Introduction

Practice Questions

871. The emergency department nurse is caring for a client who has been identified as a victim of physical abuse. In planning care for the client, which is the **priority** nursing action?
    1. Adhering to the mandatory abuse-reporting laws
    2. Notifying the caseworker of the family situation
    3. Removing the client from any immediate danger
    4. Obtaining treatment for the abusing family member
872. The nurse assesses a client with the admitting diagnosis of bipolar affective disorder, mania. Which client symptoms require the nurse's **immediate** action?
    1. Incessant talking and sexual innuendoes
    2. Grandiose delusions and poor concentration
    3. Outlandish behaviors and inappropriate dress
    4. Nonstop physical activity and poor nutritional intake
873. The nurse is caring for a client who was involuntarily hospitalized to a mental health unit and is scheduled for electroconvulsive therapy. The nurse notes that an informed consent has not been obtained for the procedure. Based on this information, what is the nurse's **best** determination in planning care?
    1. The informed consent does not need to be obtained.
    2. The informed consent should be obtained from the family.
    3. The informed consent needs to be obtained from the client.
    4. The health care provider will provide the informed consent.
874. A client newly diagnosed with diabetes mellitus is instructed by the primary health care provider to obtain glucagon for emergency home use. The client asks a home care nurse about the purpose of the medication. What is the nurse's **best** response to the client's question?
    1. "It will boost the cells in your pancreas if you have insufficient insulin."
    2. "It will help promote insulin absorption when your glucose levels are high."
    3. "It is for the times when your blood glucose is too low from too much insulin."
    4. "It will help prevent lipoatrophy from the multiple insulin injections over the years."
875. The nurse is providing care to a Puerto Rican–American client who is terminally ill. Numerous family members are present most of the time, and

many of the family members are very emotional. What is the **most appropriate** nursing action for this client?

1. Restrict the number of family members visiting at one time.
2. Inform the family that emotional outbursts are to be avoided.
3. Make the necessary arrangements so that family members can visit.
4. Contact the primary health care provider to speak to the family regarding their behaviors.

876. A client presents to the emergency department with upper gastrointestinal bleeding and is in moderate distress. In planning care, what is the **priority** nursing action for this client?

1. Assessment of vital signs
2. Completion of abdominal examination
3. Insertion of the prescribed nasogastric tube
4. Thorough investigation of precipitating events

877. The nurse is performing an assessment on a client with dementia. Which piece of data gathered during the assessment indicates a manifestation associated with dementia?

1. Use of confabulation
2. Improvement in sleeping
3. Absence of sundown syndrome
4. Presence of personal hygienic care

878. The nurse is caring for a client with anorexia nervosa. Which behavior is characteristic of this disorder and reflects anxiety management?

1. Engaging in immoral acts
2. Always reinforcing self-approval
3. Observing rigid rules and regulations
4. Having the need always to make the right decision

879. The nurse provides instructions to a malnourished pregnant client regarding iron supplementation. Which client statement indicates an understanding of the instructions?

1. "Iron supplements will give me diarrhea."
2. "Meat does not provide iron and should be avoided."
3. "The iron is best absorbed if taken on an empty stomach."
4. "On the days that I eat green leafy vegetables or calf liver I can omit taking the iron supplement."

880. Levothyroxine is prescribed for a client diagnosed with hypothyroidism. Upon review of the client's record, the nurse notes that the client is taking warfarin. Which modification to the plan of care should the nurse review with the client's primary health care provider?

1. A decreased dosage of levothyroxine
2. An increased dosage of levothyroxine
3. A decreased dosage of warfarin sodium
4. An increased dosage of warfarin sodium

881. The nurse is teaching a client with emphysema about positions that help breathing during dyspneic episodes. The nurse instructs the client that which positions alleviate dyspnea? **Select all that apply.**

- ☐ 1. Sitting up and leaning on a table
- ☐ 2. Standing and leaning against a wall
- ☐ 3. Lying supine with the feet elevated
- ☐ 4. Sitting up with the elbows resting on knees
- ☐ 5. Lying on the back in a low-Fowler's position

882. A client is about to undergo a lumbar puncture. The nurse describes to the client that which position will be used during the procedure?
    1. Side-lying with a pillow under the hip
    2. Prone with a pillow under the abdomen
    3. Prone in slight Trendelenburg's position
    4. Side-lying with the legs pulled up and the head bent down onto the chest

883. The nurse recognizes that which interventions are likely to facilitate effective communication between a dying client and family? **Select all that apply.**
    - ☐ 1. The nurse encourages the client and family to identify and discuss feelings openly.
    - ☐ 2. The nurse assists the client and family in carrying out spiritually meaningful practices.
    - ☐ 3. The nurse removes autonomy from the client to alleviate any unnecessary stress for the client.
    - ☐ 4. The nurse makes decisions for the client and family to relieve them of unnecessary demands.
    - ☐ 5. The nurse maintains a calm attitude and one of acceptance when the family or client expresses anger.

884. A depressed client verbalizes feelings of low self-esteem and self-worth typified by statements such as "I'm such a failure. I can't do anything right." How should the nurse plan to respond to the client's statement?
    1. Reassure the client that things will get better.
    2. Tell the client that this is not true and that we all have a purpose in life.
    3. Identify recent behaviors or accomplishments that demonstrate the client's skills.
    4. Remain with the client and sit in silence; this will encourage the client to verbalize feelings.

885. The nurse has just admitted to the nursing unit a client with a basilar skull fracture who is at risk for increased intracranial pressure. Pending specific primary health care provider prescriptions, the nurse should safely place the client in which positions? **Select all that apply.**
    - ☐ 1. Head midline
    - ☐ 2. Neck in neutral position

☐ 3. Head of bed elevated 30 to 45 degrees

☐ 4. Head turned to the side when flat in bed

☐ 5. Neck and jaw flexed forward when opening the mouth

886. The nurse reviews the arterial blood gas results of a client with emphysema and notes that the laboratory report indicates a pH of 7.30, $PaCO_2$ of 58 mm Hg, PaO_2 of 80 mm Hg, and HCO_3 of 27 mEq/L (27 mmol/L). The nurse interprets that the client has which acid–base disturbance?
    1. Metabolic acidosis
    2. Metabolic alkalosis
    3. Respiratory acidosis
    4. Respiratory alkalosis
887. The nurse has admitted a client to the clinical nursing unit after undergoing a right mastectomy. The nurse should plan to place the right arm in which position?
    1. Elevated on a pillow
    2. Level with the right atrium
    3. Dependent to the right atrium
    4. Elevated above shoulder level
888. On the second postpartum day, a client complains of burning on urination, urgency, and frequency of urination. A urinalysis indicates the presence of a urinary tract infection. The nurse instructs the client regarding measures to take for the treatment of the infection. Which client statement indicates to the nurse the **need for further instruction**?
    1. "I need to urinate frequently throughout the day."
    2. "The prescribed medication must be taken until it is finished."
    3. "My fluid intake should be increased to at least 3000 mL daily."
    4. "Foods and fluids that will increase urine alkalinity should be consumed."
889. A client received 20 units of Humulin N insulin subcutaneously at 08:00. At what time should the nurse plan to assess the client for a hypoglycemic reaction?
    1. 10:00
    2. 11:00
    3. 17:00
    4. 24:00
890. The nurse is the first responder after a tornado has destroyed many homes in the community. Which victim should the nurse attend to **first**?
    1. A pregnant woman who exclaims, "My baby is not moving."
    2. A woman who is complaining, "My leg is bleeding so bad, I am afraid it is going to fall off!"
    3. A young child standing next to an adult family member who is screaming, "I want my mommy!"
    4. An older victim who is sitting next to her husband sobbing, "My husband is dead. My husband is dead."
891. A pregnant client at 10 weeks' gestation calls the prenatal clinic to report a recent exposure to a child with rubella. The nurse reviews the client's chart.

What is the nurse’s **best** response to the client? **Refer to chart.**

History and Physical	Laboratory and Diagnostic Results	Medications
Gravida, Term Births, Preterm Births, Abortions, Living Children (GTPAL) 1,0,0,0,0	Venereal Disease Research Laboratory (VDRL) nonreactive	Prenatal vitamins
Weight 135 lb (61 kg)	Rubella immune	
Positive Goodell and Chadwick	Rh positive, type O	

1. “You should avoid all school-age children during pregnancy.”
2. “There is no need to be concerned if you don’t have a fever or rash within the next 2 days.”
3. “You were wise to call. Your rubella titer indicates that you are immune and your baby is not at risk.”
4. “Be sure to tell the primary health care provider in 2 weeks, as additional screening will be prescribed during your second trimester.”

892. A breast-feeding mother of an infant with lactose intolerance asks the nurse about dietary measures. What foods should the nurse tell the mother are acceptable to consume while breast-feeding? **Select all that apply.**

- ☐ 1. 1% milk
- ☐ 2. Egg yolk
- ☐ 3. Dried beans
- ☐ 4. Hard cheeses
- ☐ 5. Green leafy vegetables

893. A client with diabetes mellitus is told that amputation of the leg is necessary to sustain life. The client is very upset and tells the nurse, “This is all my primary health care provider’s fault. I have done everything I’ve been asked to do!” Which nursing interpretation is **best** for this situation?

1. An expected coping mechanism
2. An ineffective defense mechanism
3. A need to notify the hospital lawyer
4. An expression of guilt on the part of the client

894. A client with terminal cancer arrives at the emergency department dead on arrival (DOA). After an autopsy is prescribed, the client’s family requests that no autopsy be performed. Which response to the family is **most appropriate**?

1. “The decision is made by the medical examiner.”
2. “An autopsy is mandatory for any client who is DOA.”
3. “I will contact the medical examiner regarding your request.”
4. “It is required by federal law. Tell me why you don’t want the autopsy done.”

895. A client who is positive for human immunodeficiency virus (HIV) delivers a newborn infant. The nurse provides instructions to help the client with care of her infant. Which client statement indicates the **need for further instruction**?

1. “I will be sure to wash my hands before and after bathroom use.”
2. “I need to breast-feed, especially for the first 6 weeks postpartum.”
3. “Support groups are available to assist me with understanding my diagnosis of HIV.”
4. “My newborn infant should be on antiviral medications for the first 6 weeks after delivery.”

896. An adolescent client is diagnosed with conjunctivitis, and the nurse provides information to the client about the use of contact lenses. Which client statement indicates the **need for further information**?
    1. “I should obtain new contact lenses.”
    2. “I should not wear my contact lenses.”
    3. “My old contact lenses should be discarded.”
    4. “My contact lenses can be worn if they are cleaned as directed.”
897. The nurse teaches a client newly diagnosed with type 1 diabetes about storing Humulin N insulin. Which statement indicates to the nurse that the client understood the discharge teaching?
    1. “I should keep the insulin in the cabinet during the day only.”
    2. “I know I have to keep my insulin in the refrigerator at all times.”
    3. “I can store the open insulin bottle in the kitchen cabinet for 1 month.”
    4. “The best place for my insulin is on the windowsill, but in the cupboard is just as good.”
898. The nurse is caring for a client scheduled for a transsphenoidal hypophysectomy. The preoperative teaching instructions should include which statement?
    1. “Your hair will need to be shaved.”
    2. “You will receive spinal anesthesia.”
    3. “You will need to ambulate after surgery.”
    4. “Brushing your teeth needs to be avoided for at least 2 weeks after surgery.”
899. During a routine prenatal visit, a client complains of gums that bleed easily with brushing. The nurse performs an assessment and teaches the client about proper nutrition to minimize this problem. Which client statement indicates an understanding of the proper nutrition to minimize this problem?
    1. “I will drink 8 oz of water with each meal.”
    2. “I will eat 3 servings of cracked wheat bread each day.”
    3. “I will eat 2 saltine crackers before I get up each morning.”
    4. “I will eat fresh fruits and vegetables for snacks and for dessert each day.”
900. A 6-year-old child has just been diagnosed with localized Hodgkin’s disease, and chemotherapy is planned to begin immediately. The mother of the child asks the nurse why radiation therapy was not prescribed as a part of the treatment. What is the nurse’s **best** response?
    1. “It’s very costly, and chemotherapy works just as well.”
    2. “I’m not sure. I’ll discuss it with the primary health care provider.”
    3. “Sometimes age has to do with the decision for radiation

therapy."
4. "The primary health care provider would prefer that you discuss treatment options with the oncologist."

