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NCLEX-RN

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8.) The patient has had abdominal surgery. The nurse is teaching her about deep vein thrombosis (DVT). The nurse should include all of the following in the instructions EXCEPT:

a.) Exercise to decrease the risk of developing DVT.
b.) Briskly massage any red, tender areas in the calf.
c.) Follow up for lab work as instructed.
d.) Report any leg discomfort immediately.

9.) In most healthcare facilities, medication administration policies note that the assigned nurse must administer her patient's regularly scheduled medications:

a.) 30 minutes before to 30 minutes after the scheduled time.
b.) Within 5 minutes of the scheduled time.
c.) One hour before to one hour after the scheduled time.
d.) The 5 minute rule only applies to oral medications.

10.) Patient ambulation as soon as possible after injury or surgery helps prevent:

a.) Aneurysms.
b.) Gall stones.
c.) Seizures.
d.) Pneumonia.

11.) The nurse has an unusually heavy patient load due to a staff shortage. The nurse can best meet her usual standard of good patient care by:

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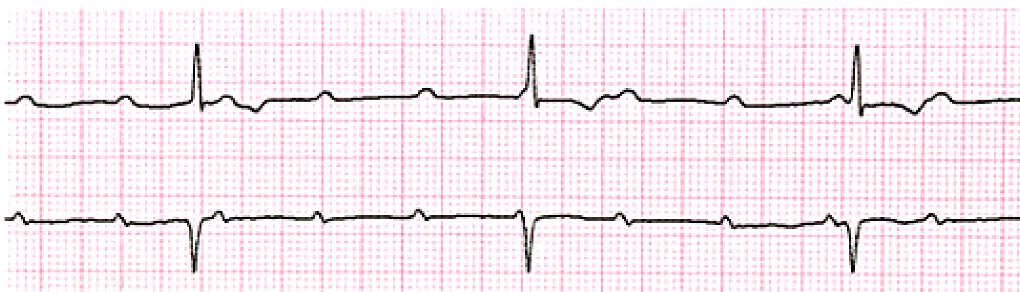
a.) Skipping her meal break.
b.) Asking for assistance.
c.) Prioritizing patient care needs early in her shift.
d.) Skipping unnecessary tasks like baths.

12.) The nurse takes postural (orthostatic) vital signs on a patient who is 2 days post operative following abdominal surgery. The patient has been complaining of dizziness. The set of blood pressures and pulses that may indicate blood loss is:

Response	Supine	Sitting	Standing
a)	120/68, 82	120/66, 86	118/66, 86
b)	132/72, 76	132/70, 78	130/74, 78
c)	124/66, 68	104/70, 84	100/76, 90
d)	114/62, 74	112/60, 76	112/60, 78

13.) The nurse is caring for a patient who has been admitted for chest pain. The patient is on a cardiac monitor. Upon entering the room, the nurse notes that the patient's rhythm has changed to this rhythm:



The most appropriate action at this time is to:

a.) Begin CPR.
b.) Do nothing; this is a regular rhythm.

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c.) Prepare to defibrillate.
d.) Prepare for transcutaneous pacing.

14.) The nurse receives report on a patient whose condition has been deteriorating over night. The patient is on a non-rebreather face mask with an oxygen concentration of 45%. The following vital signs are noted on the chart:

Time	Blood Pressure	Pulse	Respirations
0100	120/68	88	14
0300	108/62	94	18
0500	92/58	82	22
0700	84/42	54	24

When the nurse enters the room and attempts to rouse the patient, the nurse discovers that the patient is not responsive but has a pulse and is breathing. The most appropriate intervention for the nurse to do is to:

a.) Call the Rapid Response Team (RRT).
b.) Begin CPR.
c.) Ask the family to leave the room.
d.) Increase the oxygen.

15.) The nurse is caring for a patient who is two days post myocardial infarction. The patient has been stable following a cardiac catheterization with stent placement. The nurse is working with an unlicensed caregiver who has gone through the facility aide training. The intervention that the nurse can safely delegate to this caregiver is to:

a.) Assess the patient’s lung and bowel sounds.

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b.) Teach the patient about what foods will be appropriate on a low sodium diet.
c.) Record the patient's intake and output.
d.) Talk to the patient about how to prevent further heart problems.

16.) The nurse is working in a clinic that does remote monitoring of patients with congestive heart failure (CHF). Mrs. Smith, the patient being monitored, has weight scales and blood pressure monitoring equipment that transmits daily data to the nurse in the clinic. The nurse reviews Mrs. Smith's data:

Mrs. Smith Remote Monitoring Results		
Date	**Blood Pressure**	**Weight**
1/15/2015	110/66	128
1/16/2015	116/72	130
1/17/2015	118/80	134
1/18/2015	120/84	136

When the nurse calls the patient, the most appropriate first question would be:

a.) "How much liquid have you been drinking each day?"
b.) "How do you feel today?"
c.) "Are you becoming more short of breath?"
d.) "When was the last time your machines were calibrated?"

