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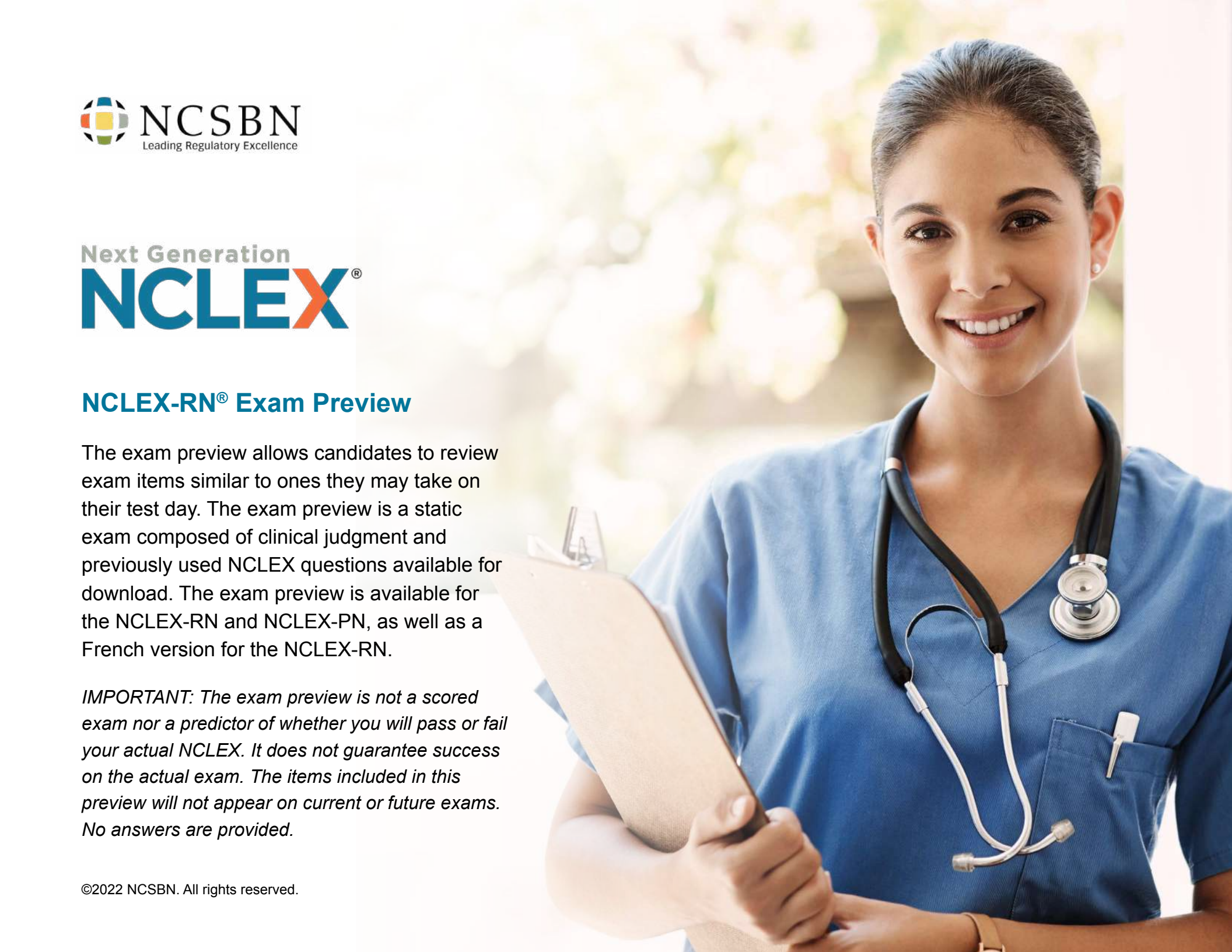
NCLEX®



NCLEX-RN® Exam Preview

The exam preview allows candidates to review exam items similar to ones they may take on their test day. The exam preview is a static exam composed of clinical judgment and previously used NCLEX questions available for download. The exam preview is available for the NCLEX-RN and NCLEX-PN, as well as a French version for the NCLEX-RN.

IMPORTANT: The exam preview is not a scored exam nor a predictor of whether you will pass or fail your actual NCLEX. It does not guarantee success on the actual exam. The items included in this preview will not appear on current or future exams. No answers are provided.

The charge nurse has received a change-of-shift report on the following clients in labor.

The charge nurse should ask a staff member to **first** see the client in the

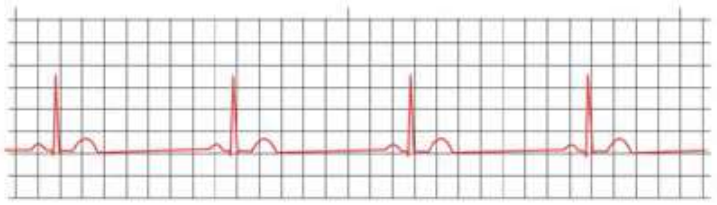
1. first stage of labor who has an oral temperature of 99.7° F (37.6° C)
2. first stage of labor whose contractions are occurring every 30 seconds
3. second stage of labor who has respirations of 26
4. second stage of labor whose contractions are lasting for 60 seconds

The nurse is observing a staff member caring for a client who has chickenpox.

Which of the following actions by the staff member would require the nurse to intervene?

1. placing the client in a private room with monitored negative air pressure
2. placing a box of disposable face shields outside the client's room
3. placing an alcohol-based hand rub in the client's room for hand hygiene
4. placing a surgical mask on the client during transport out of the client's room

The nurse is caring for a client who reports feeling faint and is experiencing the cardiac rhythm shown in the electrocardiogram (ECG) strip below.



Which of the following actions would be appropriate for the nurse to take? **Select all that apply.**

1. Administer the client's prescribed beta blocker.
2. Prepare for transcutaneous pacing.
3. Instruct the client to perform the Valsalva maneuver.
4. Begin chest compressions.
5. Assess the client for angina.