901. An infant born with an imperforate anus returns from surgery after requiring a colostomy. The nurse assesses the stoma and notes that it is red and edematous. Based on this finding, which action should the nurse take?
    1. Elevate the buttocks.
    2. Document the findings.
    3. Apply ice immediately.
    4. Call the primary health care provider.
902. The nurse is performing an initial assessment on a newborn infant. When assessing the infant's head, the nurse notes that the ears are low-set. Which nursing action is **most appropriate**?
    1. Document the findings.
    2. Arrange for hearing testing.
    3. Notify the pediatrician.
    4. Cover the ears with gauze pads.
903. The clinic nurse is assessing jaundice in a child with hepatitis. Which anatomical area would provide the **best** data regarding the presence of jaundice?
    1. The nail beds
    2. The skin in the sacral area
    3. The skin in the abdominal area
    4. The membranes in the ear canal
904. The nurse is assigned to care for a client in traction. The nurse creates a plan of care for the client and should include which action in the plan?
    1. Ensure that the knots are at the pulleys.
    2. Check the weights to ensure that they are off of the floor.
    3. Ensure that the head of the bed is kept at a 45- to 90-degree angle.
    4. Monitor the weights to ensure that they are resting on a firm surface.
905. The nurse is setting up the physical environment for an interview with a client and plans to obtain subjective data regarding the client's health. Which interventions are appropriate? **Select all that apply.**
    - ☐ 1. Set the room temperature at a comfortable level.
    - ☐ 2. Remove distracting objects from the interviewing area.
    - ☐ 3. Place a chair for the client across from the nurse's desk.
    - ☐ 4. Ensure comfortable seating at eye level for the client and nurse.
    - ☐ 5. Provide seating for the client so that the client faces a strong light.
    - ☐ 6. Ensure that the distance between the client and nurse is at least 7 feet (2.1 meters).
906. The nurse is caring for an older adult who has been placed in Buck's

extension traction after a hip fracture. On assessment of the client, the nurse notes that the client is disoriented. What is the **best** nursing action based on this information?

1. Apply restraints to the client.
2. Ask the family to stay with the client.
3. Place a clock and calendar in the client's room.
4. Ask the laboratory to perform electrolyte studies.

907. The nurse is creating a plan of care for a client in skin traction. The nurse should monitor for which **priority** finding in this client?

1. Urinary incontinence
2. Signs of skin breakdown
3. The presence of bowel sounds
4. Signs of infection around the pin sites

908. The home care nurse is visiting a client who is in a body cast. While performing an assessment, the nurse plans to evaluate the psychosocial adjustment of the client to the cast. What is the **most appropriate** assessment for this client?

1. The need for sensory stimulation
2. The amount of home care support available
3. The ability to perform activities of daily living
4. The type of transportation available for follow-up care

909. What action should the nurse consider when counseling a client of the Amish tradition?

1. Speak only to the husband.
2. Use complex medical terminology.
3. Avoid using scientific or medical jargon.
4. Stand close to the client and speak loudly.

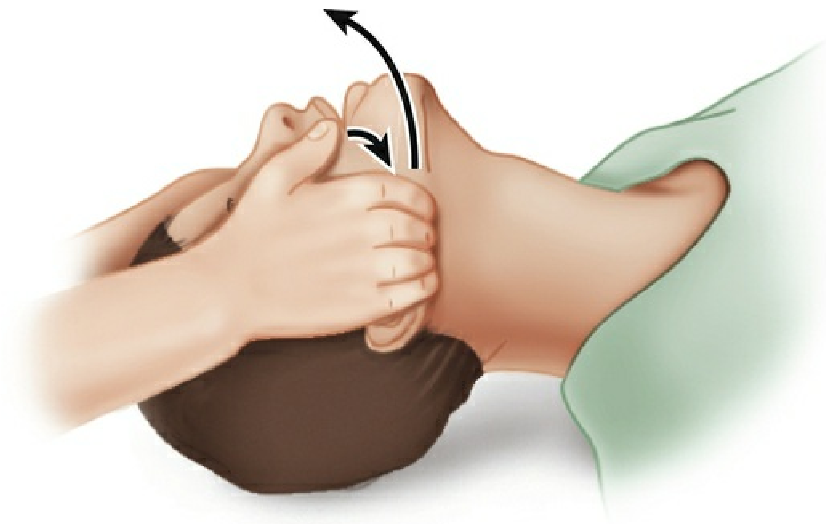
910. A client has refused to eat more than a few spoonfuls of breakfast. The primary health care provider has prescribed that tube feedings be initiated if the client fails to eat at least half of a meal because the client has lost a significant amount of weight during the previous 2 months. The nurse enters the room, looks at the tray, and states, "If you don't eat any more than that, I'm going to have to put a tube down your throat and get a feeding in that way." The client begins crying and tries to eat more. Based on the nurse's actions, the nurse may be accused of which violation?

1. Assault
2. Battery
3. Slander
4. Invasion of privacy

911. When creating an assignment for a team consisting of a registered nurse (RN), 1 licensed practical nurse (LPN), and 2 assistive personnel (AP), which is the **best** client for the LPN?

1. A client requiring frequent temperature checks
2. A client requiring assistance with ambulation every 4 hours
3. A client on a mechanical ventilator requiring frequent assessment and suctioning
4. A client with a spinal cord injury requiring urinary catheterization every 6 hours

912. To perform cardiopulmonary resuscitation (CPR), the nurse should use the method pictured to open the airway in which situation? **Refer to figure.**



1. If neck trauma is suspected
2. In all situations requiring CPR
3. If the client has a history of seizures
4. If the client has a history of headaches

913. The nurse teaches skin care to a client receiving external radiation therapy. Which client statement indicates the **need for further instruction**?

1. "I will handle the area gently."
2. "I will wear loose-fitting clothing."
3. "I will avoid the use of deodorants."
4. "I will limit sun exposure to 1 hour daily."

914. The primary health care provider's prescription reads levothyroxine, 150 mcg orally daily. The medication label reads levothyroxine, 0.1 mg per tablet. The nurse should administer how many tablet(s) to the client? **Fill in the blank.**

Answer: _____ tablet(s)

915. Metformin is prescribed for a client with type 2 diabetes mellitus. What is the **most** common side effect that the nurse should include in the client's teaching plan?

1. Weight gain
2. Hypoglycemia
3. Flushing and palpitations
4. Gastrointestinal disturbances

916. Which nursing actions apply to the care of a child who is having a seizure? **Select all that apply.**

☐ 1. Time the seizure.

☐ 2. Restrain the child.

- [ ] 3. Stay with the child.
- [ ] 4. Insert an oral airway.
- [ ] 5. Loosen clothing around the child's neck.
- [ ] 6. Place the child in a lateral side-lying position.

917. The nurse is conducting an interview of an older client and is concerned about the possibility of benign prostatic hyperplasia (BPH). Which are characteristics of this disorder? **Select all that apply.**

- [ ] 1. Nocturia
- [ ] 2. Incontinence
- [ ] 3. Enlarged prostate
- [ ] 4. Nocturnal emissions
- [ ] 5. Decreased desire for sexual intercourse

918. The nursing instructor asks a nursing student to identify the priorities of care for an assigned client. Which statement indicates that the student correctly identifies the **priority** client needs?

1. Actual or life-threatening concerns
2. Completing care in a reasonable time frame
3. Time constraints related to the client's needs
4. Obtaining needed supplies to care for the client

919. A client arrives at the clinic complaining of fatigue, lack of energy, constipation, and depression. Hypothyroidism is diagnosed, and levothyroxine is prescribed. What is an expected outcome of the medication?

1. Alleviate depression
2. Increase energy levels
3. Increase blood glucose levels
4. Achieve normal thyroid hormone levels

920. The community health nurse is creating a poster for an educational session for a group of women and will be discussing the risk factors associated with breast cancer. Which risk factors for breast cancer should the nurse list on the poster? **Select all that apply.**

- [ ] 1. Multiparity
- [ ] 2. Early menarche
- [ ] 3. Early menopause
- [ ] 4. Family history of breast cancer
- [ ] 5. High-dose radiation exposure to chest
- [ ] 6. Previous cancer of the breast, uterus, or ovaries

921. The nurse is caring for a client with acute pancreatitis and is monitoring the client for paralytic ileus. Which piece of assessment data should alert the nurse to this occurrence?

1. Inability to pass flatus
2. Loss of anal sphincter control
3. Severe, constant pain with rapid onset
4. Firm, nontender mass palpable at the lower right costal margin

922. The nurse inspects the color of the drainage from a nasogastric tube on a postoperative client approximately 24 hours after gastric surgery. Which finding indicates the need to notify the primary health care provider (PHCP)?
    1. Dark red drainage
    2. Dark brown drainage
    3. Green-tinged drainage
    4. Light yellowish-brown drainage
923. The nurse is preparing to discontinue a client's nasogastric tube. The client is positioned properly, and the tube has been flushed with 15 mL of air to clear secretions. Before removing the tube, the nurse should make which statement to the client?
    1. "Take a deep breath when I tell you, and hold it while I remove the tube."
    2. "Take a deep breath when I tell you, and bear down while I remove the tube."
    3. "Take a deep breath when I tell you, and slowly exhale while I remove the tube."
    4. "Take a deep breath when I tell you, and breathe normally while I remove the tube."
924. A client with a history of lung disease is at risk for developing respiratory acidosis. The nurse should assess the client for which signs and symptoms characteristic of this disorder?
    1. Bradycardia and hyperactivity
    2. Decreased respiratory rate and depth
    3. Headache, restlessness, and confusion
    4. Bradypnea, dizziness, and paresthesias
925. The nurse is caring for a client with a resolved intestinal obstruction who has a nasogastric tube in place. The primary health care provider has now prescribed that the nasogastric tube be removed. What is the **priority** nursing assessment prior to removing the tube?
    1. Checking for normal serum electrolyte levels
    2. Checking for normal pH of the gastric aspirate
    3. Checking for proper nasogastric tube placement
    4. Checking for the presence of bowel sounds in all 4 quadrants
926. The nurse has reviewed with the preoperative client the procedure for the administration of an enema. Which statement by the client would indicate the **need for further instruction?**
    1. "The enema will be given while I am sitting on the toilet."
    2. "I should try and hold the fluid as long as possible after it is run in."
    3. "I know that there will be some cramping after the enema solution is run in."
    4. "I should tell the nurse if cramping occurs when the fluid is

running in."

927. A client experiencing a great deal of stress and anxiety is being taught to use self-control therapy. Which statement by the client indicates a **need for further teaching** about the therapy?
    1. "This form of therapy can be applied to new situations."
    2. "An advantage of this technique is that change is likely to last."
    3. "Talking to oneself is a basic component of this form of therapy."
    4. "This form of therapy provides a negative reinforcement when the stimulus is produced."

928. The nurse is preparing a list of home care instructions regarding stoma and laryngectomy care for a client with laryngeal cancer who had a laryngectomy. Which instructions should be included in the list? **Select all that apply.**
    - ☐ 1. Restrict fluid intake.
    - ☐ 2. Obtain a MedicAlert bracelet.
    - ☐ 3. Keep the humidity in the home low.
    - ☐ 4. Prevent debris from entering the stoma.
    - ☐ 5. Avoid exposure to people with infections.
    - ☐ 6. Avoid swimming and use care when showering.