17.) A man on the way to the hospital to visit his dying mother was involved in a motor vehicle crash in which he sustained a head laceration and contusion followed by a short period of loss of consciousness. Mildly confused after the accident,

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the patient was admitted to the hospital for observation. When he awakens the following morning, the patient asks the nurse to turn on the television to a sports station so that he can catch up with the scores. He becomes agitated when the nurse will not comply with his request. The nurse should do which of the following (select all that apply):

a.) Turn on the TV to calm the patient.
b.) Evaluate the patient's pupils.
c.) Take the patient to see his mother.
d.) Administer a sedative to relax the patient.
e.) Assess the patient's level of pain.
f.) Assess the patient's level of consciousness.

18.) The nurse is caring for a patient who had an exploratory laporatomy 16 hours ago. At 0800, the woman is awake and oriented with stable vital signs. The plan of care includes a dressing and packing change at 0900. The nurse notes that the physician has written an order for morphine sulfate 2-4 mg IV every 2 hours as needed for pain. The nurse looks at the medication administration record that reveals the following:

Time	Pain Level (Scale 1-10)	Medication administered
0300	10	Morphine sulfate 4 mg IV
0500	8	Morphine sulfate 4 mg IV
0700	3	Morphine sulfate 2 mg IV
0900	1	?

The nurse should:

a.) Call the physician to have the medication order changed.

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b.) The patient's pain is well controlled; do the dressing change.
c.) Medicate with morphine sulfate 4 mg IV after the dressing change if needed.
d.) Premedicate with morphine sulfate 2 mg IV before the dressing change.

19.) The nurse arrives at the medical-surgical unit at 0700 and is assigned four patients. The nurse should plan to do her initial assessments in what order? Prioritize these patients:

a.) A patient in pain 2 days after hiatal hernia surgery who is requesting pain medication.
b.) A patient waiting for surgery at 1000 who needs to sign his operative consent.
c.) A patient with a gastric ulcer who complains of sudden onset abdominal pain.
d.) A patient with suspected rectal cancer who is NPO in preparation for a colonoscopy at 0900.

20.) The nurse is completing a health history on a patient at a community clinic. The nurse assesses that the patient does not take an active role in her health care. The most effective intervention for the nurse to use to encourage the patient to take an active role in her care is to:

a.) Ask the patient about her views on her health and healthcare.
b.) Have the patient read written instructions.
c.) Have the patient fill out a detailed questionnaire.

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d.) Ask the patient if she has questions about her healthcare.

21.) Review the following statement: Alcohol gel is a substitute for hand washing. Based on this statement, the nurse knows that the true statement is that the nurse can use alcohol gel:

a.) When finishing with one patient and going to another room.
b.) Alcohol gel is never a substitute for hand washing, it is only to be used as back up when soap and water are not available.
c.) Before beginning a dressing change.
d.) When you need your hands to be sterile.

22.) The patient in severe alcohol withdrawal:

a.) Will experience a state of euphoria.
b.) Should have a roommate.
c.) Will need higher doses of pain medication.
d.) Should not ambulate alone.

23.) There is currently no vaccine available for:

a.) Hepatitis C.
b.) Shingles.
c.) Chicken pox.
d.) Hepatitis A.

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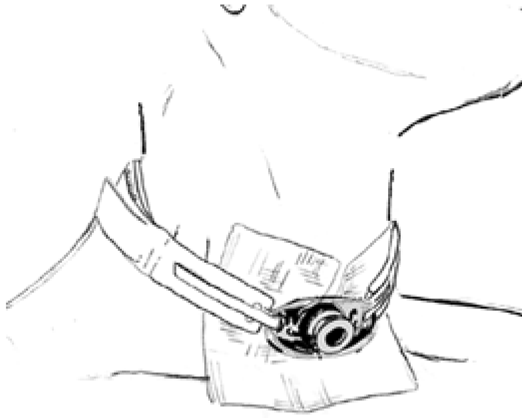
79.) The nurse is caring for a patient with a new tracheostomy. Upon entering the room, the nurse assesses the trach of the patient:



The nurse knows that the first intervention is to:

a.) Do nothing; this trach is placed correctly.
b.) Reposition the fastening ties to the back of the patient's neck.
c.) Reposition the gauze so the slit points down.
d.) Suction the trach.

80.) The most appropriate diet for a patient with chronic obstructive pulmonary disease (COPD) is:

a.) High protein and high calories.
b.) No added salt.
c.) Soft and bland.
d.) Low cholesterol.

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81.) The nurse's patient has a new prescription for zolpidem, also known as Ambien. The nurse should instruct this patient to report which of the following symptoms:

a.) Discolored urine.
b.) Irregular heart beat.
c.) Sudden headache.
d.) Sleepiness during the day.

82.) Drug toxicity is a serious problem associated with:

a.) Acute renal failure.
b.) Diverticulitis.
c.) Pancreatic cancer.
d.) Stomach ulcers.

83.) A patient has an order for sublingual nitroglycerin (NTG) PRN for chest pain. Standard protocol allows that:

a.) One NTG may be administered under the tongue. If chest pain continues, begin CPR.
b.) One NTG may be administered as needed until chest pain subsides.
c.) Vitals must be checked after administration since BP will rise.
d.) Up to 3 NTG tablets may be administered sub lingual at the same time.