The nurse is planning care for a client with moderate Alzheimer's disease (AD).

Which of the following interventions should the nurse include in the client's plan of care?

1. Encourage the client to reminisce about happy memories.
2. Confront the client when inappropriate or agitated behaviors occur.
3. Administer to the client the cholinesterase inhibitor to reverse the course of AD.
4. Provide the client with information about activity choices in the morning so the client can make plans for the day.

The nurse is teaching a client how to ambulate using crutches.

Which of the following information should the nurse include?

1. “Use your hands and arms to support your body weight.”
2. “Wear slippers when ambulating with the crutches in your home.”
3. “Maintain the crutches 12 in (30 cm) in front of your feet while standing.”
4. “Adjust the hand grips of the crutches so that your elbows are fully extended.”

The nurse has taught a client with multiple sclerosis (MS).

Which of the following statements by the client would indicate a correct understanding of the teaching?

1. "I will complete all of my household chores in the morning when I am well rested."
2. "I have learned how to massage my bladder to help empty my bladder completely."
3. "I will take a hot bath in the evening to help me relax if I have had a stressful day at work."
4. "I should expect the blurred vision to resolve after I have received medications for several weeks."

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Click to highlight the findings below that would require follow-up.

Nurses' Notes

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

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For each assessment finding below, click to specify if the finding is consistent with the disease process of bowel obstruction, appendicitis, or ruptured spleen. Each finding may support more than 1 disease process.

Assessment Findings	Bowel Obstruction	Appendicitis	Ruptured Spleen
appetite	☐	☐	☐
pain level	☐	☐	☐
bowel pattern	☐	☐	☐
gastrointestinal symptoms	☐	☐	☐

Note: Each column must have at least 1 response option selected.

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Select the 3 complications the client is at risk for developing.

1. anemia
2. peritonitis
3. septic shock
4. hypovolemia
5. dysrhythmias
6. cardiac arrest

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1130: Notified primary health care provider about client status. Awaiting orders.

The nurse has reviewed the Nurses' Notes from 1130.

For each potential intervention, click to specify whether the intervention is indicated or not indicated for the client.

Potential Interventions	Indicated	Not Indicated
clear liquid diet	○	○
soapsuds enema	○	○
heating pad to abdomen	○	○
abdominal girth measurements	○	○
abdominal computed tomography (CT) scan	○	○

Note: Each row must have 1 response option selected.

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

1130: Notified primary health care provider about client status. Awaiting orders.

1230: Client transported to radiology department for abdominal computed tomography (CT) scan.

1245: 20-gauge peripheral venous access device (VAD) inserted into the left hand. VAD site patent without signs of infiltration. 0.9% sodium chloride (normal saline) infusing at 75 mL/hr.

1400: Client reports sudden relief of abdominal pain. Vital signs: T 102.5° F (39.2° C), P 110, RR 20, BP 125/86.

1415: Primary health care provider notified about client status. Order received for an additional abdominal CT scan. Client transported to radiology department.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

Complete the following sentences by choosing from the lists of options.

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

The nurse should prepare the client for surgery within Select… .

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

1445: Free intraperitoneal fluid noted consistent with a ruptured appendix.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

Complete the following sentences by choosing from the lists of options.

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

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1445: Free intraperitoneal fluid noted consistent with a ruptured appendix.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

Complete the following sentences by choosing from the lists of options.

The nurse should insert Select… .

Select…
a rectal tube
a nasogastric (NG) tube
an indwelling urethral catheter

It would be a **priority** for
prescription for an Selec

The nurse should prepare lect… .

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Abdominal CT scan

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The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

Complete the following sentences by choosing from the lists of options.

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

Select…
analgesic medication
antipyretic medication
anti-infective medication

The nurse should p…y within Select… .

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

1445: Free intraperitoneal fluid noted consistent with a ruptured appendix.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

Complete the following sentences by choosing from the lists of options.

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

The nurse should prepare the client for surgery within Select… .

Select…
6 hours
8 hours
24 hours

The nurse in the medical-surgical unit is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

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1400: Client reports sudden relief of abdominal pain. Vital signs: T 102.5° F (39.2° C), P 110, RR 20, BP 125/86.

1415: Primary health care provider notified about client status. Order received for an additional abdominal CT scan. Client transported to radiology department.

1800: Client transported to the operating room for an open appendectomy.

Medical-Surgical Unit

2030: Client transported back to the medical-surgical unit.

2230: Client performing coughing and deep-breathing exercises every hour while awake with the incentive spirometer. Performing postoperative leg exercises every hour while awake. Nasogastric (NG) tube removed. Drinking clear liquids. Abdomen boardlike with diminished bowel sounds in all quadrants. Rebound tenderness present.

The nurse has reviewed the Nurses' Notes from 1800, 2030, and 2230.

Which of the following findings would indicate the client is progressing as expected? **Select all that apply.**

- [ ] 1. clear liquid diet
- [ ] 2. boardlike abdomen
- [ ] 3. rebound tenderness
- [ ] 4. incentive spirometry use
- [ ] 5. diminished bowel sounds
- [ ] 6. performance of leg exercises

The nurse has attended a staff education program about caring for clients who are receiving positive pressure mechanical ventilation.

Which of the following statements by the nurse would indicate a correct understanding of the teaching?

1. “Clients should avoid range-of-motion (ROM) exercises until weaned from ventilation.”
2. “Clients may develop stress ulcers and gastrointestinal bleeding.”
3. “Clients will be chemically paralyzed to improve oxygenation.”
4. “Clients will experience diuresis and polyuria.”

The charge nurse must transfer a female client from the medical-surgical unit to the maternity unit to make a bed available.

It would be **most** appropriate for the nurse to transfer the client who is

1. 28 years old, had a right mastectomy and has a closed-wound drainage system
2. 49 years old, has diabetes mellitus (type 2) and has begun receiving insulin
3. 56 years old, has hepatitis C (HCV) and has been afebrile for 24 hours
4. 70 years old, has a fractured left tibia and had an external fixation device applied 48 hours ago

The nurse has been made aware of the following client situations.