929. The primary health care provider prescribes 2000 mL of 5% dextrose and half-normal saline to infuse over 24 hours. The drop factor is 15 drops (gtt)/mL. The nurse should set the flow rate at how many drops per minute? **Fill in the blank. Record your answer to the nearest whole number.**

    Answer: _____ gtt/minute

930. A client is returned to the nursing unit after thoracic surgery with chest tubes in place. During the first few hours postoperatively, what type of drainage should the nurse expect?
    1. Serous
    2. Bloody
    3. Serosanguineous
    4. Bloody, with frequent small clots

931. A client has had radical neck dissection and begins to hemorrhage at the incision site. The nurse should take which actions in this situation? **Select all that apply.**
    - ☐ 1. Monitor vital signs.
    - ☐ 2. Monitor the client's airway.
    - ☐ 3. Apply manual pressure over the site.
    - ☐ 4. Lower the head of the bed to a flat position.
    - ☐ 5. Call the primary health care provider (PHCP) immediately.

932. A sexually active young adult client has developed viral hepatitis. Which client statement indicates the **need for further teaching**?
    1. "I should avoid drinking alcohol."

2. “I can go back to work right away.”
3. “My partner should get the vaccine.”
4. “A condom should be used for sexual intercourse.”

933. The nurse should include which interventions in the plan of care for a client with hypothyroidism? **Select all that apply.**

- ☐ 1. Provide a cool environment for the client.
- ☐ 2. Instruct the client to consume a high-fat diet.
- ☐ 3. Instruct the client about thyroid replacement therapy.
- ☐ 4. Encourage the client to consume fluids and high-fiber foods in the diet.
- ☐ 5. Inform the client that iodine preparations will be prescribed to treat the disorder.
- ☐ 6. Instruct the client to contact the primary health care provider (PHCP) if episodes of chest pain occur.

934. The nurse is preparing to care for a client who will be weaned from a cuffed tracheostomy tube. The nurse is planning to use a tracheostomy plug and plans to insert it into the opening in the outer cannula. Which nursing action is required before plugging the tube?

1. Deflate the cuff on the tube.
2. Place the inner cannula into the tube.
3. Ensure that the client is able to speak.
4. Ensure that the client is able to swallow.

935. A client is diagnosed with glaucoma. Which piece of nursing assessment data identifies a risk factor associated with this eye disorder?

1. Cardiovascular disease
2. Frequent urinary tract infections
3. A history of migraine headaches
4. Frequent upper respiratory infections

936. A client with retinal detachment is admitted to the nursing unit in preparation for a repair procedure. Which prescription should the nurse anticipate?

1. Allowing bathroom privileges only
2. Elevating the head of the bed to 45 degrees
3. Wearing dark glasses to read or watch television
4. Placing an eye patch over the client’s affected eye

937. The nurse is caring for a client who is on strict bed rest and creates a plan of care with goals related to the prevention of deep vein thrombosis and pulmonary emboli. Which nursing action is **most** helpful in preventing these disorders from developing?

1. Restricting fluids
2. Placing a pillow under the knees
3. Encouraging active range-of-motion exercises
4. Applying a heating pad to the lower extremities

938. The nurse is caring for a client who is at risk for suicide. What is the **priority**

nursing action for this client?

1. Provide authority, action, and participation.
2. Display an attitude of detachment, confrontation, and efficiency.
3. Demonstrate confidence in the client's ability to deal with stressors.
4. Provide hope and reassurance that the problems will resolve themselves.

939. A client with tuberculosis whose status is being monitored in an ambulatory care clinic asks the nurse when it is permissible to return to work. What factor should the nurse include when responding to the client?

1. Five blood cultures are negative.
2. Three sputum cultures are negative.
3. A blood culture and a chest x-ray are negative.
4. A sputum culture and a tuberculin skin test are negative.

940. A client comes to the emergency department after an assault and is extremely agitated, trembling, and hyperventilating. What is the **priority** nursing action for this client?

1. Begin to teach relaxation techniques.
2. Encourage the client to discuss the assault.
3. Remain with the client until the anxiety decreases.
4. Place the client in a quiet room alone to decrease stimulation.

941. The nurse is caring for a client admitted to the hospital with a suspected diagnosis of acute appendicitis. Which laboratory result should the nurse expect to note if the client does have appendicitis?

1. Leukopenia with a shift to the left
2. Leukocytosis with a shift to the left
3. Leukopenia with a shift to the right
4. Leukocytosis with a shift to the right

942. The nurse is creating a plan of care for a client who was experiencing anxiety after the loss of a job. The client is now verbalizing concerns regarding the ability to meet role expectations and financial obligations. What is the **priority** nursing problem for this client?

1. Anxiety
2. Unrealistic outlook
3. Lack of ability to cope effectively
4. Disturbances in thoughts and ideas

943. The nurse is monitoring the chest tube drainage system in a client with a chest tube. The nurse notes intermittent bubbling in the water seal chamber. Which is the **most appropriate** nursing action?

1. Check for an air leak.
2. Document the findings.
3. Notify the primary health care provider.
4. Change the chest tube drainage system.

944. After performing an initial abdominal assessment on a client with nausea and vomiting, the nurse should expect to note which finding?

1. Waves of loud gurgles auscultated in all 4 quadrants
2. Low-pitched swishing auscultated in 1 or 2 quadrants
3. Relatively high-pitched clicks or gurgles auscultated in all 4

quadrants

4. Very high-pitched, loud rushes auscultated especially in 1 or 2 quadrants

945. The primary health care provider prescribes erythromycin suspension 800 mg by mouth. After reconstitution, how many milliliters should the nurse pour into the medicine cup to deliver the prescribed dose? **Refer to figure. Fill in the blank.**

Answer: _____ mL

TO PATIENT:
Shake well before using.
Keep tightly closed. Store in refrigerator and discard unused portion after ten days. Oversize bottle provides shake space.
TO THE PHARMACIST:
When prepared as directed, each 5 mL teaspoonful contains erythromycin ethylsuccinate equivalent to 200 mg of erythromycin in a cherry-flavored suspension.
Bottle contains erythromycin ethylsuccinate equivalent to 8 g of erythromycin.
Usual Dose: See package outsert.
Store at room temperature in dry form.
Child-Resistant closure not required; Reference: Federal Register Vol.39 No.29.
DIRECTIONS FOR PREPARATION: Slowly add 140 mL of water and shake vigorously to make 200 mL of suspension.
BARR LABORATORIES, INC.
Pomona, NY 10970
R11-90

BARR LABORATORIES, INC.
Erythromycin Ethylsuccinate for Oral Suspension, USP
200 mg of erythromycin activity per 5 mL reconstituted
Caution: Federal law prohibits dispensing without prescription.
200 mL (when mixed)

NDC 0555-0215-23
NSN 6505-00-080-0653
3 0555-0215-23 3
SAMPLE
Exp. Date:
Lot No.:

(Brown, Mulholland, 2012.)

Answers

871. ***Answer:*** 3

Rationale: Whenever an abused client remains in the abusive environment, priority must be placed on ascertaining whether the client is in any immediate danger. If so, emergency action must be taken to remove the client from the abusing situation. Options 1, 2, and 4 may be appropriate interventions but are not the priority.

Test-Taking Strategy: Note the **strategic word**, *priority*. Use **Maslow's Hierarchy of Needs theory**, remembering that if a physiological need is not present, safety is the priority. This will direct you to the correct option, the only one that directly addresses client safety.

Level of Cognitive Ability: Applying

Client Needs: Safe and Effective Care Environment

Integrated Process: Nursing Process—Planning

Content Area: Mental Health

Health Problem: Mental Health: Abusive behaviors

Priority Concepts: Interpersonal Violence; Safety

Reference: Varcarolis (2017), p. 343.

872. ***Answer:*** 4

Rationale: Mania is a mood characterized by excitement, euphoria, hyperactivity, excessive energy, decreased need for sleep, and impaired ability to concentrate or complete a single train of thought. The client's mood is predominantly elevated, expansive, or irritable. All of the options reflect a client's possible symptoms. However, the correct option clearly presents a problem that compromises physiological integrity and needs to be addressed immediately.

Test-Taking Strategy: Note the **strategic word**, *immediate*, and use **Maslow's Hierarchy of Needs theory** to assist you in answering the question. The correct option is the only one that reflects a physiological need.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Mental Health
Health Problem: Mental Health: Mood disorders
Priority Concepts: Psychosis; Safety
Reference: Varcarolis (2017), pp. 227, 229.

873. ***Answer:*** 3

Rationale: Clients who are admitted involuntarily to a mental health unit do not lose their right to informed consent. Clients must be considered legally competent until they have been declared incompetent through a legal proceeding. The best determination for the nurse to make is to obtain the informed consent from the client.

Test-Taking Strategy: Focus on the **subject**, informed consent for an involuntarily admitted client, and note the **strategic word**, *best.* Knowledge regarding the hospital admission processes and client's rights will direct you to the correct option.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Leadership/Management: Ethical/Legal
Health Problem: Mental Health: Mood disorders
Priority Concepts: Ethics; Health Care Law
Reference: Varcarolis (2017), p. 63.

874. ***Answer:*** 3

Rationale: Glucagon is used to treat hypoglycemia resulting from insulin overdose. The family of the client is instructed in how to administer the medication. In an unconscious client, arousal usually occurs within 20 minutes of glucagon injection. When consciousness has been regained, oral carbohydrates should be given. Lipoatrophy and lipohypertrophy result from insulin injections.

Test-Taking Strategy: Focus on the **subject**, the purpose of glucagon. Also note the **strategic word**, *best*. Noting the word glucagon will assist you in determining that the medication contains some form of glucose. This relationship will direct you

to the correct option.

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Teaching and Learning

Content Area: Adult Health: Endocrine

Health Problem: Adult Health: Endocrine: Diabetes mellitus

Priority Concepts: Client Education; Glucose Regulation

Reference: Ignatavicius, Workman, Rebar (2018), pp. 1281, 1310.

875. ***Answer:*** 3

Rationale: In the Puerto Rican–American culture, loud crying and other physical manifestations of grief are considered socially acceptable. Of the options provided, the correct option is the only one that identifies a culturally sensitive approach on the part of the nurse. Options 1, 2, and 4 are inappropriate nursing interventions.

Test-Taking Strategy: Note the **strategic words**, *most appropriate.* Focus on the clients of the question, the family members. Use therapeutic nursing interventions, recalling the characteristics of the culture and the importance of cultural sensitivity. This will direct you to the correct option.

Level of Cognitive Ability: Applying

Client Needs: Psychosocial Integrity

Integrated Process: Culture and Spirituality

Content Area: Foundations of Care: Spirituality, culture, ethnicity

Health Problem: Mental Health: Grief/Loss

Priority Concepts: Culture; Family Dynamics

Reference: Lewis et al. (2017), pp. 25, 30.

876. ***Answer:*** 1

Rationale: The priority nursing action is to assess the vital signs. This would provide information about the amount of blood loss that has occurred and provide a baseline by which to monitor the progress of treatment. The client may be unable to provide subjective data until the immediate physical needs are met. Although an abdominal examination and an assessment of the precipitating events may be necessary, these actions are not the priority. Insertion of a nasogastric tube is not the priority and will require a primary health care provider's prescription; in addition, the vital signs should be checked before performing this procedure.

Test-Taking Strategy: Note the **strategic word**, *priority*, and use the **ABCs—airway, breathing, circulation**. This will direct you to the correct option.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Implementation

Content Area: Complex Care: Emergency Situations/Management

Health Problem: Adult Health: Gastrointestinal: Upper GI disorders

Priority Concepts: Care Coordination; Clinical Judgment

Reference: Lewis et al. (2017), p. 924.

877. *Answer:* 1

Rationale: The clinical picture of dementia ranges from mild cognitive deficits to severe, life-threatening alterations in neurological functioning. For the client to use confabulation or the fabrication of events or experiences to fill in memory gaps is not unusual. Often, lack of inhibitions on the part of the client may constitute the first indication of something being "wrong" to the client's significant others (e.g., the client may undress in front of others, or the formerly well-mannered client may exhibit slovenly table manners). As the dementia progresses, the client will have difficulty sleeping and episodes of wandering or sundowning.

Test-Taking Strategy: Focus on the client's diagnosis and note the **subject**, a manifestation of dementia. Think about the characteristics of dementia to direct you to the correct option.