84.) An oral medication is to be administered based on a child's weight. The order is to give 2 mgs per kg of body weight. The

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available vial shows the medication comes 10 mg in 5 ml. The child weighs 44 pounds. You will give:

a.) 20 ml.
b.) 30 ml.
c.) 22 ml.
d.) 40 ml.

85.) When preparing to change a right subclavian vein Total Parenteral Nutrition (TPN) bag and tubing, the patient instructions must include:

a.) Inhale deeply, hold it, and bear down.
b.) Breathe normally.
c.) Exhale slowly and hold it.
d.) Turning the head to the left.

86.) Total Parenteral Nutrition (TPN) may not have any medications added to it except:

a.) Xanax.
b.) Phenergan.
c.) Insulin.
d.) Demerol.

87.) A patient receiving parenteral nutrition may have it administered via all of the following routes EXCEPT:

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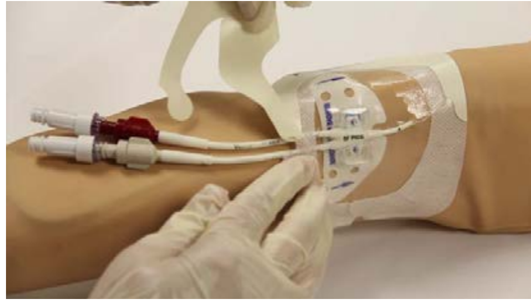
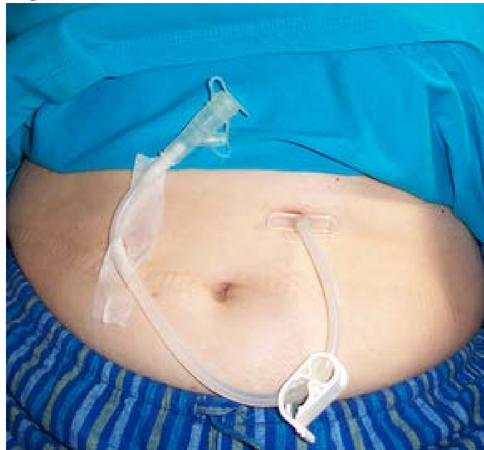
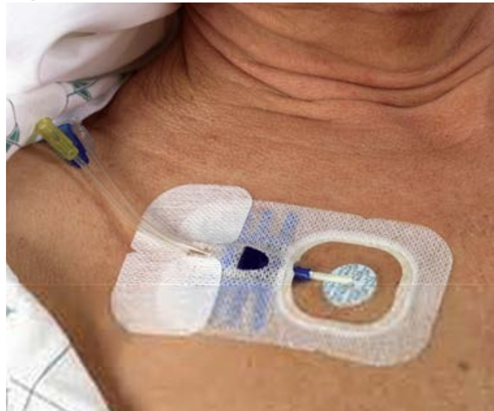
a.) Figure 5: PICC line



b.) Figure 6: PEG tube



c.) Figure 7: Subclavian IV



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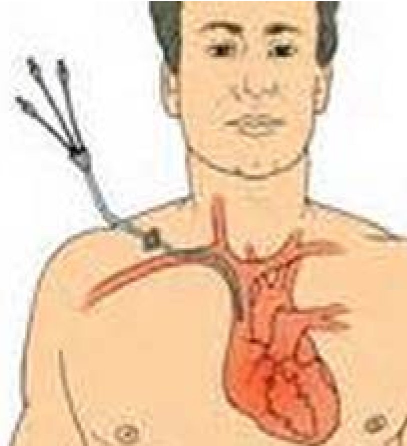
d.) Figure 8: Central Venous Catheter



88.) Parenteral nutrition differs from enteral nutrition because:

a.) Parenteral nutrition can be given through the digestive system.
b.) Either type of nutrition can be given through an IV.
c.) Parenteral nutrition bypasses the digestive system.
d.) Enteral nutrition bypasses the digestive system.

89.) A medication order must have all of these components to be legally administered by the nurse:

a.) Time and date, patient name, medication name, dosage, frequency, indication for administration.
b.) Time and date, medication name, patient name, dosage, route, frequency, physician's signature, indication for administration.
c.) Time and date, medication name and classification, route, physician's signature, indication for administration.
d.) Time and date, medication name, frequency, route, nurse manager's signature, patient's signature.

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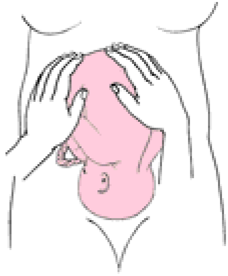
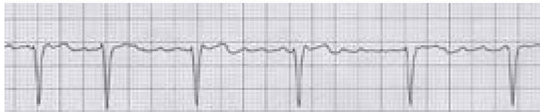
116.) The nurse in the prenatal clinic is examining a patient who is 33 weeks pregnant. Using Leopold's maneuvers, the nurse is palpating the woman's uterus.



The maneuver being demonstrated is:

a.) First maneuver.
b.) Second maneuver.
c.) Third maneuver.
d.) Fourth maneuver.

117.) The nurse is caring for a patient who has been admitted to the hospital with a diagnosis of chest pain/rule out myocardial infarction. The nurse notes this rhythm on the monitor:



The nurse identifies the rhythm as:

a.) Sinus rhythm.
b.) Atrial fibrillation.
c.) First degree heart block.
d.) Ventricular fibrillation.