The nurse should **first** assess the client with

1. heart failure who has a productive cough and is anxious
2. regional enteritis (Crohn's disease) who is reporting cramping abdominal pain and diarrhea
3. idiopathic thrombocytopenic purpura (ITP) who has petechiae on the trunk and is reporting heavy menses
4. chronic obstructive pulmonary disease (COPD) who has dyspnea with exertion and is using accessory muscles to breathe

The nurse and unlicensed assistive personnel (UAP) are caring for assigned clients.

Which of the following tasks would be appropriate for the nurse to assign to UAP?

1. assisting a client with atrial fibrillation to shower
2. checking the ability of a client to swallow water after a transesophageal echocardiogram (TEE)
3. observing while a client with dysphagia begins a thickened liquid diet
4. transporting a client with respiratory distress to the radiology department for a chest radiograph

The nurse has taken a nutritional history from parents of clients.

It would be a **priority** for the nurse to follow up with the

1. 5-month-old client whose only source of nutrition is 5 formula feedings daily
2. 7-month-old client who eats several crackers as finger food
3. 9-month-old client whose typical daily diet includes 10 bottles of 2% milk, 1 cup of apple juice, and 3 servings of infant cereal
4. 1-year-old client whose typical food intake includes 4 breast-feedings and 3 servings of cooked vegetables, pears, or sliced cheese

The nurse is planning a staff education program about client privacy.

Which of the following scenarios should the nurse include as an example of a violation of client privacy?

1. discussing with an unlicensed assistive personnel (UAP) that the UAP's assigned client will require a smaller condom catheter
2. sharing the client's blood alcohol level (BAL) test result with the police officer who brought the client to the emergency department (ED)
3. responding to the call light of the client who is assigned to another nurse and needs assistance in the bathroom
4. allowing a nursing student who has been assigned to the client to review the client's medical record

The nurse has become aware of the following client situations.

The nurse should **first** assess the client

1. who had a right pneumonectomy 24 hours ago and is in the high-Fowler's position while lying on the right side
2. with chronic obstructive pulmonary disease (COPD) who is using pursed-lip breathing and reporting hemoptysis
3. who had a wedge resection of the left lung 24 hours ago and is sitting in the high-Fowler's position
4. with heart failure who has a productive cough and is restless

The nurse is caring for a 3-year-old client with a cerebral concussion who is being observed overnight in the pediatric unit.

Which of the following observations would be **most** significant for the nurse to report to the oncoming shift?

1. The client has a blood pressure of 94/58 mm Hg and an apical pulse of 90.
2. The client is sleeping but is easily aroused.
3. The client's pupils are equal and reactive to light.
4. The client has an axillary temperature of 99.0° F (37.2° C) and respirations of 24.

The nurse in the same-day surgical center has received a change-of-shift report on the following clients.

The nurse should **first** see the client who had

1. closed reduction of a fractured tibia with cast application 1 hour ago and is reporting that the casted leg feels hot
2. extraction of a cataract lens 2 hours ago and is reporting nausea
3. an arthroscopy of the right knee 3 hours ago and is reporting knee pain rated as 4 on a scale of 0 (no pain) to 10 (severe pain)
4. a laparoscopic cholecystectomy 4 hours ago and is reporting right shoulder pain

The nurse is planning care for a client with multiple sclerosis (MS) who has ataxia.

Which of the following interventions should the nurse include in the client's plan of care?

1. Add thickener to thin liquids for the client.
2. Obtain a referral to a physical therapist for the client.
3. Face the client directly when speaking with the client.
4. Provide a board with pictures to help the client communicate needs.

The home-health nurse is assigned to visit the following clients who live within 3 miles (4.8 km) of one another.

The nurse should **first** visit the client with

1. breast cancer who had a mastectomy 2 days ago and has had 25 mL of drainage from the closed-wound drainage system in the past 12 hours
2. lung cancer who received a dose of chemotherapy 2 weeks ago and has a temperature of 101.1° F (38.4° C)
3. chronic obstructive pulmonary disease (COPD) who is reporting expectorating large amounts of thick, yellow mucus
4. diabetes mellitus (type 1) who had a right below-the-knee amputation (BKA) and is reporting having right toe pain

The nurse has become aware of the following client situations.

The nurse should **first** assess the client

1. who had a total abdominal hysterectomy (TAH) 1 day ago and is unable to void 7 hours after the indwelling urethral catheter was removed
2. who had a total knee replacement 24 hours ago, is restless, and has a petechial rash on the chest
3. with bacterial pneumonia who has bronchial breath sounds auscultated between the scapulae and a temperature of 103.3° F (39.6° C)
4. with hepatic cirrhosis who has an elevated aspartate aminotransferase (AST) level and respirations of 24

The nurse is planning care for a pediatric client being admitted with pertussis.

Which of the following interventions should the nurse include in the client's plan of care?

1. Keep the client NPO.
2. Place a dehumidifier in the client's room.
3. Encourage the client to ambulate frequently.
4. Implement droplet precautions.

The nurse has attended a staff education program about infection control precautions.

It would indicate a correct understanding of the teaching if the nurse is observed

1. wearing a particulate respirator mask (N95) when entering the room of a client with Haemophilus influenzae pneumonia
2. placing a client with streptococcal pneumonia in a room with a client who has respiratory syncytial virus (RSV)
3. wearing a protective gown when entering the room of a client with Escherichia coli O157.H7 who is incontinent
4. placing a client with pediculosis capitis (head lice) in a room with a client who has scabies

The nurse is assessing an older adult client who is scheduled for discharge and is at risk for falls.