Level of Cognitive Ability: Analyzing

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process—Assessment

Content Area: Mental Health

Health Problem: Mental Health: Neurocognitive impairment

Priority Concepts: Cognition; Coping

Reference: Ignatavicius, Workman, Rebar (2018), pp. 860-861.

878. *Answer:* 3

Rationale: Clients with anorexia nervosa have the desire to please others. Their need to be correct or perfect interferes with rational decision-making processes. These clients are moralistic. Rules and rituals help these clients manage their anxiety.

Test-Taking Strategy: Focus on the **subject**, managing anxiety. Eliminate options 2 and 4 because of the **closed-ended word** "always." Option 1 is not characteristic of a client with anorexia.

Level of Cognitive Ability: Analyzing

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process—Assessment

Content Area: Mental Health

Health Problem: Mental Health: Eating disorders

Priority Concepts: Anxiety; Coping

Reference: Lewis et al. (2017), pp. 871-872.

879. *Answer:* 3

Rationale: Iron is needed to allow for transfer of adequate iron to the fetus and to permit expansion of the maternal red blood cell mass. During pregnancy, the relative excess of plasma causes a decrease in the hemoglobin concentration and hematocrit, known as *physiological anemia of pregnancy*. This is a normal adaptation during pregnancy. Iron is best absorbed if taken on an empty stomach. Taking it with a fluid high in ascorbic acid such as tomato juice enhances absorption. Iron supplements usually cause constipation. Meats are an excellent source of iron. The client needs to take the iron supplements regardless of food intake.

Test-Taking Strategy: Note the **subject**, iron supplementation during pregnancy. Focus on the words *understanding of the instructions*. Knowledge of basic principles related to nutrition during pregnancy will assist in eliminating options 2 and 4. From the remaining options, remember that iron causes constipation.
Level of Cognitive Ability: Evaluating
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Evaluation
Content Area: Maternity: Antepartum
Health Problem: Adult Health: Gastrointestinal: Nutrition Problems
Priority Concepts: Client Education; Nutrition
Reference: McKinney et al. (2018), p. 266.

880. ***Answer:*** 3

Rationale: Levothyroxine accelerates the degradation of vitamin K–dependent clotting factors. As a result, the effects of warfarin are enhanced. If thyroid hormone replacement therapy is instituted in a client who has been taking warfarin, the dosage of warfarin should be reduced.
Test-Taking Strategy: Focus on the **subject**, the use of levothyroxine concurrently with warfarin. Recalling that levothyroxine enhances the effects of warfarin will direct you to the correct option.
Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Analysis
Content Area: Pharmacology: Endocrine Medications: Thyroid hormones
Health Problem: Adult Health: Endocrine: Thyroid disorders
Priority Concepts: Collaboration; Safety
Reference: Hodgson, Kizior (2018), pp. 674-675.

881. ***Answer:*** 1, 2, 4

Rationale: The client should use the positions outlined in options 1, 2, and 4. These allow for maximal chest expansion. The client should not lie on the back because this reduces movement of a large area of the client's chest wall. Sitting is better than standing, whenever possible. If no chair is available, leaning against a wall while standing allows accessory muscles to be used for breathing and not posture control.
Test-Taking Strategy: Focus on the **subject**, the positions that could alleviate dyspnea. Remember that upright positions are best. Also, note that options 1, 2, and 4 are **comparable or alike** in that they all address upright positions.
Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Adult Health: Respiratory
Health Problem: Adult Health: Respiratory: Obstructive pulmonary disease
Priority Concepts: Client Education; Gas Exchange
Reference: Ignatavicius, Workman, Rebar (2018), pp. 546, 578.

882. ***Answer:*** 4

Rationale: A client undergoing lumbar puncture is positioned lying on the side, with the legs pulled up to the abdomen and the head bent down onto the chest. This position helps open the spaces between the vertebrae and allows for easier needle insertion by the primary health care provider. The nurse remains with the client during the procedure to help the client maintain this position. The other options identify incorrect positions for this procedure.

Test-Taking Strategy: Focus on the **subject**, lumbar puncture. Recalling that a lumbar puncture is the introduction of a needle into the subarachnoid space will direct you to the correct option. It is reasonable that the position of the client must facilitate this, and the correct option is the only position that flexes the vertebrae and widens the spaces between them.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Foundations of Care: Diagnostic Tests
Health Problem: N/A
Priority Concepts: Intracranial Regulation; Safety
Reference: Ignatavicius, Workman, Rebar (2018), p. 855.

883. ***Answer:*** 1, 2, 5

Rationale: Maintaining effective and open communication among family members affected by death and grief is of the greatest importance. Option 1 describes encouraging discussion of feelings and is likely to enhance communication. Option 2 is also an effective intervention because spiritual practices give meaning to life and have an impact on how people react to crisis. Option 5 is also an effective technique because the client and family need to know that someone will be there who is supportive and nonjudgmental. The remaining options describe the nurse removing autonomy and decision making from the client and family, who are already experiencing feelings of loss of control in that they cannot change the process of dying. These are ineffective interventions that could impair communication further.

Test-Taking Strategy: Focus on the **subject**, the interventions that will facilitate effective communication. Use of **therapeutic communication techniques** and focusing on the **subject** will assist you in answering correctly. The incorrect options remove control from the client and family.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Caring
Content Area: Developmental Stages: End-of-Life Care
Health Problem: Mental Health: Grief/Loss
Priority Concepts: Caregiving; Family Dynamics
Reference: Potter et al. (2017), pp. 763-764.

884. ***Answer:*** 3

Rationale: Feelings of low self-esteem and worthlessness are common symptoms of a depressed client. An effective plan of care to enhance the client's personal self-esteem is to provide experiences for the client that are challenging but that will not be met with failure. Reminders of the client's past accomplishments or personal successes are ways to interrupt the client's negative self-talk and distorted cognitive view of self. Options 1 and 2 give advice and devalue the client's feelings. Silence may be interpreted as agreement.

Test-Taking Strategy: Use **therapeutic communication techniques** and focus on the client's diagnosis. You can eliminate options 1 and 2 easily because they are nontherapeutic. From the remaining options, focusing on the client's diagnosis will direct you to the correct option.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Mental Health
Health Problem: Mental Health: Mood disorders
Priority Concepts: Caregiving; Mood and Affect
Reference: Varcarolis (2017), pp. 207-208.

885. ***Answer:*** 1, 2, 3

Rationale: Use of proper positions promotes venous drainage from the cranium to keep intracranial pressure from elevating. The head of the client at risk for or with increased intracranial pressure should be positioned so that it is in a neutral, midline position. The head of the bed should be raised to 30 to 45 degrees. The nurse should avoid flexing or extending the client's neck or turning the client's head from side to side.

Test-Taking Strategy: Focus on the **subject**, care of the client with increased intracranial pressure. Visualize each of the positions identified in the options and identify those that will promote venous drainage from the cranium.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Adult Health: Neurological
Health Problem: Adult Health: Neurological: Head injury/trauma
Priority Concepts: Intracranial Regulation; Safety
Reference: Ignatavicius, Workman, Rebar (2018), p. 947.

886. ***Answer:*** 3

Rationale: The normal pH is 7.35 to 7.45. Normal $PaCO_2$ is 35 to 45 mm Hg. In respiratory acidosis, the pH is low and $PaCO_2$ is elevated. Options 1, 2, and 4 are incorrect interpretations of the values identified in the question.

Test-Taking Strategy: Focus on the **subject**, interpretation of arterial blood gas levels. Remember that in a respiratory imbalance you will find an opposite response between the pH and $PaCO_2$. Also, remember that the pH is low in an acidotic condition. Recalling this information will allow you to eliminate each of the incorrect

options.
Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Analysis
Content Area: Foundations of Care: Acid–base
Health Problem: Adult Health: Respiratory: Obstructive Pulmonary Disease
Priority Concepts: Acid–base Balance; Clinical Judgment
Reference: Lewis et al. (2017), pp. 291, 457.

887. ***Answer:*** 1

Rationale: The client's operative arm should be positioned so that it is elevated on a pillow and not exceeding shoulder elevation. This position promotes optimal drainage from the limb, without impairing the circulation to the arm. If the arm is positioned flat (option 2) or dependent (option 3), this could increase the edema in the arm, which is contraindicated because of lymphatic disruption caused by surgery.
Test-Taking Strategy: Focus on the **subject**, care of the client following mastectomy. Read each option carefully and attempt to visualize the position identified in the option. Using the principles of circulation and gravity will direct you to the correct option. The correct option avoids the two extremes of height (dependent, above shoulder level) in positioning the limb affected by surgery.
Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Planning
Content Area: Adult Health: Oncology
Health Problem: Adult Health: Cancer: Breast
Priority Concepts: Perfusion; Tissue Integrity
Reference: Ignatavicius, Workman, Rebar (2018), pp. 1453-1454.

888. ***Answer:*** 4

Rationale: A client with a urinary tract infection must be encouraged to take the prescribed medication for the entire time it is prescribed. The client should also be instructed to drink at least 3000 mL of fluid each day to flush the infection from the bladder and to urinate frequently throughout the day. Foods and fluids that acidify the urine need to be encouraged.
Test-Taking Strategy: Note the **strategic words**, *need for further instruction*. These words indicate a **negative event query** and ask you to select an option that is incorrect. Recall that foods and fluids that acidify the urine should be consumed, rather than foods and fluids that cause urine alkalinity.
Level of Cognitive Ability: Evaluating
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Maternity: Postpartum
Health Problem: Adult Health: Renal and Urinary: Inflammation/Infections
Priority Concepts: Client Education; Infection

Reference: McKinney et al. (2018), p. 611.

889. *Answer:* 3

Rationale: Humulin N is an intermediate-acting insulin. The onset of action is 60 to 120 minutes, it peaks in 6 to 14 hours, and the duration of action is 16 to 24 hours. Hypoglycemic reactions most likely occur during peak time.

Test-Taking Strategy: Focus on the **subject**, characteristics of Humulin N insulin, and use knowledge regarding the onset, peak, and duration of action. Recalling that it is an intermediate-acting insulin and recalling that peak action is between 6 and 14 hours will direct you to the correct option.

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Planning

Content Area: Pharmacology: Endocrine Medications: Insulin

Health Problem: Adult Health: Endocrine: Diabetes mellitus

Priority Concepts: Glucose Regulation; Safety

Reference: Lewis et al. (2017), p. 1126.

890. *Answer:* 2

Rationale: Priority nursing care in disaster situations needs to be delivered to the living and not the dead. The victim who is bleeding badly is the priority. The bleeding could be from an arterial vessel; if the bleeding is not stopped, the victim is at risk for shock and death. The pregnant client is the next priority, but the absence of fetal movement may or may not be indicative of fetal demise. The young child is with a family member and is safe at this time. The older victim will need comfort measures; there is no information indicating she is physically hurt.

Test-Taking Strategy: Note the **strategic word**, *first*. Use **Maslow's Hierarchy of Needs theory** when answering this question. Remember that physical needs should be addressed before psychosocial needs and use the **ABCs—airway, breathing, and circulation**. Bleeding is the priority.

Level of Cognitive Ability: Synthesizing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Assessment

Content Area: Leadership/Management: Mass Causality Preparedness and Response

Health Problem: Adult Health: Cardiovascular: Shock

Priority Concepts: Care Coordination; Clinical Judgment

Reference: Lewis et al. (2017), pp. 1631-1632.

891. *Answer:* 3

Rationale: Rubella virus is spread by aerosol droplet transmission through the upper respiratory tract and has an incubation period of 14 to 21 days. The risks of maternal and subsequent fetal infection during the second trimester include hearing loss and congenital anomalies; these risks decrease after the first 12 weeks of

pregnancy. Rubella titer determination is a standard prenatal test for pregnant women during their initial screening and entry into the health care delivery system. As noted in this client's chart, she is immune to rubella. The correct option is the only option that helps clarify maternal concerns with accurate information.

Test-Taking Strategy: Note the **strategic word**, *best*, and recall knowledge regarding the transmission of rubella virus to the fetus. Also, use of **therapeutic communication techniques** will direct you to the correct option. The correct option addresses the client's concerns.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Caring
Content Area: Maternity: Antepartum
Health Problem: Maternity: Infections/Inflammations
Priority Concepts: Immunity; Safety
Reference: Lowdermilk et al. (2016), p. 166.