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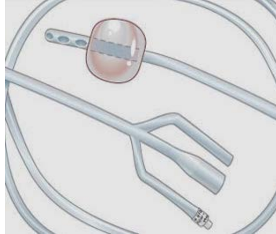
118.) The nurse is caring for a patient following a transurethral resection of the prostate (TURP). The nurse notes that the patient has this catheter in place that is connected to irrigation fluid.



The nurse knows that the purpose of this irrigation catheter is to:

a.) Prevent infection.
b.) Stop bleeding in the bladder.
c.) Prevent blood clots from clogging the catheter.
d.) Administer antibiotics into the bladder.

119.) The nurse is preparing to suction the tracheostomy of an adult patient with chronic obstructive pulmonary disease (COPD). The nurse should:

a.) Use clean gloves.
b.) Insert the catheter approximately 1 inch into the tracheostomy cannula.
c.) Insert clean tap water into the cannula to loosen secretions.
d.) Pre-oxygenate the patient.

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120.) The nurse is preparing a patient for an intravenous pyelogram (IVP). The nurse should be sure to tell the patient that they may experience:

a.) Facial flushing.
b.) Chest pain.
c.) A taste of metal in the mouth.
d.) Chills.

121.) A paradoxical effect has occurred when:

a.) The wrong antibiotic has been prescribed.
b.) A medication produces an effect in the patient that is opposite of what is expected.
c.) The body does not metabolize a medication and liver damage occurs.
d.) A medication's peak and trough levels are significantly different than what is expected.

122.) A patient with congestive heart failure (CHF) is taking Lasix (furosemide) every day. She begins to complain of pain and cramps in her legs. The nurse would expect that the patient's lab results will probably show:

a.) Potassium level that is below normal limits.
b.) Potassium level that is above normal limits.
c.) Sodium level that is above normal limits.
d.) Sodium level that is below normal limits.

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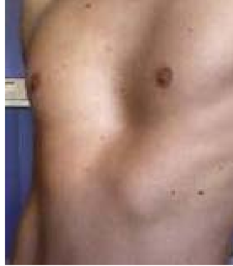
130.) The nurse is doing an assessment on a 20 year old male patient. When assessing the patient's chest, the nurse sees this chest:



Proper documentation would describe this chest as:

a.) Barrel chest.
b.) Pectus excavatus.
c.) Poland syndrome.
d.) Jeune syndrome.

131.) The pediatric nurse is caring for a 14 year old patient with poorly controlled Type 1 diabetes mellitus. At the change of shift assessment, the patient complains of nausea and "feeling bad". The nurse notes that the patient's breath has a distinctive fruity odor. The patient ate lunch 2 hours ago. The insulin prescription is for Lispro insulin. The nurse knows that the most appropriate FIRST intervention is to:

a.) Administer a dose of Lispro insulin per prescription.
b.) Call the physician.
c.) Encourage the patient to drink a glass of juice.
d.) Start an IV of normal saline.

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132.) The nurse is talking to a couple that has just learned that they are pregnant with their first child. The mother-to-be tells the nurse that she is worried about having a child with cystic fibrosis since one of her cousins has a child with the disease. The most appropriate response by the nurse is to tell the couple that:

a.) The disease only occurs in male children.
b.) There is no evidence to suggest that the disease has a genetic basis.
c.) The risk is highest when both parents carry the recessive gene.
d.) Since the gene is carried on the X chromosome, there is little risk for this child.

133.) The nurse is caring for a patient who had an exploratory abdominal surgery one day ago. At the time of assessment, the nurse notes petechiae under the blood pressure cuff on the patient's upper arm and bright red bloody drainage on the dressing. The nurse notes the following:

Time	Assessment Finding	Value
0600	Platelet Count	80,000/mm^3
1500	Temperature	98.0° F
1500	Pulse	130
1500	Urine Output	350 mL since 0700

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The findings associated with disseminated intravascular coagulation (DIC) include (Select all that apply):

a.) Temperature.
b.) Petechiae under the blood pressure cuff.
c.) Platelet count.
d.) Heart rate.
e.) Urine output.
f.) Bright red blood on the abdominal dressing.

134.) The nurse knows that cardiogenic shock is characterized by:

a.) Increased cardiac output.
b.) Decreased circulating volume.
c.) Myocardial infarction.
d.) Decreased myocardial contractility.

135.) The pediatric nurse is caring for a 4-year-old child who has had nausea, vomiting and diarrhea for the past 3 days. He has been admitted with dehydration. The most accurate way to determine the child's fluid loss is to:

a.) Weigh the child.
b.) Measure intake and output.
c.) Monitor vital signs.
d.) Assess skin turgor.

136.) The nurse in the Emergency Department is caring for a patient who came to the hospital with complaints of headache, rapid respirations, and dizziness. The physician orders lab work, including arterial blood gases (ABGs). The results of the ABGs show:

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pH	CO_2	Bicarbonate
7.20	48 mm Hg	25 mEq/L

The nurse knows that these ABGs show an acid base imbalance of:

a.) The ABGs are normal.
b.) Metabolic acidosis.
c.) Metabolic alkalosis.
d.) Respiratory acidosis.
e.) Respiratory alkalosis.