Which of the following are extrinsic risk factors for falling? **Select all that apply.**

- [ ] 1. uneven stairs
- [ ] 2. throw rugs
- [ ] 3. hemiparesis
- [ ] 4. dim lighting
- [ ] 5. confusion

The nurse is caring for a 3-year-old client with impetigo.

Which of the following infection control precautions should the nurse implement? **Select all that apply.**

1. Wear a surgical mask when bathing the client.
2. Wear a protective gown when changing the client's bed linens.
3. Keep the door to the client's room closed.
4. Place a box of clean gloves outside the client's door.
5. Place a surgical mask on the client during transport to other departments.

The nurse is evaluating a staff member's care of a client with active pulmonary tuberculosis (TB).

Which of the following actions by the staff member would indicate to the nurse an understanding of the principles of infection control for tuberculosis isolation?

1. instructing visitors to wash their hands before entering the client's room
2. putting on a mask, gown, and gloves before entering the client's room
3. placing tissues and a trash receptacle within the client's reach
4. asking the client to put on a clean mask each time someone enters the room

The nurse in the pediatric unit is preparing to admit a client with rubeola (measles).

The nurse should assign the client to a

1. private room at the end of the hallway
2. private room with monitored negative air pressure
3. room with a client who has chickenpox
4. room with a client who has atopic dermatitis (eczema)

The charge nurse is observing the following client situations.

It would require intervention if a

1. client with hepatitis B (HBV) is eating food brought into the facility by a visitor
2. visitor is sitting on the side of the bed of a client with acute pancreatitis
3. staff member is entering the room of a client with Haemophilus influenzae meningitis wearing a protective gown and gloves
4. family member of a client with mycoplasma pneumonia leaves the door to the client's room open

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Pulmonary	denies shortness of breath; reports discomfort in the lower left side of chest when taking a deep breath
Gastrointestinal	reports feeling abdominal fullness and is occasionally nauseated
Musculoskeletal	sustained an injury to the left rib cage after being struck by a mechanically pitched baseball in a batting cage last week; reports intermittent pain in the left shoulder rated 6/10 on the Numerical Rating Scale and feels light-headed; significant bruising to the shoulder; history of an orthoscopic repair to the left shoulder for a torn rotator cuff last year
Psychosocial	client has not felt well enough to attend baseball practice since the injury

Which of the following assessment findings require **immediate** follow-up? **Select all that apply.**

- [ ] 1. lung sounds
- [ ] 2. shoulder pain
- [ ] 3. laboratory results
- [ ] 4. productive cough
- [ ] 5. abdominal assessment findings
- [ ] 6. pulse, respirations, and blood pressure
- [ ] 7. temperature and pulse oximetry reading

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Emergency Department

Day 1

0900: Client appears pale and slightly diaphoretic. Large amount of bruising noted along the left torso and over the left upper quadrant (LUQ) of the abdomen. Tenderness, guarding, and dullness to percussion noted on abdominal assessment. Slightly diminished breath sounds noted in the left lung fields on auscultation; client has a productive cough. Electrocardiogram (ECG) shows normal sinus rhythm.

Which of the following assessment findings require **immediate** follow-up? **Select all that apply.**

- [ ] 1. lung sounds
- [ ] 2. shoulder pain
- [ ] 3. laboratory results
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- [ ] 5. abdominal assessment findings
- [ ] 6. pulse, respirations, and blood pressure
- [ ] 7. temperature and pulse oximetry reading

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | Nurses' Notes | Vital Signs | Laboratory Results

	Emergency Department Day 1 0900
T	97.8° F (36.6° C)
P	116
RR	24
BP	90/50
Pulse oximetry reading	98% on room air

Which of the following assessment findings require **immediate** follow-up? **Select all that apply.**

1. lung sounds
2. shoulder pain
3. laboratory results
4. productive cough
5. abdominal assessment findings
6. pulse, respirations, and blood pressure
7. temperature and pulse oximetry reading

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History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Laboratory Test and Reference Range	Emergency Department Day 1 0900
white blood cell (WBC) count Adult/child > 2 years: 5,000–10,000/mm^3 (5–10 x 10^9/L)	19,000/mm^3 (19 x 10^9/L)
hemoglobin (Hgb) Male: 14–18 g/dL (140–180 g/L) Female: 12–16 g/dL (120–160 g/L)	9 g/dL (90 g/L)
hematocrit (HCT) Male: 42%–52% (0.42–0.52) Female: 37%–47% (0.37–0.47)	27% (0.27)

Which of the following assessment findings require **immediate** follow-up? **Select all that apply.**

1. lung sounds
2. shoulder pain
3. laboratory results
4. productive cough
5. abdominal assessment findings
6. pulse, respirations, and blood pressure
7. temperature and pulse oximetry reading

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Pulmonary	denies shortness of breath; reports discomfort in the lower left side of chest when taking a deep breath
Gastrointestinal	reports feeling abdominal fullness and is occasionally nauseated
Musculoskeletal	sustained an injury to the left rib cage after being struck by a mechanically pitched baseball in a batting cage last week; reports intermittent pain in the left shoulder rated 6/10 on the Numerical Rating Scale and feels light-headed; significant bruising to the shoulder; history of an orthoscopic repair to the left shoulder for a torn rotator cuff last year
Psychosocial	client has not felt well enough to attend baseball practice since the injury

Which of the following issues is the client at risk of developing?
Select all that apply.

- [ ] 1. stroke
- [ ] 2. hemothorax
- [ ] 3. bowel perforation
- [ ] 4. splenic laceration
- [ ] 5. pulmonary embolism
- [ ] 6. abdominal aortic aneurysm

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Pulmonary	denies shortness of breath; reports discomfort in the lower left side of chest when taking a deep breath
Gastrointestinal	reports feeling abdominal fullness and is occasionally nauseated
Musculoskeletal	sustained an injury to the left rib cage after being struck by a mechanically pitched baseball in a batting cage last week; reports intermittent pain in the left shoulder rated 6/10 on the Numerical Rating Scale and feels light-headed; significant bruising to the shoulder; history of an orthoscopic repair to the left shoulder for a torn rotator cuff last year
Psychosocial	client has not felt well enough to attend baseball practice since the injury

Complete the following sentence by choosing from the list of options.