892. ***Answer:*** 2, 3, 5

Rationale: Breast-feeding mothers with lactose-intolerant infants need to be encouraged to limit dairy products. Milk and cheese are dairy products. Alternative calcium sources that can be consumed by the mother include egg yolk, dried beans, green leafy vegetables, cauliflower, and molasses.

Test-Taking Strategy: Focus on the **subject**, foods acceptable for a breast-feeding mother with a lactose-intolerant infant. Recall that lactose is the sugar found in dairy products. Also note that options 1 and 4 are **comparable or alike** and are dairy products.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Foundations of Care: Nutrition
Health Problem: Newborn: Newborn feeding
Priority Concepts: Client Education; Nutrition
Reference: Lowdermilk et al. (2016), pp. 352–353.

893. ***Answer:*** 1

Rationale: The nurse needs to be aware of the effective and ineffective coping mechanisms that can occur in a client when loss is anticipated. The expression of anger is known to be a normal response to impending loss, and the anger may be directed toward the self, God or other spiritual being, or caregivers. Notifying the hospital lawyer is inappropriate. Guilt may or may not be a component of the client's feelings, and the data in the question do not indicate that guilt is present.

Test-Taking Strategy: Note the **subject**, psychosocial care of a client needing amputation. Also note the **strategic word**, *best*. Note that the correct option and option 2 address coping and defense mechanisms. This provides you with the clue that one of these options may be the correct response. In addition, knowledge of the stages of grief associated with loss will direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Mental Health
Health Problem: Mental Health: Coping
Priority Concepts: Anxiety; Coping
Reference: Lewis et al. (2017), p. 133.

894. *Answer:* 3

Rationale: An autopsy is required by state law in certain circumstances, including the sudden death of a client and a death that occurs under suspicious circumstances. A client may have provided oral or written instructions regarding an autopsy after death. If an autopsy is not required by law, these oral or written requests will be granted. If no oral or written instructions were provided, state law determines who has the authority to consent for an autopsy. Most often, the decision rests with the surviving relative or next of kin.

Test-Taking Strategy: Note the **strategic words**, *most appropriate*. Use knowledge regarding the laws and issues surrounding autopsy and **therapeutic communication techniques** to answer the question. Eliminate options 2 and 4 because these statements are not completely accurate and are not therapeutic in this situation. From the remaining options, the correct option is the therapeutic and appropriate response to the family.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Caring
Content Area: Developmental Stages: End-of-Life Care
Health Problem: Mental Health: Grief/Loss
Priority Concepts: Health Care Law; Professional Identity
Reference: Potter et al. (2017), pp. 307, 765-766.

895. *Answer:* 2

Rationale: The mode of perinatal transmission of HIV to the fetus or neonate of an HIV-positive woman can occur during the prenatal, intrapartal, or postpartum period. HIV transmission can occur during breast-feeding. In the United States and most developed countries, HIV-positive clients are encouraged to bottle-feed their infants (the primary health care provider's prescription is always followed). Frequent hand washing is encouraged. Support groups and community agencies can be identified to assist the parents with the newborn infant's home care, the impact of the diagnosis of HIV infection, and available financial resources. It is recommended that infants of HIV-positive clients receive antiviral medications for the first 6 weeks of life.

Test-Taking Strategy: Note the **strategic words**, *need for further instruction*. These words indicate a **negative event query** and ask you to select an option that is incorrect. Recalling the methods of transmission of HIV and that breast-feeding is discouraged in the HIV-positive woman will direct you to the correct option.

Level of Cognitive Ability: Evaluating
Client Needs: Safe and Effective Care Environment
Integrated Process: Teaching and Learning
Content Area: Maternity: Newborn
Health Problem: Newborn: Newborn of a mother with HIV/AIDS
Priority Concepts: Client Education; Infection
Reference: McKinney et al. (2018), pp. 568-569, 940.

896. ***Answer:*** 4

Rationale: If the adolescent wears contact lenses, the adolescent should be instructed to discontinue wearing them until the infection has cleared completely. Obtaining new contact lenses would eliminate the chance of reinfection from contaminated contact lenses and would lessen the risk of a corneal ulceration.
Test-Taking Strategy: Note the **strategic words**, *need for further information*. These words indicate a **negative event query** and ask you to select an option that is incorrect. Options 1, 2, and 3 are **comparable or alike** in that they relate to avoiding the use of contact lenses during infection.
Level of Cognitive Ability: Evaluating
Client Needs: Safe and Effective Care Environment
Integrated Process: Teaching and Learning
Content Area: Pediatrics: Eye/Ear
Health Problem: Pediatric-Specific: Conjunctivitis
Priority Concepts: Client Education; Infection
Reference: McKinney et al. (2018), p. 1363.

897. ***Answer:*** 3

Rationale: An insulin vial in current use can be kept at room temperature for 1 month without significant loss of activity. Direct sunlight and heat must be avoided. Therefore, options 1, 2, and 4 are incorrect.
Test-Taking Strategy: Note the **subject**, client understanding of discharge instructions related to storage of insulin. Noting the **closed-ended words** "only" in option 1 and *all* in option 2 will assist you in eliminating these options. Recalling that direct sunlight and heat need to be avoided will assist you in eliminating option 4.
Level of Cognitive Ability: Evaluating
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Evaluation
Content Area: Pharmacology: Endocrine Medications: Insulin
Health Problem: Adult Health: Endocrine: Diabetes mellitus
Priority Concepts: Client Education; Glucose Regulation
Reference: Ignatavicius, Workman, Rebar (2018), p. 1297.

898. ***Answer:*** 4

Rationale: A trans-sphenoidal hypophysectomy is a surgical approach that uses the nasal sinuses and nose for access to the pituitary gland. Based on the location of

the surgical procedure, spinal anesthesia would not be used. In addition, the hair would not be shaved. Although ambulating is important, specific to this procedure is avoiding brushing the teeth to prevent disruption of the surgical site.

Test-Taking Strategy: Focus on the **subject**, a preoperative instruction. Consider the anatomical location and the surgical procedure itself to eliminate options 1 and 2. Although you may be tempted to select option 3, note the location of the surgery to direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Adult Health: Endocrine
Health Problem: Adult Health: Endocrine: Pituitary disorders
Priority Concepts: Safety; Tissue Integrity
Reference: Ignatavicius, Workman, Rebar (2018), p. 1249.

899. *Answer:* 4

Rationale: Fresh fruits and vegetables provide vitamins and minerals needed for healthy gums. Drinking water with meals has no direct effect on gums. Cracked wheat bread may abrade the tender gums. Eating saltine crackers can also abrade the tender gums.

Test-Taking Strategy: Focus on the **subject**, dental health during pregnancy. Eliminate options 2 and 3 first because these measures could irritate fragile gums. From the remaining options, eliminate option 1 by remembering that drinking water with meals has no direct effect on gums and does not provide needed vitamins and minerals.

Level of Cognitive Ability: Evaluating
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Evaluation
Content Area: Maternity: Antepartum
Health Problem: Adult Health: Hematological: Bleeding/clotting disorders
Priority Concepts: Client Education; Nutrition
Reference: Lowdermilk et al. (2016), p. 320.

900. *Answer:* 3

Rationale: Radiation therapy is usually delayed until a child is 8 years old, whenever possible, to prevent retardation of bone growth and soft tissue development. Options 1, 2, and 4 are inappropriate responses to the mother and place the mother's question on hold.

Test-Taking Strategy: Note the **strategic word**, *best.* Also, note the **subject**, effects of radiation therapy, and the age of the child. In addition, use **therapeutic communication techniques** and knowledge regarding the effects of radiation to answer this question. Options 1, 2, and 4 are nontherapeutic and place the mother's inquiry on hold. Also use the child's age as a guide in directing you to the correct option.

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Pediatrics: Oncological
Health Problem: Pediatric-Specific: Cancers
Priority Concepts: Development; Safety
Reference: McKinney et al. (2018), pp. 1146-1147.

901. ***Answer:*** 2

Rationale: A fresh colostomy stoma would be red and edematous, but this would decrease with time. The colostomy site then becomes pink without evidence of abnormal drainage, swelling, or skin breakdown. The nurse should document these findings, because this is a normal expectation. Options 1, 3, and 4 are inappropriate and unnecessary interventions.
Test-Taking Strategy: Focus on the **subject**, postoperative colostomy assessment. Note the words *returns from surgery*. The nurse should expect redness and edema at this time.
Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Pediatrics: Gastrointestinal
Health Problem: Pediatric-Specific: Gastrointestinal and Rectal problems
Priority Concepts: Clinical Judgment; Tissue Integrity
Reference: Perry et al. (2018), pp. 933, 938.

902. ***Answer:*** 3

Rationale: Low or oddly placed ears are associated with various congenital defects and should be reported immediately. Although the findings should be documented, the most appropriate action would be to notify the primary health care provider. Options 2 and 4 are inaccurate and inappropriate nursing actions.
Test-Taking Strategy: Note the **strategic words**, *most appropriate.* Focus on the **subject**, normal assessment findings in a newborn. Use knowledge regarding the normal assessment findings in a newborn infant to answer this question. Recalling that low-set ears are an abnormal finding will direct you to the correct option.
Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Maternity: Newborn
Health Problem: Pediatric-Specific: Disorders of prenatal development
Priority Concepts: Clinical Judgment; Development
Reference: McKinney et al. (2018), p. 437.

903. ***Answer:*** 1

Rationale: Jaundice, if present, is best assessed in the sclera, nail beds, and mucous membranes. Generalized jaundice appears in the skin throughout the body.

Option 4 is an inappropriate area to assess for the presence of jaundice.

Test-Taking Strategy: Note the **strategic word**, *best*. Options 2 and 3 can be eliminated first, because jaundice present in the skin is known as generalized jaundice. From the remaining options, recalling that skin discoloration can best be assessed in the nail beds will direct you to the correct option.

Level of Cognitive Ability: Analyzing

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process—Assessment

Content Area: Pediatrics: Gastrointestinal

Health Problem: Pediatric-Specific: Hepatitis

Priority Concepts: Clinical Judgment; Development

Reference: Hockenberry, Wilson, Rodgers (2017), pp. 89, 719.

904. ***Answer:*** 2

Rationale: To achieve proper traction, weights need to be free-hanging, with knots kept away from the pulleys. Weights should not be kept resting on a firm surface. The head of the bed is usually kept low to provide countertraction.

Test-Taking Strategy: Focus on the **subject**, care for a client in traction. Attempt to visualize the traction, recalling that there must be weight to exert the pull from the traction setup. This concept will assist in eliminating options 1 and 4. Recalling that countertraction is needed will assist in eliminating option 3.

Level of Cognitive Ability: Creating

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Planning

Content Area: Adult Health: Musculoskeletal

Health Problem: Adult Health: Musculoskeletal: Skeletal injury

Priority Concepts: Mobility; Safety

Reference: Ignatavicius, Workman, Rebar (2018), pp. 1040-1041.

905. ***Answer:*** 1, 2, 4

Rationale: When preparing the physical environment for an interview, the nurse should set the room temperature at a comfortable level. The nurse should provide sufficient lighting for the client and nurse to see each other. The nurse should avoid having the client face a strong light because the client would have to squint into the full light. Distracting objects and equipment should be removed from the interview area. The nurse should arrange seating so that the nurse and client are seated comfortably at eye level, and the nurse avoids facing the client across a desk or table, because this creates a barrier. The distance between the nurse and the client should be set by the nurse at 4 to 5 feet (1.2 to 1.5 meters). If the nurse places the client any closer, the nurse will be invading the client's private space and may create anxiety in the client. If the nurse places the client farther away, the nurse may be seen as distant and aloof by the client.

Test-Taking Strategy: Focus on the **subject**, interviewing techniques. Read each intervention carefully and think about a conducive environment. Use the guidelines for preparing the physical environment for conducting an interview to select the

appropriate interventions.