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Answer Key Multiple Choice

8.) Answer: B.

Massaging the thrombotic area can dislodge all or parts of the clot and cause severe complications and death; therefore, massage of tender areas in the calf should be avoided. Exercise before a DVT develops increases circulation and decreases the risk of DVT.

Frequent lab work may be necessary to test clotting time and the potential risk for DVT. Leg pain, swelling, redness, or hot spots are signs of DVT.

9.) Answer: A.

Facility policy should always be followed regarding timing of medication administration. The most typical policy is that the medication should be administered within one hour (30 minutes before or 30 minutes after) the scheduled administration time. If the nurse does not administer the medication according to policy, a variance report, incident report, or medication error report must be completed. The type of report and procedure depends on the state and facility policies. There is no 5-minute rule. In most cases, medication administration one hour early or one hour late constitutes a medication error. Medications are scheduled so that the therapeutic dose remains constant in the body. Oral medications fall under the same guidelines as all other medications.

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10.) Answer: D.

A major complication of prolonged bed rest, even with regular turning, is pneumonia. If the patient is unable to ambulate, it is important for the nurse to encourage the patient to turn, deep breathe, and cough. An incentive spirometer is often ordered to help prevent pneumonia. A lack of ambulation has not been shown to cause aneurysms. Ambulation after surgery or injury has no relationship to gallstones. Seizures are not caused by prolonged bed rest.

11.) Answer: C.

Prioritizing and scheduling tasks for each patient early in the shift will decrease chaos, make sure nothing is missed, and allow the nurse to be organized. This also helps ensure the safety of the nurse's patients. Skipping meals will add to the nurse's frustration, and increase the likelihood of mistakes. Assistance may be hard to acquire on a unit that is already short staffed. The nurse may be able to team with other personnel, but she should not count on getting assistance on a day when the unit is short of staff. Baths are important to the patient's sense of well-being and to their health. Bathing patients keeps bacteria under control that can spread quickly through a facility.

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12.) Answer: C.

Postural or orthostatic vital signs are measurements of vital signs taken in a supine, sitting and standing position. The purpose of this test is to determine if the patient has volume depletion, usually due to blood loss. The fact that the patient reports dizziness is a sign that the patient may be volume depleted. Although not all experts agree on what constitutes a positive test, many clinicians use the "20-10-20" rule as a guide. That is, if the systolic blood pressure decreases by 20 mm Hg, the diastolic blood pressure increases by 10 mm Hg, and the pulse rate increases by 20 beats per minute, the clinician can call this a positive postural, or tilt, test. In this example, response C is the only set of vital signs that fulfills these criteria.

13.) Answer: D.

This question requires that the nurse knows 1) that the rhythm is a 3rd degree heart block and 2) that the correct intervention is to prepare for transcutaneous pacing. A 3rd degree heart block is characterized by identifiable and normal P waves that are not related to a QRS complex. Therefore, the nurse will not be able to measure the PR interval. In this rhythm strip, the P waves are regular but each P wave is NOT followed by a QRS complex. Therefore, it is not a regular rhythm and the patient is likely to deteriorate if action is not taken. As long as the patient has a pulse and is breathing, it is not appropriate to begin CPR. Defibrillation is not indicated for a 3rd degree heart block.

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14.) Answer: A.

This patient is deteriorating, but is not coding. If the facility has a Rapid Response Team, the nurse should immediately call the team. Instead of waiting for total collapse of the patient, the concept of the RRT is that picking up on warning signs and intervening early can, in many cases, prevent collapse and the need for CPR. In many facilities, the family becomes an integral part of the RRT since they may be the ones who recognize subtle changes even before vital signs change. There is no need to ask the family to leave. Simply increasing the patient's oxygen will probably not prevent further deterioration of the patient's condition.

15.) Answer: C.

The assumption is that the aide has been trained in recording the patient's intake and output since she has gone through the facility training. This is the only intervention that can be safely and legally delegated to the unlicensed staff. Physical assessment of the patient is a function that only an RN, NP, PA or physician can perform. Teaching about diet is best done by a licensed dietician. Education about prevention of further heart problems should be done by an RN or other licensed provider.

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16.) Answer: C.

Although all of these responses may be appropriate for this patient, the most critical question to ask in this situation is to assess if the patient is becoming more short of breath. The answer to this question will tell the nurse much more than simply asking how the patient is feeling. In this case, the patient has gained 8 pounds in 4 days with steadily increasing blood pressure. This should be enough information for the nurse to assume that the patient with congestive heart failure is probably becoming more short of breath. Machine calibration is important and can be a question that the nurse asks if the patient is NOT short of breath and is feeling fine. However, it would be unusual for all of the machinery to go out of calibration at the same time. The test taker should always default to the response that responds to the most basic needs of breathing, food and water. Remembering Maslow's hierarchy can be very helpful in answering this kind of question.

17.) Answer: B, E, F.