The nurse should **first** address the client's Select…

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Pulmonary	denies shortness of breath; reports discomfort in the lower left side of chest when taking a deep breath
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Musculoskeletal	sustained an injury to the left rib cage after being struck by a mechanically pitched baseball in a batting cage last week; reports intermittent pain in the left shoulder rated 6/10 on the Numerical Rating Scale and feels light-headed; significant bruising to the shoulder; history of an orthoscopic repair to the left shoulder for a torn rotator cuff last year
Psychosocial	client has not felt well enough to attend baseball practice since the injury

Complete the following sentence by choosing from the list of options.

The nurse should **first** address the client's [Select…]

- Select…
- abdominal pain
- respiratory status
- laboratory results

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | Nurses' Notes | Vital Signs | Laboratory Results

Emergency Department

Day 1

0900: Client appears pale and slightly diaphoretic. Large amount of bruising noted along the left torso and over the left upper quadrant (LUQ) of the abdomen. Tenderness, guarding, and dullness to percussion noted on abdominal assessment. Slightly diminished breath sounds noted in the left lung fields on auscultation; client has a productive cough. Electrocardiogram (ECG) shows normal sinus rhythm.

1000: Client diagnosed with a splenic laceration and a left-sided hemothorax per the physician.

The nurse has reviewed the Nurses' Notes from 1000.

For each potential order, click to specify whether the potential order is indicated or not indicated for the client.

Potential Orders	Indicated	Not Indicated
intravenous fluids	○	○
serum type and screen	○	○
chest percussion therapy	○	○
insertion of a nasogastric (NG) tube	○	○
administration of prescribed pain medication	○	○

Note: Each row must have 1 response option selected.

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Emergency Department

Day 1

0900: Client appears pale and slightly diaphoretic. Large amount of bruising noted along the left torso and over the left upper quadrant (LUG) of the abdomen. Tenderness, guarding, and dullness to percussion noted on abdominal assessment. Slightly diminished breath sounds noted in the left lung fields on auscultation; client has a productive cough. Electrocardiogram (ECG) shows normal sinus rhythm.

1000: Client diagnosed with a splenic laceration and a left-sided hemothorax per the physician.

1030: Client referred for immediate surgery.

The nurse has reviewed the Nurses' Notes from 1030.

Which of the following actions should the nurse take?
Select all that apply.

- [ ] 1. Mark the surgical site.
- [ ] 2. Provide the client with ice chips.
- [ ] 3. Perform a medication reconciliation.
- [ ] 4. Obtain consent for surgery from the client.
- [ ] 5. Insert a peripheral venous access device (VAD).
- [ ] 6. Inform the client about the risks and benefits of the surgery.
- [ ] 7. Assess the client's previous experience with surgery and anesthesia.
- [ ] 8. Ask the client's parents to wait in the waiting room while the plan of care is discussed with the client.

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Pulmonary	denies shortness of breath; reports discomfort in the lower left side of chest when taking a deep breath
Gastrointestinal	reports feeling abdominal fullness and is occasionally nauseated
Musculoskeletal	sustained an injury to the left rib cage after being struck by a mechanically pitched baseball in a batting cage last week; reports intermittent pain in the left shoulder rated 6/10 on the Numerical Rating Scale and feels light-headed; significant bruising to the shoulder; history of an orthoscopic repair to the left shoulder for a torn rotator cuff last year
Psychosocial	client has not felt well enough to attend baseball practice since the injury

The nurse has reviewed the Progress Notes from 0800.

Click to highlight the findings below that indicate a worsening of the client's status.

Progress Notes

Day 3

0800: Client is postoperative day 3 after a splenectomy and is able to ambulate in the corridor 3 or 4 times daily with minimal assistance. Client has clear breath sounds a left-sided chest tube in place attached to a closed-chest drainage system. Tidaling of the water chamber noted on deep inspiration. Client refuses to use the incentive spirometer, stating it causes left-sided chest pain. Client is using prescribed patient-controlled analgesia (PCA) device maximally every hour and continues to have intermittent nausea and vomiting. Adequate urine output. Abdominal surgical incision site with dressing is clean, dry, and intact with no erythema, edema, or drainage.

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Pulmonary	denies shortness of breath; reports discomfort in the lower left side of chest when taking a deep breath
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The nurse is reviewing the orders of a client who has acute kidney injury.

Which of the following orders should the nurse clarify?

1. computed tomography (CT) scan of the abdomen with intravenous contrast media
2. urine specimen for urinalysis
3. blood specimen for arterial blood gas (ABG)
4. referral to registered dietitian for parenteral nutrition evaluation

The nurse is planning a staff education program about caring for clients with restraints.

Which of the following information should the nurse include?

1. "Restraints should be removed once during a shift to perform passive range-of-motion (ROM) exercises for the client."
2. "Restraints should be secured to the side rails of the client's bed for quick release."
3. "Restraints require an order from the primary health care provider."
4. "Restraints may be used p.r.n. for clients who are confused."

The nurse is caring for a client with active pulmonary tuberculosis (TB).

Which of the following should the nurse include in the client's plan of care?

1. placing the client in a private room with the door open
2. putting a surgical mask on the client during transport to the radiology department
3. instructing the primary caregivers to wear surgical masks when caring for the client
4. instituting the standards for droplet precautions while caring for the client

The home-health nurse is teaching the parents of a 4-year-old client with impetigo.

Which of the following information should the nurse include?

1. “Put a surgical mask on your child when around siblings.”
2. “Cleanse the lesions with a povidone-iodine solution daily.”
3. “Apply petroleum jelly to the lesions daily.”
4. “Instruct your child not to use the same towels as siblings.”

The nurse has attended a staff education program about bioterrorism.