Level of Cognitive Ability: Analyzing
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process: Planning
Content Area: Health Assessment/Physical Exam: Health History
Health Problem: N/A
Priority Concepts: Communication; Health Promotion
Reference: Jarvis (2016), pp. 29–30.

906. ***Answer:*** 3

Rationale: An inactive older adult may become disoriented because of lack of sensory stimulation. The most appropriate nursing intervention would be to reorient the client frequently and to place objects such as a clock and a calendar in the client's room to maintain orientation. Restraints may cause further disorientation and should not be applied unless specifically prescribed; agency policies and procedures should be followed before the application of restraints. The family can assist with orientation of the client, but it is inappropriate to ask the family to stay with the client. It is not within the scope of nursing practice to prescribe laboratory studies.

Test-Taking Strategy: Note the **strategic word**, *best*, and eliminate option 4 first because it is not within the realm of nursing practice to prescribe laboratory studies. Next, eliminate option 1 because restraints may add to the disorientation that the client is experiencing. It is inappropriate to place the responsibility of the client on the family, so eliminate option 2. Also, note the relationship between the words *disoriented* in the question and the implications of reorientation in the correct option.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Adult Health: Musculoskeletal
Health Problem: Adult Health: Musculoskeletal: Skeletal injury
Priority Concepts: Cognition; Sensory Perception
Reference: Ignatavicius, Workman, Rebar (2018), pp. 26, 864-865.

907. ***Answer:*** 2

Rationale: Skin traction is achieved by Ace wraps, boots, or slings that apply a direct force on the client's skin. Traction is maintained with 5 to 8 lb (2.3 to 3.6 kg) of weight, and this type of traction can cause skin breakdown. Urinary incontinence is not related to the use of skin traction. Although constipation can occur as a result of immobility and monitoring bowel sounds may be a component of the assessment, this intervention is not the priority assessment. There are no pin sites with skin traction.

Test-Taking Strategy: Note the **strategic word**, *priority*. Eliminate option 4 first because there are no pin sites with skin traction. Visualizing the traction setup and knowledge of the complications associated with this type of traction will direct you to the correct option.

Level of Cognitive Ability: Creating

Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Adult Health: Musculoskeletal
Health Problem: Adult Health: Musculoskeletal: Skeletal injury
Priority Concepts: Mobility; Tissue Integrity
Reference: Lewis et al. (2017), pp. 1470-1471.

908. ***Answer:*** 1

Rationale: A psychosocial assessment of a client who is immobilized would most appropriately include the need for sensory stimulation. This assessment should also include such factors as body image, past and present coping skills, and coping methods used during the period of immobilization. Although home care support, the ability to perform activities of daily living, and transportation are components of an assessment, they are not as specifically related to psychosocial adjustment as is the need for sensory stimulation.

Test-Taking Strategy: Focus on the **strategic words**, *most appropriate*, and note the **subject**, psychosocial adjustment. Option 3 can be eliminated first because it relates to physiological integrity rather than psychosocial integrity. Next, eliminate options 2 and 4 because they are most closely related to physical supports, rather than psychosocial needs of the client.
Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Adult Health: Musculoskeletal
Health Problem: Adult Health: Musculoskeletal: Skeletal Injury
Priority Concepts: Mobility; Sensory Perception
Reference: Lewis et al. (2017), pp. 1430, 1477.

909. ***Answer:*** 3

Rationale: Complex scientific or medical terminology should be avoided when counseling an Amish client (or any client). When counseling a female Amish client, most often the husband and wife will want to discuss health care options together. Standing close and speaking loudly is inappropriate in most counseling situations.

Test-Taking Strategy: Use knowledge of the Amish society and **therapeutic communication techniques** to answer this question. Options 2 and 4 can be eliminated first because option 4 is inappropriate and option 2 is not a therapeutic intervention. In addition, note that options 2 and 3 are opposite, which may indicate that one of these options is correct. Option 1 can be eliminated because of Amish cultural habits.
Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Culture and Spirituality
Content Area: Foundations of Care: Spirituality, Culture, and Ethnicity
Health Problem: N/A
Priority Concepts: Communication; Culture

Reference: Lewis et al. (2017), p. 26.

910. ***Answer:*** 1

Rationale: Assault occurs when a person puts another person in fear of harmful or offensive contact and the victim fears and believes that harm will result from the threat. In this situation, the nurse could be accused of the tort of assault. Battery is the intentional touching of another's body without the person's consent. Slander is verbal communication that is false and harms the reputation of another. Invasion of privacy is committed when the nurse intrudes into the client's personal affairs or violates confidentiality.

Test-Taking Strategy: Note the **subject**, legal implications for nursing care. Focusing on the words used by the nurse and noting that the nurse threatens the client will direct you to the correct option.

Level of Cognitive Ability: Applying

Client Needs: Safe and Effective Care Environment

Integrated Process: Nursing Process—Implementation

Content Area: Leadership/Management: Ethical/Legal

Health Problem: N/A

Priority Concepts: Ethics; Health Care Law

Reference: Potter et al. (2017), p. 308.

911. ***Answer:*** 4

Rationale: When creating nursing assignments, the nurse needs to consider the skills and educational level of the nursing staff. Frequent temperature checks and ambulation can most appropriately be provided by the AP, considering the clients identified in each option. The client on the mechanical ventilator requiring frequent assessment and suctioning should most appropriately be cared for by the RN. The LPN is skilled in urinary catheterization, so the client in option 4 would be assigned to this staff member.

Test-Taking Strategy: Note the **strategic word**, *best*; focus on the **subject**, the principles related to delegation and assignments; and consider the education and job position as described by the Nurse Practice Act and employee guidelines. Note the word *assessment* in option 3. This should alert you that this client should be assigned to the RN. Options 1 and 2 can be eliminated because an AP can perform these tasks.

Level of Cognitive Ability: Creating

Client Needs: Safe and Effective Care Environment

Integrated Process: Nursing Process—Planning

Content Area: Leadership/Management: Delegating/Supervising

Health Problem: N/A

Priority Concepts: Care Coordination; Safety

Reference: Lewis et al. (2017), pp. 11-12.

912. ***Answer:*** 1

Rationale: The jaw thrust without the head tilt maneuver is used when head or

neck trauma is suspected. This maneuver opens the airway while maintaining proper head and neck alignment, reducing the risk of further damage to the neck. Options 2, 3, and 4 are incorrect. In addition, it is unlikely that the nurse would be able to obtain data about the client's history.

Test-Taking Strategy: Focus on the figure and note that it is a jaw thrust maneuver. Eliminate option 2 because of the **closed-ended word** "all." Noting that the client requires CPR and that the figure illustrates that the client's neck remains stable will assist in eliminating options 3 and 4.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Implementation

Content Area: Complex Care: Basic Life Support/Cardiopulmonary Resuscitation/Cardiac Arrest

Health Problem: N/A

Priority Concepts: Gas Exchange; Safety

Reference: Lewis et al. (2017), pp. 1630, 1650-1651.

913. ***Answer:*** 4

Rationale: The client needs to be instructed to avoid exposure to the sun. Because of the risk of altered skin integrity, options 1, 2, and 3 are accurate measures in the care of a client receiving external radiation therapy.

Test-Taking Strategy: Note the **strategic words**, *need for further instruction.* These words indicate a **negative event query** and ask you to select an option that is an incorrect statement. Eliminate option 1 because of the word *gently* and option 2 because of the word *loose.* From the remaining options, recalling that sun exposure is to be avoided will assist in answering the question.

Level of Cognitive Ability: Evaluating

Client Needs: Physiological Integrity

Integrated Process: Teaching and Learning

Content Area: Adult Health: Oncology

Health Problem: N/A

Priority Concepts: Client Education; Tissue Integrity

Reference: Ignatavicius, Workman, Rebar (2018), p. 390.

914. ***Answer:*** 1.5

Rationale: It is necessary to convert 150 mcg to mg. In the metric system, to convert smaller to larger, divide by 1000 or move the decimal 3 places to the left: 150 mcg = 0.15 mg. Next, use the formula to calculate the correct dose.

Formula:

$$\frac{\text{Desired}}{\text{Available}} \times \text{Quantity} = \text{tablet (s)}$$

$$\frac{0.15\text{ mg}}{0.1\text{ mg}}\times 1\text{ tablet}=1.5\text{ tablets}$$

Test-Taking Strategy: Focus on the **subject**, a medication calculation problem. In this medication calculation problem, it is necessary first to convert micrograms to milligrams. Next, use the formula to calculate the correct dose. Recheck your work using a calculator, and make sure that the answer makes sense.

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Implementation

Content Area: Skills: Dosage Calculations

Health Problem: Adult Health: Endocrine: Thyroid Disorders

Priority Concepts: Clinical Judgment; Safety

Reference: Potter et al. (2017), pp. 327-329.

915. ***Answer:*** 4

Rationale: The most common side effect of metformin is gastrointestinal disturbances, including decreased appetite, nausea, and diarrhea. These generally subside over time. This medication does not cause weight gain; clients lose an average of 7 to 8 lb (3.2 to 3.6 kg) because the medication causes nausea and decreased appetite. Although hypoglycemia can occur, it is not the most common side effect. Flushing and palpitations are not specifically associated with this medication.

Test-Taking Strategy: Note the **strategic word**, *most*. To answer correctly, it is necessary to recall that the most common side effect of metformin is gastrointestinal disturbances.

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Teaching and Learning

Content Area: Pharmacology: Endocrine Medications: Oral hypoglycemics

Health Problem: Adult Health: Endocrine: Diabetes mellitus

Priority Concepts: Client Education; Glucose Regulation

Reference: Hodgson, Kizior (2018), p. 734.

916. ***Answer:*** 1, 3, 5, 6

Rationale: During a seizure, the nurse should stay with the child to reduce the risk of injury and allow for observation and timing of the seizure. The child is not restrained, because this could cause injury to the child. The child is placed on his or her side in a lateral position. Nothing is placed in the child's mouth during a seizure because this could injure the child's mouth, gums, or teeth. Positioning on the side prevents aspiration, because saliva drains out of the corner of the child's mouth. The nurse should loosen clothing around the child's neck and ensure a patent airway.

Test-Taking Strategy: Focus on the **subject**, care of the child experiencing

seizures, and visualize this clinical situation. Recalling that airway patency and safety are the priorities will assist in determining the correct interventions.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Pediatrics: Neurological
Health Problem: Pediatric-Specific: Seizures
Priority Concepts: Intracranial Regulation; Safety
Reference: McKinney et al. (2018), pp. 1299, 1301.

917. ***Answer:*** 1, 2, 3

Rationale: Nocturia, incontinence, and an enlarged prostate are characteristics of BPH and need to be assessed for in all male clients over 50 years of age. Nocturnal emissions are commonly associated with prepubescent males. Low testosterone levels (not BPH) may be associated with a decreased desire for sexual intercourse.

Test-Taking Strategy: Focus on the **subject**, characteristics of BPH. Thinking about the pathophysiology associated with this disorder will assist you in answering correctly.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Adult Health: Renal and Urinary
Health Problem: Adult Health: Renal and Urinary: Obstructive problems
Priority Concepts: Clinical Judgment; Elimination
Reference: Lewis et al. (2017), p. 1269.

918. ***Answer:*** 1

Rationale: Setting priorities means deciding which client needs or problems require immediate action and which can be delayed until a later time because they are not urgent. Client problems that involve actual or life-threatening concerns are always considered first. Although completing care in a reasonable time frame, time constraints, and obtaining needed supplies are components of time management, these items are not the priority in planning care for the client, based on the options provided.

Test-Taking Strategy: Note the **strategic word**, *priority*. Recall the principles related to prioritizing to answer the question. Noting the words *life-threatening* in the correct option will assist in directing you to this option.

Level of Cognitive Ability: Evaluating
Client Needs: Safe and Effective Care Environment
Integrated Process: Teaching and Learning
Content Area: Leadership/Management: Prioritizing
Health Problem: N/A
Priority Concepts: Care Coordination; Clinical Judgment
Reference: Potter et al. (2017), pp. 241, 284-285.