Following any head injury, particularly one that involves loss of consciousness, a patient should be closely monitored for decreasing level of consciousness and other signs that his

brain has been affected. In this case, the patient was on the way to see his dying mother, but seems to have totally forgotten that when he awakens the next morning. Inappropriate agitation can be an early sign of increased intracranial pressure. The appropriate responses are to assess the patient's pupils, level of pain and level of consciousness to determine if there are indications of increased intracranial pressure. Turning on the TV and taking the patient to see his mother may be appropriate interventions after brain injury has been ruled out. It is not appropriate to administer a sedative or pain medication to any patient who may have increased intracranial pressure until the physician has been notified about the physical findings.

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18.) Answer: D.

Dressing and packing changes can be extremely painful. Although the patient indicates that their pain is well-controlled at 0900 (with a pain level of 1), the nurse should anticipate that the dressing change will increase this level. Although the maximum prescription of Morphine sulfate 4 mg is probably not indicated, it is a good nursing practice to premedicate a patient before a painful procedure. There is no indication that the medication should be changed since the previously administered doses have controlled the patient's pain. Waiting to medicate the patient until after the dressing change may mean that the patient will be in significant pain until the medication takes effect. "Getting ahead of the pain" by premedicating will keep the pain under much better control than waiting until the patient has increased pain.

19.) Answer: C, A, B, D.

The most potentially critical patient is the patient with a diagnosis of gastric ulcer who complains of sudden onset abdominal pain. This patient may have bleeding from the ulcer which is causing the pain. The nurse should remember that blood outside a blood vessel is an extreme irritant that can cause a great deal of pain. Evaluate this patient first. The second patient to evaluate would be the other patient with pain. Since he is 2 days post operative, it is likely that his pain does not indicate an acute problem. Evaluate this patient and medicate him as necessary. The third patient to see would be the pre-operative patient who needs to sign the surgical consent. Since he is not scheduled to go the operating room for three hours, the nurse should have enough time to do the pre-operative teaching and get the consent signed. Finally, there is no indication that the patient with rectal cancer who is going for a colonoscopy has any immediate needs. The nurse should ensure that another staff member checks on him until the nurse can get in to see him.

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20.)Answer: A.

The nurse should explore the reasons that the patient does not take an active role in her care. The first step in this process is to determine what the patient thinks about her health, the care she receives and the healthcare system. During this process, the nurse can determine if the patient can read and write. Instructing the patient to read instructions and fill out questionnaires may not be possible and may not be something the patient is willing to do. Asking the patient if she has questions about her care should come later in the conversation after some baseline information is obtained.

21.)Answer: B.

Studies show that there is no substitute for proper hand washing to control the spread of infection. Good hand washing technique with soap and water should be used between patient contacts when available. Hand washing and gloves are needed for dressing changes. This is particularly true when the nurse's hands or gloves become soiled with bodily fluids. It is not possible for the skin to be sterilized.

22.)Answer: D.

The nurse should expect weakness, fatigue, shaking, and mood swings, all of which increase the risk for falls and injuries in the withdrawal patient. Euphoria is not typically part of the withdrawal process. Alcohol withdrawal can cause loud and violent behavior. It is best for this patient to not have a roommate. Medication for a withdrawal patient is usually restricted.

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23.) Answer: A.
Researchers have not yet produced a vaccine for Hepatitis C. Shingles can be treated with a vaccination, Zostavax. Children receive the varicella vaccine as part of their vaccination regime. This vaccination typically confers lifelong immunity to the person who has been immunized. Preschool children should receive one dose; older children and adults should receive 2 doses. Vaccines are available for both Hepatitis A and B.

79.) Answer: A.
The tube, ties and gauze are all positioned correctly so the nurse does not need to intervene. The ties on any tracheostomy should be tied or fastened on the side of the patient's neck so that the trach can be released quickly and so the tie or fastener is not putting pressure on the back of the neck. The slit of the gauze pad should be pointed up. Particularly with patients who have short or fat necks, this allows the gauze to be applied and removed more easily. The unbroken part of the gauze will also absorb more drainage if it is on the bottom part of the trach. There is no indication that the patient needs to be suctioned and the nurse should do a respiratory assessment before suctioning the patient.

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80.) Answer: A.
The patient with COPD will experience shortness of breath; with this problem, the patient will also have increased work that will tend to burn more calories resulting in weight loss. Therefore, the best diet for a patient with COPD without other co-morbidities is one high in calories and protein. The nurse should also remember that the patient with COPD may get short of breath and tired when eating so it should be part of the teaching to eat several small meals over the course of the day rather than three large meals. There is no indication that this patient has underlying coronary artery disease or other heart disease so no added salt and low cholesterol diets may not be needed. Without an indication of other problems with teeth or digestion, a soft and bland diet is not necessary.

81.) Answer: D.
If daytime sleepiness is a problem, the physician should be consulted. The medication dose may need to be decreased or the medication should be changed. The nurse should also know that a more serious problem may be that the zolpidem is not being properly metabolized which could signal kidney or liver problems. Ambien induces sleep and does not discolor urine. This medication has no adverse effect on heart rate or regularity. Ambien has not been shown to cause headache.