Which of the following statements by the nurse would require follow-up?

1. “Botulism is transmitted by ingestion of contaminated canned foods.”
2. “Hemorrhagic fever is spread by direct contact with blood or body fluids.”
3. “Anthrax is spread through direct contact with the bacteria and its spores.”
4. “Bubonic plague is transmitted from person to person via airborne droplets.”

The nurse observes a coworker who is assessing a client's thoracic expansion.

Which of the following would indicate that the coworker is using the correct assessment technique?

1. percussion from the apex of the scapula downward on each side
2. placement of the hands flat on the back with the thumbs at the level of the tenth ribs pointing to the spine, then asking the client to inhale
3. measurement of the anteroposterior diameter of the chest
4. placement of the palms at the level of the tenth ribs with thumbs pointing to the xiphoid process, then asking the client to inhale

The nurse at a health fair is talking with a client who is in perimenopause and is experiencing hot flashes.

Which of the following lifestyle modifications would be appropriate for the nurse to recommend?

1. increasing fluid intake
2. exercising daily
3. decreasing sodium intake
4. wearing clothing in layers

The nurse in a community-based setting is teaching clients over 65 years of age about health promotion activities.

Which of the following information should the nurse include?

1. "Purchase all of your prescribed medications at the same pharmacy."
2. "Schedule an appointment for a vision screening every 3 years."
3. "Participate in daily aerobic exercises for 60 minutes."
4. "Increase your intake of fat-soluble vitamins."

The nurse is screening clients for those at increased risk for developing cancer.

At **highest** risk for developing leukemia is the client who

1. received more than 3 blood transfusions
2. has a magnetic resonance imaging (MRI) scan annually
3. has polycythemia vera and requires phlebotomy treatments
4. had colon cancer and received chemotherapy treatments

The nurse is caring for an older adult client in the postoperative period.

The nurse should know that this client, compared with younger clients in the postoperative period, will have an **increased** need for

1. oral hygiene
2. analgesics
3. high-calorie foods
4. early mobilization

The nurse is planning a staff education program about the prevention of urinary tract infections (UTIs) in children.

Which of the following information should the nurse include? **Select all that apply.**

1. "Teach the child to perform Kegel exercises."
2. "Encourage the child to empty the bladder completely."
3. "Encourage the child to maintain an adequate fluid intake."
4. "Teach the child how to properly cleanse the perineal area."
5. "Offer the child noncarbonated, decaffeinated beverage choices."

The nurse is teaching the family member of a client with moderate Alzheimer's disease (AD).

Which of the following interventions should the nurse include in the teaching? **Select all that apply.**

1. Use distraction when the client becomes agitated.
2. Place calendars within clear view of the client.
3. Use short, simple sentences and provide step-by-step instructions for the client.
4. Avoid reminiscing with the client about past experiences in order to avoid feelings of loss and loneliness.
5. Encourage the client to participate in a daytime exercise program to promote restful sleep at night.

The nurse is preparing to administer a unit of packed red blood cells (PRBCs) to a client.

Which of the following actions should the nurse take?

1. Assess the client's recent urine output.
2. Prime a Y-tubing blood administration set with lactated Ringer's solution.
3. Ensure that the client has a peripheral venous access device (VAD) that is 24-gauge or larger.
4. Verify with another nurse that the client's room number is on both the blood product label and the client's identification band.

The nurse is assessing the coping strategies of a client who had a myocardial infarction (MI) 3 days ago.

Which of the following statements by the client would indicate ineffective coping?

1. "I know that stopping smoking will be difficult."
2. "I plan to attend a cardiac rehabilitation support group."
3. "I have trouble believing this has really happened to me."
4. "I have let down my family because I will not be able to financially support them any longer."

The hospice nurse has taught an in-home caregiver about comfort care for a client at the end of life.

Which of the following statements by the caregiver would require follow-up?

1. "I have been applying petroleum jelly to keep the client's lips moist."
2. "I have been offering healthy foods frequently to keep up the client's strength."
3. "A blowing fan seems to be less anxiety-producing for the client than an oxygen mask."
4. "Sitting upright seems to reduce the client's noisy breathing more than lying down in the bed."

The nurse is witnessing the client's signature on a consent form.

Which of the following conditions should the nurse recognize must be met to ensure the consent is valid?
Select all that apply.

1. The client gave consent voluntarily.
2. The client received adequate disclosure.
3. The consent form is witnessed by 2 health care professionals.
4. The client understands the scheduled procedure or treatment.
5. The consent form is signed within 24 hours of the scheduled procedure or treatment.

The nurse is talking with a client who has been sexually assaulted. The client states, “I never should have walked home late at night. I am to blame for what has happened to me.”

Which of the following would be an appropriate response for the nurse to make? **Select all that apply.**

1. “The police officers who brought you into the hospital will be with you during this interview.”
2. “You should take a warm, calming shower in order to feel more relaxed.”
3. “You did the best you could in very difficult circumstances.”
4. “Sometimes the victim’s behavior causes the violence.”
5. “You are safe here.”

The nurse is planning care for a client with moderate Alzheimer's disease (AD).

Which of the following interventions should the nurse include in the client's plan of care? **Select all that apply.**

1. Establish a daily routine for the client.
2. Assist the client to void every 2 hours.
3. Introduce self upon interacting with the client.
4. Display a clock and calendar in the client's room.
5. Keep the client's television on during the day to distract the client.

A parent is discussing with the nurse about the behaviors of a 4-year-old child following the death of a grandparent.

The nurse should understand that the child may be experiencing dysfunctional grieving if the parent reports that the child

1. conducts mock funerals with stuffed animals
2. refuses to go to sleep at night
3. continues to talk about the grandparent coming to visit
4. asks to play with the grandparent while at the cemetery

The nurse has taught a client who has been ordered a low-sodium diet about appropriate food choices.

Which of the following statements by the client would indicate a correct understanding of the teaching?