919. ***Answer:*** 4

Rationale: Laboratory determinations of the serum thyroid-stimulating hormone (TSH) level are an important means of evaluation. Successful therapy causes elevated TSH levels to decline. These levels begin their decline within hours of the onset of therapy and continue to decrease as plasma levels of thyroid hormone build up. If an adequate dosage is administered, TSH levels remain suppressed for the duration of therapy. Although energy levels may increase and the client's mood may improve following effective treatment, these are not noted until normal thyroid hormone levels are achieved with medication therapy. An increase in the blood glucose level is not associated with this condition.

Test-Taking Strategy: Focus on the **subject**, therapeutic effects of this medication. Note the words *expected outcome*. Relate the diagnosis of hypothyroidism with thyroid hormone levels in the correct option.

Level of Cognitive Ability: Evaluation

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Evaluation

Content Area: Pharmacology: Endocrine Medications: Thyroid hormones

Health Problem: Adult Health: Endocrine: Thyroid disorders

Priority Concepts: Cellular Regulation; Evidence

Reference: Lewis et al. (2017), pp. 1168-1169.

920. ***Answer:*** 2, 4, 5, 6

Rationale: Risk factors for breast cancer include nulliparity or first child born after age 30 years; early menarche; late menopause; family history of breast cancer; high-dose radiation exposure to the chest; and previous cancer of the breast, uterus, or ovaries. In addition, specific inherited mutations in BReast CAncer (*BRCA)1* and *BRCA2* increase the risk of female breast cancer; these mutations are also associated with an increased risk for ovarian cancer.

Test-Taking Strategy: Focus on the **subject**, the risk factors associated with breast cancer. Thinking about the physiology associated with the reproductive system and the most common causes of cancer will assist in answering the question.

Level of Cognitive Ability: Analyzing

Client Needs: Health Promotion and Maintenance

Integrated Process: Nursing Process—Assessment

Content Area: Adult Health: Oncology

Health Problem: Adult Health: Cancer: Breast

Priority Concepts: Cellular Regulation; Client Education

Reference: Ignatavicius, Workman, Rebar (2018), p. 1442.

921. ***Answer:*** 1

Rationale: An inflammatory reaction such as acute pancreatitis can cause paralytic ileus, the most common form of nonmechanical obstruction. Inability to pass flatus is a clinical manifestation of paralytic ileus. Loss of sphincter control is not a sign of paralytic ileus. Pain is associated with paralytic ileus, but the pain usually manifests

as a more constant generalized discomfort. Option 4 is the description of the physical finding of liver enlargement. The liver may be enlarged in cases of cirrhosis or hepatitis. Although this client may have an enlarged liver, an enlarged liver is not a sign of paralytic ileus or intestinal obstruction.

Test-Taking Strategy: Focus on the **subject**, clinical manifestations of paralytic ileus. Noting the word *paralytic* will assist in directing you to the correct option.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Assessment

Content Area: Adult Health: Gastrointestinal

Health Problem: Adult Health: Gastrointestinal: GI Accessory organs

Priority Concepts: Elimination; Inflammation

Reference: Lewis et al. (2017), pp. 950-951.

922. ***Answer:*** 1

Rationale: For the first 12 hours after gastric surgery, the nasogastric tube drainage may be dark brown to dark red. Later, the drainage should change to a light yellowish-brown color. The presence of bile may cause a green tinge. The PHCP should be notified if dark red drainage, a sign of hemorrhage, is noted 24 hours postoperatively.

Test-Taking Strategy: Focus on the **subject**, the need to notify the PHCP. Recall that bleeding is a concern in the postoperative client. This concept will direct you to the correct option.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Analysis

Content Area: Adult Health: Gastrointestinal

Health Problem: Adult Health: Gastrointestinal: Upper GI Disorders

Priority Concepts: Clinical Judgment; Collaboration

Reference: Lewis et al. (2017), p. 344.

923. ***Answer:*** 1

Rationale: The client should take a deep breath, because the client's airway will be temporarily obstructed during tube removal. The client is then told to hold the breath and the tube is withdrawn slowly and evenly over the course of 3 to 6 seconds (coil the tube around the hand while removing it) while the breath is held. Bearing down could inhibit the removal of the tube. Exhaling is not possible during removal because the airway is temporarily obstructed during removal. Breathing normally could result in aspiration of gastric secretions during inhalation.

Test-Taking Strategy: Focus on the **subject**, the procedure for removal of a nasogastric tube, and attempt to visualize the process of tube removal to direct you to the correct option. Remember, holding the breath facilitates the process of removal.

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Implementation
Content Area: Skills: Tube Care
Health Problem: N/A
Priority Concepts: Gas Exchange; Safety
Reference: Potter et al. (2017), p. 1178.

924. *Answer:* 3

Rationale: When a client is experiencing respiratory acidosis, the respiratory rate and depth increase in an attempt to compensate. The client also experiences headache; restlessness; mental status changes, such as drowsiness and confusion; visual disturbances; diaphoresis; cyanosis as the hypoxia becomes more acute; hyperkalemia; rapid, irregular pulse; and dysrhythmias. Options 1, 2, and 4 are not specifically associated with this disorder.

Test-Taking Strategy: Focus on the **subject**, clinical manifestations associated with respiratory acidosis, and use knowledge of the signs and symptoms of respiratory acidosis to answer this question. Eliminate options 2 and 4 first because they are **comparable or alike** and address a decreased respiratory rate. Remember that headache, restlessness, and confusion occur in respiratory acidosis.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Foundations of Care: Acid–Base
Health Problem: Adult Health: Respiratory: Obstructive Pulmonary Disease
Priority Concepts: Acid–Base Balance; Clinical Judgment
Reference: Ignatavicius, Workman, Rebar (2018), pp. 192-193.

925. *Answer:* 4

Rationale: Distention, vomiting, and abdominal pain are a few of the symptoms associated with intestinal obstruction. Nasogastric tubes may be used to remove gas and fluid from the stomach, relieving distention and vomiting. Bowel sounds return to normal as the obstruction is resolved and normal bowel function is restored. Discontinuing the nasogastric tube before normal bowel function may result in a return of the symptoms, necessitating reinsertion of the nasogastric tube. Serum electrolyte levels, pH of the gastric aspirate, and tube placement are important assessments for the client with a nasogastric tube in place but would not assist in determining the readiness for removing the nasogastric tube.

Test-Taking Strategy: Eliminate options 2 and 3 first because they are **comparable or alike**. Assessing the pH of the gastric aspirate is one method of assessing tube placement. Also, note the **strategic word**, *priority*. Focus on the client's diagnosis to direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Adult Health: Gastrointestinal
Health Problem: Adult Health: Gastrointestinal: Lower GI disorders

Priority Concepts: Clinical Judgment; Safety
Reference: Potter et al. (2017), pp. 1177-1178.

926. ***Answer:*** 1

Rationale: The enema is never administered while on a toilet due to safety. The enema is administered while the client is in a left side-lying (Sims') position with the right knee flexed. This allows enema solution to flow downward by gravity along the natural curve of the sigmoid colon and rectum. It is important for the client to retain the fluid for as long as possible to promote peristalsis and defecation. If the client complains of fullness or pain, the flow is stopped for 30 seconds and restarted at a slower rate. The higher the solution container is held above the rectum, the faster the flow and the greater the force in the rectum; this could increase cramping.
Test-Taking Strategy: Note the **strategic words**, *need for further instruction*. This indicates a **negative event query**, and the need to select the option that is incorrect. Eliminate options 3 and 4 first because they are **comparable or alike**. From the remaining options, focusing on the **subject**, safety, will direct you to the correct option.
Level of Cognitive Ability: Evaluating
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Skills: Elimination
Health Problem: N/A
Priority Concepts: Client Education; Elimination
Reference: Potter et al. (2017), pp. 1165, 1170-1171.

927. ***Answer:*** 4

Rationale: Negative reinforcement when the stimulus is produced is descriptive of aversion therapy. Options 1, 2, and 3 are characteristics of self-control therapy.
Test-Taking Strategy: Note the **strategic words**, *need for further teaching*. These words indicate a **negative event query** and ask you to select an option that is incorrect. Think about the **subject**, self-control. This **subject** will assist you in answering correctly.
Level of Cognitive Ability: Evaluating
Client Needs: Psychosocial Integrity
Integrated Process: Teaching and Learning
Content Area: Mental Health
Health Problem: Mental Health: Coping
Priority Concepts: Anxiety; Stress
Reference: Varcarolis (2017), p. 23.

928. ***Answer:*** 2, 4,5, 6

Rationale: The nurse should teach the client how to care for the stoma, depending on the type of laryngectomy performed. Most interventions focus on protection of the stoma and the prevention of infection. Interventions include obtaining a

MedicAlert bracelet, preventing debris from entering the stoma, avoiding exposure to people with infections, and avoiding swimming and using care when showering. Additional interventions include wearing a stoma guard or high-collared clothing to protect the stoma, increasing the humidity in the home, and increasing fluid intake to 3000 mL/day to keep the secretions thin.

Test-Taking Strategy: Focus on the **subject**, client instructions regarding stoma care. Recalling that most interventions focus on protection of the stoma and the prevention of infection will assist in identifying the client instructions for home care.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Adult Health: Oncology
Health Problem: Adult Health: Cancer: Laryngeal and lung
Priority Concepts: Client Education; Gas Exchange
Reference: Lewis et al. (2017), p. 495.

929. ***Answer:*** 21

Rationale: Use the intravenous flow rate formula.
Formula:

$$\frac{\text{Total volume prescribed} \times \text{Drop factor}}{\text{Time in minutes}} = \text{gtt/minute}$$

$$\frac{2000 \text{ mL} \times 15 \text{ gtt/mL}}{1440 \text{ minutes}} = 20.8 \text{ gtt/minute} = 21 \text{ gtt/minute}$$

Test-Taking Strategy: Focus on the **subject**, a medication calculation. Use the formula for calculating intravenous flow rates when answering the question. Verify the answer using a calculator, and be sure to round the answer to the nearest whole number.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Skills: Dosage Calculations
Health Problems: N/A
Priority Concepts: Clinical Judgment; Safety
Reference: Potter et al. (2017), pp. 978-979.

930. ***Answer:*** 2

Rationale: In the first few hours after surgery, the drainage from the chest tube is bloody. After several hours, it becomes serosanguineous. The client should not experience frequent clotting. Proper chest tube function should allow for drainage of blood before it has the chance to clot in the chest or the tubing.

Test-Taking Strategy: Focus on the **subject**, expected findings after thoracic surgery. Recall that after thoracic surgery, there may be considerable capillary oozing for hours in the postoperative period. This will lead you to choose the bloody drainage option over the serous or serosanguineous drainage options. Knowing that patent chest tubes do not allow blood to collect in the pleural space eliminates the option of blood with clots.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Assessment

Content Area: Adult Health: Respiratory

Health Problem: N/A

Priority Concepts: Clinical Judgment; Gas Exchange

Reference: Lewis et al. (2017), pp. 524-525.

931. ***Answer:*** 1, 2, 3, 5

Rationale: If the client begins to hemorrhage from the surgical site after radical neck dissection, the nurse elevates the head of the bed to maintain airway patency and prevent aspiration. The nurse applies pressure over the bleeding site and calls the surgeon immediately. The nurse also monitors the client's airway and vital signs.

Test-Taking Strategy: Focus on the **subject**, nursing actions for hemorrhage, and on the client situation. Use the **ABCs—airway, breathing, and circulation**—to assist you in answering the question. Note that lowering the head of the bed to a flat position increases the client's risk for aspiration.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Implementation

Content Area: Complex Care: Emergency Situations/Management

Health Problem: Adult Health: Cancer: Laryngeal and lung

Priority Concepts: Clinical Judgment; Gas Exchange

Reference: Lewis et al. (2017), pp. 494-495.

932. ***Answer:*** 2

Rationale: To prevent transmission of hepatitis, vaccination of the partner is advised. In addition, a condom is advised during sexual intercourse. Alcohol should be avoided because it is detoxified in the liver and may interfere with recovery. Rest is especially important until laboratory studies show that liver function has returned to normal. The client's activity is increased gradually, and the client should not return to work right away.