82.) Answer: A.
Drugs are cleared out of the body via urine. In the case of renal failure, the kidneys do not filter. Therefore,

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medications can build up to toxic levels. This is the reason that one of the relative contraindications of many medications is renal or liver failure. Diverticulitis is an inflammation of the intestine that does not cause a buildup of medication in the body. Drug toxicity is not caused by pancreatic cancer; however, drugs and alcohol can contribute to the development of this cancer. Liver failure can also be a problem with pancreatic cancer, which might have an effect on drug metabolism. Though many drugs can cause stomach ulcers, this condition does not cause drug toxicity.

83.) Answer: B.
When a patient is having chest pain, one nitroglycerin tablet is placed under the tongue to dissolve. If the pain is not completely gone in 5 minutes, another may be given. Once 5 more minutes pass, if pain has not significantly subsided, another may be administered. Typically, if pain is not relieved after three doses, the physician should be notified. There is no indication that the patient is pulseless and not breathing. CPR is never begun on a patient whose heart is beating. Vitals must be checked, but blood pressure is typically lowered by NTG. The patient should be instructed to get up slowly due to the tendency of NTG to lower blood pressure. No more than one NTG tablet is given at a time. This is a powerful drug that can dangerously lower the blood pressure in a matter of minutes, slow the heart, and cause death.

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84.) Answer: A.

This question requires that the test taker knows how to convert pounds to kilograms. Since there are 2.2 pounds per kg, divide the number of pounds by 2.2. (44/2.2=20 kg) In the available concentration, there are 2 mg per ml. (10mg/5ml) The order is to give 2mg/kg of weight. (1ml X 20 kg = 20 ml). The other calculations are incorrect.

85.) Answer: A.
Asking the patient to inhale and hold his breath helps build intrathoracic pressure to keep air from entering the subclavian vein. Normal breathing may increase the risk of a dangerous amount of air entering the vein when the tubing is changed. Exhaling and holding his breath will not produce the positive pressure needed to exclude outside air. Turning the head is not necessary, though the patient may prefer it. When changing the bag only on a central line, there is no need for the patient to hold his breath since the nurse can occlude the tubing to prevent air from entering the site.

86.) Answer: C.
Insulin is an acceptable additive for patients who need it with their TPN. No other additive or component should be added to the TPN solution. Xanax cannot be given via a PN line, since it must pass through the digestive system. Phenergan, and many other drugs, can cause precipitation in the TPN formulation. Demerol cannot be administered with TPN.

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87.) Answer: B.
A peg tube empties formula directly into the stomach to be digested. Parenteral nutrition bypasses the digestive system by administration directly into the bloodstream. A PICC line is inserted into a peripheral vein, but is long enough to empty into the large veins going directly into the heart; therefore, it is appropriate for parenteral nutrition. A subclavian line empties directly into the large vein of the heart, reducing risk of damage to smaller veins. A CVC also empties just above the heart muscle to be distributed.

88.) Answer: C.
Parenteral nutrition is formulated to be administered directly into the bloodstream of patients whose digestive system is non-functional. Parenteral nutrition goes directly into the bloodstream, bypassing the digestive system. In fact, the nurse should know that parenteral means "outside the intestine". Enteral nutrition cannot be given IV as it must go through the digestive system to be processed. Enteral nutrition is processed through the digestive system, usually through a tube that empties into the stomach. The test taker should suspect that response C or D will be the correct response since they are "opposite" responses.

89.) Answer: B.
The components that must be included on a medication order include: medication name, dosage, route, frequency, indication for administration, patient name, time, date, and physician's signature. One of the components frequently forgotten is the indication for administration; for example, a physician might document that a certain medication will be

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given "for pain or shortness of breath". Classification of a medication is not required. Neither the nurse manager nor the patient has the authority to sign the medication order. However, if the nurse has taken a telephone order, the medication order should clearly indicate that the order was taken from a named physician by the named nurse.

Leopold's maneuvers are four steps during which the clinician palpates the uterus to determine the size, lie and presentation of the fetus. These maneuvers are typically done at each visit during the woman's third trimester. The first maneuver is done by palpating the fundus or top of the uterus. This maneuver will determine if the fetus is in a vertical or transverse lie. The second maneuver is done by applying pressure to the sides of the mother's abdomen to determine the location of the spine and small parts (arms and legs). The third maneuver involves using the thumb and fingers of one hand to palpate above the symphysis pubis to establish if the presenting part is engaged in the birth canal. Finally, the fourth maneuver is done facing the woman's feet. This maneuver is done to determine how the head is flexed in relationship to the fetal spine in the case of a cephalic presentation.

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117.) Answer: B.
Atrial fibrillation is a rhythm with irregular beating. This rhythm is characterized by dissociation of the P waves and QRS wave as the atria in the heart begin to contract irregularly. This causes multiple impulses from the atria (P waves) for each QRS complex. The patient may have no symptoms or may experience palpitations and weakness or lack of energy. In sinus rhythm, there is one P wave for each QRS complex. First degree heart block is characterized by a prolonged PR interval on the ECG. Finally, ventricular fibrillation is a chaotic rhythm that is deadly if not treated promptly. In V Fib, the heart quivers, or fibrillates, rather than beating as normal.

118.) Answer: C.
Following a TURP, it is common for the surgeon to place a 3-way catheter for continuous bladder irrigation using normal saline solution. This irrigation catheter is used to prevent blood clots from clogging the urinary catheter. Although antibiotics may be instilled into the bladder to prevent infection, this is not the main reason the 3-way catheter is inserted for continuous irrigation. Continuous irrigation does not stop bleeding in the bladder.