1. “I will eat steamed, fresh broccoli with herbs and spices for an evening meal.”
2. “I will add cottage cheese and other dairy products to my daily diet.”
3. “I am glad I can still enjoy eating cereals, such as bran flakes with raisins.”
4. “I am glad I can eat lean meats daily because I eat ham sandwiches for an afternoon meal.”

The nurse is caring for a client who had a left modified radical mastectomy. The client received discharge instructions for performing range-of-motion (ROM) exercises on her left arm.

Which of the following, if reported by the client on her return visit to the clinic, would indicate to the nurse that the instructions have been followed correctly?

1. regular squeezing of a tennis ball in her left hand
2. placing her left palm against a wall and “climbing” the wall with the left fingers
3. carrying light hand weights while walking 1 mile every other day
4. performing isometric exercises with both arms extended

The nurse is planning care for a client who has expressive aphasia after a left-sided stroke.

Which of the following statements by the client's spouse would indicate a correct understanding of the client's communication abilities and interaction needs? **Select all that apply.**

1. "My spouse's response of 'fine' when asked how the day has been may or may not be what my spouse meant to communicate."
2. "I can anticipate what my spouse wants to say, so I complete my spouse's sentences to make communication quicker."
3. "I will purchase a picture board to help my spouse express common needs, thoughts, and feelings that are difficult to communicate."
4. "My spouse's angry response when we have a conversation makes me hesitant to try further communication."
5. "I have arranged for my spouse to meet with a speech therapist twice each week to improve communication skills."

The nurse is caring for a client who is in Buck traction.

Which of the following would require **immediate** intervention?

1. A pillow is placed under the knee.
2. The foot is 2 in (5 cm) away from the foot plate.
3. The weights attached to the pulley are 6 in (15 cm) from the floor.
4. A pillow is placed under the lower leg with the heel off the bed.

The nurse has taught the adult child caregiver of a client with moderate Alzheimer's disease (AD) about home care.

Which of the following statements by the adult child would indicate a correct understanding of the teaching?

1. "I will only allow my parent to smoke while my parent is outdoors."
2. "I will place a picture on the bathroom door to indicate which room in our home is the bathroom."
3. "I will encourage family members to visit in large groups to keep my parent interested in the conversation."
4. "I will encourage my parent to take walks in the park when the weather permits to get the exercise needed."

The nurse is teaching a client newly diagnosed with diverticulosis.

Which of the following information should the nurse include?

1. “Limit your daily fluid intake to 2 L to avoid bloating.”
2. “You may be prescribed a bulk-forming laxative.”
3. “Limit your intake of dairy products such as milk and yogurt.”
4. “You should avoid consuming cooked vegetables.”

The nurse is preparing to administer lorazepam 2 mg, IV, now to a client who is scheduled for surgery in 30 minutes. The nurse is unfamiliar with the dosage for the medication.

Which of the following actions should the nurse take **next**?

1. Check the medication dosage in a medication reference source.
2. Ask another nurse whether the prescribed dose is a safe dose.
3. Clarify that the dose is correct with the primary health care provider.
4. Contact the pharmacist to verify the safe dosage range for the medication.

The nurse is caring for a client who is receiving a high dose of a phenothiazine.

When evaluating the client for a life-threatening syndrome related to the medication, it would be a priority for the nurse to report

1. dry mouth
2. orthostatic hypotension
3. fever
4. photophobia

The nurse in the emergency department (ED) is caring for a 78-year-old female client.

Nurses' Notes

1000: Client was brought to the ED by the client's adult child due to increased shortness of breath this morning. The adult child reports that the client has been running a fever for the past few days and has started to cough up greenish mucus and to complain of soreness throughout the body. Client was hospitalized for issues with atrial fibrillation 6 days ago. History of hypertension. Vital signs: T 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. On assessment, the client's breathing appears slightly labored, and coarse crackles (rales) are noted in the bilateral lung bases. Skin slightly cool to touch and pale pink in tone; pulses 3+ and irregular. Capillary refill is 3 seconds. Client is alert and oriented to person, place, and time. The adult child states, "Sometimes it seems like my parent is confused." Peripheral venous access device (VAD) placed in right forearm.

Select the 4 client findings that require **immediate** follow-up.

1. vital signs
2. lung sounds
3. capillary refill
4. client orientation
5. radial pulse characteristics
6. characteristics of the cough

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For each client finding below, click to specify if the finding is consistent with the disease process of pneumonia, a urinary tract infection (UTI), or influenza. Each finding may support more than 1 disease process.

Client Findings	Pneumonia	Urinary Tract Infection	Influenza
fever	☐	☐	☐
confusion	☐	☐	☐
body soreness	☐	☐	☐
cough and sputum	☐	☐	☐
shortness of breath	☐	☐	☐

Note: Each column must have at least 1 response option selected.

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Complete the following sentence by choosing from the list of options.

The client is at **highest** risk for developing Select…

The nurse in the emergency department (ED) is caring for a 78-year-old female client.

Nurses' Notes

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Complete the following sentence by choosing from the list of options.

The client is at **highest** risk for developing [Select…]

- Select…
- stroke
- hypoxia
- dysrhythmias
- a pulmonary embolism

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Nurses' Notes

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1200: Called to bedside by the adult child who states that the client "isn't acting right." On assessment, client is difficult to arouse, pale, and diaphoretic. Vital signs: P 112, RR 32, BP 90/62, pulse oximetry reading 91% on 2 L/min of oxygen via nasal cannula.

The nurse has reviewed the Nurses' Notes from 1200.

For each potential nursing intervention, click to specify whether the intervention is indicated or not indicated for the care of the client.

Potential Nursing Interventions	Indicated	Not Indicated
Prepare the client for defibrillation.	○	○
Place client in a semi-Fowler's position.	○	○
Request an order to increase the oxygen flow rate.	○	○
Request an order to insert an additional peripheral VAD.	○	○
Request an order to administer an intravenous fluid bolus.	○	○

Note: Each row must have 1 response option selected.

