing a history and exam since the doctor just did one, your best reply is:

a." In addition to providing us with valuable information about your health status, the nursing assessment will allow us to plan and deliver individualized, holistic nursing care that draws on your strengths."
b. "Its hospital policy. I know it must be tiresome, but I will try to make this quick!"
c. "I am a student nurse and need to develop the skill ofassessing your health statusand need for nursing care. This information will help me developa plan of care individualized to your unique needs."
d. We want to make sure that your responses are consistent and that all our data are accurate."

82. Mr. I. is supine. Which of the following can the nurse do to prevent external rotation of the legs?

a. Put a pillow under the client's lower legs.
b. Lower the client's legs so that they are below the hips.
c. Use a trochanter roll alongside Mr. I.'s upper thighs.
d. Place a pillow directly under the client's knees.

83. Mr. T. is a C4 quadriplegic. He has slid down in the bed. Which of the following is the best method for the nurse to use to reposition him?

a. One nurse lifting under his buttocks while he uses the trapeze.
b. One nurse lifting him under his shoulders from behind.
c. Two people lifting him up in bed with a draw sheet.
d. Two people log rolling the client from one side to the other.

84. You are surprised to detect an elevated temperature (102 F) in a patient scheduled for surgery. The patient has been afebrile and shows no other signs of being febrile.. The first thing you do is to:

a. inform the charge nurse.
b. Inform the surgeon
c. Validate your finding
d. Document your finding

85. The nurse knows the difference between the left lateral and the Sims position is that the.

a. Lateral position places the client's weight on the anterior upper chest and the left shoulder.
b.Sims position is semiprone, halfway between lateral and prone.
c.Lateral position places the weight on the right hip and shoulder.
d.Sims position places the weight on the right shoulder and hip.

86. a professional nurse committed to the principle of autonomy would be careful to:

a. Provide the information and support a patient needed to make decisions to advance her own interests.
b. Treat each patient fairly, trying to give everyone his or her due.
c. Keep any promises made to a patient or another professional caregiver.
d.Avoid causing harm to a patient.

87. Ms. S. is brought in after a motor vehicle accident. She has suffered a head injury and possible spinal injury. When moving her from the stretcher to the bed, the nurse should

a. have the client move segmentally.
b. log roll the client.
c. move Ms. S. with a draw sheet.
d. sit Ms. S. up and transfer her to the bed.

88. Ms. F. suffered a stroke and has right-sided hemiparesis. The nurse is going to transfer her from bed to wheelchair. Which of the following is the best method?

a. Place the wheelchair about a foot away from the bed.
b. Position the wheelchair closer to the weaker foot.
c. Have the client put her arms around the nurse's neck.
d. Put the wheelchair at a 45° angle to the bed.

89. The nurse knows which of the following is the proper technique for medical asepsis?

a. Gloving for all client contact.
b. Gowning to care for a one-year-old child with infectious diarrhea.
c. Using your hands to turn off the faucet after handwashing.
d. Changing hospital linen weekly.

90. The nurse is conducting a class on aseptic technique and universal precautions. Which of the following statements is correct and should be included in the discussion?

a. The term universal precautions is synonymous with disease or category-specific isolation precautions.
b.Medical asepsis is designed to decrease exposure to bloodborne pathogens.
c.Universal precautions are designed to reduce the number of potentially infectious agents.
d.Medical asepsis is designed to confine microorganisms to a specific area, limiting the number, growth, and transmission of microorganisms.

91. The nurse is to open a sterile package from central supply. Which is the correct direction to open the first flap?

a. Away from the nurse.
b. To the nurse's left or right.
c. It does not matter as long as the nurse only touches the outside edge.
d. Toward the nurse.

92. Which of the following statements or questions would be appropriate in establishing a discharge plan for a patient who has had major abdominal surgery?

a. “I will bet you will be so glad to be home in your own bed.”
b. “What are your expectations for recovery from your surgery?”

c. “Be sure and take your pain medications and change your dressing.”
d. “You will just be fine! Please stop worrying.”

93. A patient who decides to leave the hospital against medical advice (AMA) must sign a form. What is the purpose of this form?

a. To indicate the patient’s wishes
b. To use in the event of readmission
c. To release the physician and hospital from legal responsibility for the patient’s health status.
d. To ethically illustrate that the patient has control of his or her own care and treatment.

94. Ms. P. is transferred to a skilled nursing facility from the hospital because she is unable to ambulate due to a left femoral fracture. The nurse knows Ms. P.'s greatest risk factor for developing a pressure ulcer is that she

a. Is apathetic but oriented to person, place, and time.
b. Has slightly limited mobility and needs assistance to move from bed to chair.
c. Has good skin turgor, no edema, and her capillary refill is less than three seconds.
d. Is 5 ft 4 in tall, 130 lb, and eats more than half of most meals.

95. An elderly male client is transferred to a skilled nursing facility from the hospital because he is unable to ambulate due to a left femoral fracture. When doing a skin assessment, the nurse notices a 3-cm, round area partial thickness skin loss that looks like a blister on the client's sacrum. The nurse knows this is a

a. Stage II pressure ulcer.
b. Stage I pressure ulcer.
c. Stage III pressure ulcer.
d. Stage IV pressure ulcer.

96. You are to administer a medication to Mr. B. In addition to checking his identification bracelet, you can correctly identify his identity by:

a. Asking the patient his name.
b. Reading the patient’s name on the sign over the head.
c. Asking the patient’s roommate to verify his name.
d. Asking, “Are you Mr. B.?”

97. The nurse takes an 8am medication to the patient and properly identifies her. The patient asks the nurse to leave the medication on the bedside table and stats that she will take it when with breakfast when it comes. What is the best response to this request?

a. Leave the medication and return later to make sure that it was taken.
b. Tell her that it is against the rules, and take the medication with you.
c. Tell her that you cannot leave the medication but will return with it when breakfast arrives.
d. Take the drug from the room and record it as refused.

98. Why is the intravenous method of medication administration is called the “most dangerous route of administration?”

a. The vein can take only a small amount of fluid at a time.
b. The vein may harden and become nonfunctional.
c. Blood clots may become a serious problem.
Ds. The drug is placed directly into the bloodstream and its action is immediate.

99. Mr. A. is going home from the emergency room with directions to apply a cold pack to his ankle sprain. He asks how he will know if the cold pack has worked. The nurse tells him

a. there should be less pain after applying the cold pack.
b. that the skin will be blanched and numb afterward.
c. he will notice the red-blue bruises will turn purple.
d. after the first application, the swelling will be decreased.

100. A nurse discovers that she has made a medication error. Which of the following should be her first response?

a. Record the error on the medication sheet
b. Notify the physician regarding course of action.
c. Check the patient's condition to note any possible effect of the error
d. Complete an incident report, explaining how the mistake was made.