119.) Answer: D.
Before suctioning any patient, the nurse must pre-oxygenate the patient to prevent hypoxia. The nurse should use sterile gloves and equipment when suctioning a patient. The catheter should be inserted approximately 5-6 inches into the tracheostomy of an adult patient. The only fluid that should be instilled into the trachea of any patient is sterile normal saline. Tap water should not be used.

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120.) Answer: A.

Facial flushing is a common feeling from IVP dye. Chest pain and chills are not commonly experienced and may indicate an allergic reaction to the dye. The patient may experience a taste of salt in the mouth; they will typically not experience a taste of metal. Some medications and poisons can cause a metallic taste, but IVP dye does not.

121.) Answer: B.

A paradoxical effect of a medication is the opposite of the expected therapeutic effect. For example, a sleeping pill is prescribed to induce sleep. If that medication keeps the patient restless and awake, that would be identified as a paradoxical effect. Prescribing the wrong antibiotic might be classified as a medication error. Slowed metabolism of a drug is not a paradoxical effect. Peaks and troughs of a medication indicate whether or not enough medication (or too much medication) has been prescribed. These levels do not indicate a paradoxical effect.

122.) Answer: A.

Lasix, a diuretic often prescribed for CHF patients, causes an increased loss of potassium through the kidneys. Unless the potassium is replaced, severe cramps can result. Lab results would show a decrease in the patient's potassium level. The nurse should anticipate that the prescriber will also start this patient on supplemental potassium. The nurse should know that there are diuretics that are "potassium sparing" that do not cause this side effect. There would be no reason to expect an increase in blood potassium. Diuretics have no significant effect on sodium levels so the nurse would not necessarily expect to see abnormal sodium levels.

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130.) Answer: B.

This photo demonstrates pectus excavatus, a condition most often affecting males. It is believed to be caused by an overgrowth of costal cartilage although the exact etiology is not known. The savvy test taker might recognize that the root of "excavatus" is excavate. Since this photo shows a depression, or excavation, in the chest, this response would be an excellent choice if the test taker does not know the other syndromes. A barrel chest is exactly what it sounds like - the chest is barrel shaped and is very common in older patients with chronic lung disease. Poland syndrome is characterized by hypoplasia of the chest wall leading to possible deformities of the hand and arm. Jeune syndrome is a failure of the chest wall to grow in utero leading to pulmonary hypoplasia and a very narrow chest cavity.

131.) Answer: D.

The nurse should suspect that the patient's blood sugar is very high and that the child is in ketoacidosis. Nausea, feeling "bad" and a fruity odor on the child's breath should be enough for the nurse to take the aggressive action of starting an IV of normal saline. The child is probably dehydrated and an IV will help this finding. In addition, the child will probably need IV insulin and other medications. After starting the IV, the nurse should obtain blood glucose results and should report the results to the physician. The physician will order the correct dose and type of insulin. Drinking a glass of juice will only increase the patient's glucose level so should NOT be done.

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132.) Answer: C.

This question requires that the test taker have some knowledge of cystic fibrosis and specifically that the test taker knows that the disease is an autosomal recessive disorder; therefore, there is definitely a genetic basis for the disorder. This means that both parents must have the gene. Even if both parents carry the gene, there is a one in four chance that the child will have the disease. This chance will occur independently in each pregnancy for the couple. Cystic fibrosis can occur in female or male children. It is not only carried on the X chromosome.

133.) Answer: B, C, D, F.

DIC is diagnosed based on both laboratory and clinical findings, including petechiae and unexpected bleeding, low platelet count, low fibrinogen, and decreased PT levels. The pulse rate is often elevated in DIC. In this case, the urine output indicates normal renal function. Temperature is typically not related to DIC.

134.) Answer: D.

Cardiogenic shock is characterized by decreased myocardial contractility that results in decreased cardiac output. Although cardiogenic shock may be caused by a myocardial infarction, this is not always the case. Decreased circulating volume (hypovolemia) is typically associated with hypovolemic shock and NOT with cardiogenic shock.

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135.) Answer: A.

For ANY patient, the most accurate way to measure fluid loss (or gain) is to measure the patient's weight at the same time each day and using the same scale. Measuring intake and output will allow the nurse to know how much fluid is being taken in and expelled, but it does not allow the nurse to accurately understand fluid loss. Changes in vital signs and skin turgor are later signs and can be affected by conditions unrelated to fluids. A good rule of thumb for the test taker is to know that each kilogram (2.2 pounds) of weight equals approximately 1,000 milliliters of fluid.

136.) Answer: D.

Using ABG results, the nurse can determine if the condition is acidosis or alkalosis (based on the pH) and whether it is respiratory or metabolic (based on the bicarbonate and carbon dioxide levels). The low pH in this example would indicate that the underlying issue is acidosis. This piece of information allows the test taker to immediately narrow down the possible correct responses to either metabolic or respiratory acidosis. The CO_2 level is high and the Bicarbonate level is normal which would both point to the underlying issue being a respiratory acidosis.

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