Test-Taking Strategy: Focus on the **strategic words**, *need for further teaching*. These words indicate a **negative event query** and ask you to select an option that is incorrect. Think about the pathophysiology associated with hepatitis to direct you to

the incorrect client statement. Remember that rest is needed for the liver to heal.

Level of Cognitive Ability: Evaluating
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Adult Health: Gastrointestinal
Health Problem: Adult Health: Gastrointestinal: GI Accessory organs
Priority Concepts: Client Education; Infection
Reference: Ignatavicius, Workman, Rebar (2018), pp. 1182-1183.

933. ***Answer:*** 3, 4, 6

Rationale: The clinical manifestations of hypothyroidism are the result of decreased metabolism from low levels of thyroid hormone. Interventions are aimed at replacement of the hormone and providing measures to support the signs and symptoms related to decreased metabolism. The client often has cold intolerance and requires a warm environment. The nurse encourages the client to consume a well-balanced diet that is low in fat for weight reduction and high in fluids and high-fiber foods to prevent constipation. Iodine preparations may be used to treat hyperthyroidism. Iodine preparations decrease blood flow through the thyroid gland and reduce the production and release of thyroid hormone; they are not used to treat hypothyroidism. The client is instructed to notify the PHCP if chest pain occurs because it could be an indication of overreplacement of thyroid hormone.

Test-Taking Strategy: Focus on the **subject**, hypothyroidism. Recalling the manifestations of this disorder and that in this disorder the client has a decreased metabolic rate will assist in determining the appropriate interventions.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Adult Health: Endocrine
Health Problem: Adult Health: Endocrine: Thyroid disorders
Priority Concepts: Caregiving; Thermoregulation
Reference: Lewis et al. (2017), pp. 1168-1169.

934. ***Answer:*** 1

Rationale: Plugging a tracheostomy tube is usually done by inserting the tracheostomy plug (decannulation stopper) into the opening of the outer cannula. This closes off the tracheostomy, and airflow and respiration occur normally through the nose and mouth. When plugging a cuffed tracheostomy tube, the cuff must be deflated. If it remains inflated, ventilation cannot occur, and respiratory arrest could result. A tracheostomy plug could not be placed in a tracheostomy if an inner cannula was in place. The ability to swallow or speak is unrelated to weaning and plugging the tube.

Test-Taking Strategy: Focus on the **subject**, care of the client with a tracheostomy, and note the word *required* in the question. Think about the structure and function of a tracheostomy tube. Recalling that an inflated cuff would cause airway obstruction will assist in directing you to the option that addresses a priority physiological need.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Skills: Tube care
Health Problem: N/A
Priority Concepts: Gas Exchange; Safety
Reference: Lewis et al. (2017), pp. 487-488.

935. *Answer:* 1

Rationale: Hypertension, cardiovascular disease, diabetes mellitus, and obesity are associated with the development of glaucoma. Options 2, 3, and 4 do not identify risk factors associated with this eye disorder.
Test-Taking Strategy: Focus on the **subject**, a risk factor associated with glaucoma. Recall that glaucoma is associated with increased pressure in the eye. This will assist to direct you to the correct option.
Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Adult Health: Eye
Health Problem: Adult Health: Eye: Glaucoma
Priority Concepts: Health Promotion; Sensory Perception
Reference: Ignatavicius, Workman, Rebar (2018), p. 972.

936. *Answer:* 4

Rationale: The nurse places an eye patch over the client's affected eye to reduce eye movement. Some clients may need bilateral patching. Depending on the location and size of the retinal break, activity restrictions may be needed immediately. These restrictions are necessary to prevent further tearing or detachment and to promote drainage of any subretinal fluid. Therefore, reading and watching television are not allowed. The client's position is prescribed by the primary health care provider; normally, the prescription is to lie flat.
Test-Taking Strategy: Focus on the **subject**, retinal detachment. Remember that the eye needs to be protected and rested. This should direct you to the correct option.
Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Planning
Content Area: Adult Health: Eye
Health Problem: Adult Health: Eye: Retinal detachment
Priority Concepts: Sensory Perception; Safety
Reference: Ignatavicius, Workman, Rebar (2018), p. 980.

937. *Answer:* 3

Rationale: Clients at greatest risk for deep vein thrombosis and pulmonary emboli

are immobilized clients. Basic preventive measures include early ambulation, leg elevation, active leg exercises, elastic stockings, and intermittent pneumatic calf compression. Keeping the client well hydrated is essential because dehydration predisposes to clotting. A pillow under the knees may cause venous stasis. Heat should not be applied without a primary health care provider's prescription.

Test-Taking Strategy: Note the **strategic word**, *most*. Focus on the **subject**, measures to prevent deep vein thrombosis and pulmonary emboli. Use basic principles related to the care of the immobile client to answer this question.

Level of Cognitive Ability: Creating
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Planning
Content Area: Adult Health: Cardiovascular
Health Problem: Adult Health: Cardiovascular: Vascular disorders
Priority Concepts: Clinical Judgment; Clotting
Reference: Ignatavicius, Workman, Rebar (2018), p. 742.

938. ***Answer:*** 1

Rationale: A crisis is an acute, time-limited state of disequilibrium resulting from situational, developmental, or societal sources of stress. A person in this state is temporarily unable to cope with or adapt to the stressor by using previous coping mechanisms. The person who intervenes in this situation (the nurse) "takes over" for the client (authority) who is not in control and devises a plan (action) to secure and maintain the client's safety. When this has occurred, the nurse works collaboratively with the client (participates) in developing new coping and problem-solving strategies.

Test-Taking Strategy: Note the **strategic word**, *priority.* A client who experiences a suicidal crisis is in a state of acute disequilibrium. Remember that in a crisis an authority figure must emerge to take action.

Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Mental Health
Health Problem: Mental Health: Suicide
Priority Concepts: Mood and Affect; Safety
Reference: Varcarolis (2017), pp. 367, 369.

939. ***Answer:*** 2

Rationale: The client with tuberculosis must have sputum cultures performed every 2 to 4 weeks after initiation of antituberculosis medication therapy. The client may return to work when the results of three sputum cultures are negative, because the client is considered noninfectious at that point. Options 1, 3, and 4 are not reliable determinants of a noninfectious status.

Test-Taking Strategy: Focus on the **subject**, concepts related to tuberculosis. Knowing that a positive tuberculin skin test never reverts to negative helps you eliminate option 4. From the remaining options, think about the mode of

transmission of tuberculosis to direct you to the correct option. Remember, three negative sputum cultures are required.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Teaching and Learning
Content Area: Foundations of Care: Infection Control
Health Problem: Adult Health: Respiratory: Tuberculosis
Priority Concepts: Infection; Safety
Reference: Ignatavicius, Workman, Rebar (2018), p. 609.

940. *Answer:* 3

Rationale: This client is in a severe state of anxiety. When a client is in a severe or panic state of anxiety, it is crucial for the nurse to remain with the client. The client in a severe state of anxiety would be unable to learn relaxation techniques. Discussing the assault at this point would increase the client's level of anxiety further. Placing the client in a quiet room alone may also increase the anxiety level.

Test-Taking Strategy: Note the **strategic word**, *priority*. The priority action in this situation is to remain with the client.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Mental Health
Health Problem: Mental Health: Anxiety disorder
Priority Concepts: Anxiety; Caregiving
Reference: Varcarolis (2017), p. 134.

941. *Answer:* 2

Rationale: Laboratory findings do not establish the diagnosis of appendicitis, but there is often an elevation of the white blood cell count (leukocytosis) with a shift to the left (an increased number of immature white blood cells). Options 1, 3, and 4 are incorrect because they are not associated findings in acute appendicitis.

Test-Taking Strategy: Focus on the **subject**, appendicitis. Knowledge that an inflammatory process causes an increase in the white blood cell count will assist you in eliminating options 1 and 3. From the remaining options, it is necessary to understand the significance of a shift to the left.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Adult Health: Gastrointestinal
Health Problem: Adult Health: Gastrointestinal: GI Accessory organs
Priority Concepts: Cellular Regulation; Inflammation
Reference: Ignatavicius, Workman, Rebar (2018), pp. 1147-1148.

942. *Answer:* 3

Rationale: Lack of ability to cope effectively may be evidenced by a client's inability to meet basic needs, inability to meet role expectations, alteration in social participation, use of inappropriate defense mechanisms, or impairment of usual patterns of communication. Anxiety is a broad description and can occur as a result of many triggers; although the client was experiencing anxiety, the client's concern now is the ability to meet role expectations and financial obligations. There is no information in the question that indicates an unrealistic outlook or disturbances in thoughts and ideas.

Test-Taking Strategy: Note the **strategic word**, *priority.* Focus on the **subject**, concerns regarding the ability to meet role expectations and financial obligations. Option 1 can be eliminated because the client was previously experiencing anxiety. Eliminate options 2 and 4 because there are no data in the question that address these problems.

Level of Cognitive Ability: Creating

Client Needs: Psychosocial Integrity

Integrated Process: Nursing Process—Planning

Content Area: Mental Health

Health Problem: Mental Health: Anxiety disorders

Priority Concepts: Anxiety; Coping

Reference: Varcarolis (2017), pp. 142-143.

943. ***Answer:*** 2

Rationale: Bubbling in the water seal chamber is caused by air passing out of the pleural space into the fluid in the chamber. Intermittent (not constant) bubbling is normal. It indicates that the system is accomplishing one of its purposes, removing air from the pleural space. Continuous bubbling during inspiration and expiration indicates that an air leak exists. If this occurs, it must be corrected. Notifying the primary health care provider and changing the chest tube drainage system are not indicated at this time.

Test-Taking Strategy: Note the **strategic words**, *most appropriate.* Note the **subject**, chest tube drainage systems, and focus on the words *intermittent bubbling* and *water seal chamber*. Recalling that intermittent (not constant) bubbling is normal in this chamber will direct you to the correct option.

Level of Cognitive Ability: Applying

Client Needs: Physiological Integrity

Integrated Process: Nursing Process—Implementation

Content Area: Skills: Tube care

Health Problem: N/A

Priority Concepts: Clinical Judgment; Gas Exchange

Reference: Lewis et al. (2017), p. 525.

944. ***Answer:*** 1

Rationale: Although frequency and intensity of bowel sounds vary depending on the phase of digestion, normal bowel sounds are relatively high-pitched clicks or gurgles. Loud gurgles (borborygmi) indicate hyperperistalsis and are commonly

associated with nausea and vomiting. A swishing or buzzing sound represents turbulent blood flow associated with a bruit. Bruits are not normal sounds. Bowel sounds are very high-pitched and loud (hyper-resonance) when the intestines are under tension, such as in intestinal obstruction. Therefore, options 2, 3, and 4 are incorrect.

Test-Taking Strategy: Note the **subject**, techniques for abdominal assessment. Normally, bowel sounds are audible in all four quadrants, so options 2 and 4 can be eliminated. From the remaining options, focus on the **data in the question** and note that the client has nausea and vomiting; this will direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Assessment
Content Area: Health Assessment/Physical Exam: Abdomen
Health Problem: Adult Health: Gastrointestinal: Upper GI disorders
Priority Concepts: Elimination; Health Promotion
Reference: Jarvis (2016), pp. 548–549, 572.

945. ***Answer:*** 20

Rationale: Use the medication calculation formula.
Formula:

$$\frac{\text{Prescribed}}{\text{Available}} \times \text{Quantity} = \text{mL}\Big/\text{dose}$$

$$\frac{800\ \text{mg}}{200\ \text{mg}} \times 5\ \text{mL} = 20\ \text{mL}$$

Test-Taking Strategy: Note the **subject**, medication calculations. Review the label for the correct reconstitution, which states 200 mg in 5 mL. Calculate the prescribed number of milligrams per milliliter. Use a calculator to verify the answer and make sure that the answer makes sense.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Skills: Dosage Calculations
Health Problem: N/A
Priority Concepts: Clinical Judgment; Safety
Reference: Potter et al. (2017), pp. 978-979.