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Nurses' Notes

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The nurse has reviewed the Orders from 1215.

Click to highlight the orders that the nurse should consider a **priority**.

Orders

1215:

- insert an indwelling urethral catheter
- vancomycin 1 g, IV, every 12 hours
- computed tomography (CT) scan of the chest
- 0.9% sodium chloride (normal saline) 500 mL, IV, once
- laboratory tests: blood culture and sensitivity (C & S), complete blood count (CBC), arterial blood gas (ABG)

The nurse in the emergency department (ED) is caring for a 78-year-old female client.

Nurses' Notes

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Nurses' Notes | **Orders**

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For each assessment finding, click to specify if the finding indicates that the client's condition has improved, not changed, or worsened.

Assessment Findings	Improved	Not Changed	Worsened
pale skin tone	○	○	○
respirations, 36	○	○	○
blood pressure, 118/68	○	○	○
pulse oximetry reading 91%	○	○	○
client interacting with adult child at bedside	○	○	○

Note: Each row must have 1 response option selected.

The nurse in the emergency department (ED) is caring for a 78-year-old female client.

Nurses' Notes | **Orders**

1215:

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- vancomycin 1 g, IV, every 12 hours
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Assessment Findings	Improved	Not Changed	Worsened
pale skin tone	○	○	○
respirations, 36	○	○	○
blood pressure, 118/68	○	○	○
pulse oximetry reading 91%	○	○	○
client interacting with adult child at bedside	○	○	○

Note: Each row must have 1 response option selected.

The nurse is caring for a client who is receiving a blood transfusion and states, “I feel chilled and am having back pain.”

Which of the following actions should the nurse take? **Select all that apply.**

1. Stop the transfusion.
2. Check the client’s vital signs.
3. Notify the client’s primary health care provider.
4. Return the blood and infusion tubing to the blood bank.
5. Infuse 5% dextrose in water through the intravenous catheter.
6. Administer a dose of an antiemetic prescribed p.r.n. to the client.

The nurse is preparing a staff education program about total parenteral nutrition (TPN).

Which of the following information should the nurse include? **Select all that apply.**

1. "The TPN intravenous tubing should be changed once a week."
2. "TPN can be administered through a peripherally inserted central catheter (PICC)."
3. "Clients receiving TPN should be weighed daily."
4. "An infusion pump is used to deliver TPN."
5. "Serum glucose levels should be monitored in clients receiving TPN."

The nurse has taught a client with bipolar I disorder who is experiencing a manic episode and is receiving lithium.

Which of the following statements by the client would indicate a correct understanding of the teaching?

1. "I will increase my oral fluid intake to 2 to 3 L daily while taking the medication."
2. "I will experience an improvement in my condition 5 weeks after starting the medication."
3. "I should decrease my intake of dietary sodium after starting the medication."
4. "I should limit time spent in a sauna to 1 hour weekly while taking the medication."

The nurse has administered haloperidol to a client with schizophrenia who is agitated.

Which of the following findings would require **immediate** follow-up?

1. continued lack of motivation
2. reports of muscle stiffness
3. inappropriate emotional expressions
4. difficulty focusing due to blurred vision

The nurse is teaching a client who is receiving newly prescribed propylthiouracil.

Which of the following information should the nurse include?

1. “Carry emergency identification with you listing your condition and medication regimen.”
2. “The medication dose will need to be reduced if you develop agranulocytosis.”
3. “You will experience weight loss if the medication is effective.”
4. “Increase your daily intake of foods containing iodine.”

The nurse is preparing to administer a beta blocker to a client.

Which of the following would be a contraindication to administer the medication?

1. heart block
2. myocardial infarction (MI)
3. heart failure
4. angina pectoris

The nurse is planning a staff education program about informed consent.

Which of the following information should the nurse include? **Select all that apply.**

1. "The main value of informed consent is for protection against lawsuits."
2. "Clients may withdraw consent after signing the informed consent form."
3. "Clients must sign the informed consent form before receiving preprocedural medication."
4. "Nurses witness the signing of the informed consent form to confirm that consent is voluntary."
5. "The signed consent form serves as evidence that the informed consent process has taken place."

The nurse has taught a client who is receiving alendronate.

Which of the following statements by the client would indicate a correct understanding of the teaching?
Select all that apply.

1. "I will take alendronate a half hour before I eat breakfast."
2. "I should avoid weight-bearing exercises while taking alendronate."
3. "I should discontinue alendronate if I experience nausea or vomiting."
4. "I will need to remain in an upright position for 30 minutes after I take alendronate."
5. "I should notify my primary health care provider if I experience difficulty swallowing while taking alendronate."

The nurse is developing a plan of care for a client with a spinal cord injury at C5 who has an indwelling urethral catheter.

Which of the following would be a **priority** for the nurse to include in the plan of care?

1. encouraging the client to drink 6 to 8 glasses of fluid per day
2. maintaining the urine collection bag in a dependent position
3. teaching the client about foods high in fiber
4. assessing the color of the urine output

The nurse has been made aware that the following 4 clients require assistance.

The nurse should **first** assist the client who had

1. an abdominal hysterectomy 5 hours ago and is reporting severe incisional pain
2. a transurethral resection of the prostate (TURP) yesterday and whose catheter has become disconnected
3. a lumbar laminectomy 2 days ago and is reporting that the feet are still numb
4. a spinal cord injury at T2 two weeks ago and is currently diaphoretic and nauseated

The nurse has taught a client who has a positive laboratory test result for human immunodeficiency virus (HIV) infection. The client is scheduled for a viral load test.

Which of the following statements by the client would indicate a correct understanding of the teaching?

1. "The viral load test is used to determine my response to the treatment regimen I am receiving for HIV."
2. "The viral load test can rapidly detect HIV-specific antibodies in the blood."
3. "I will be able to decrease the dosage of my prescribed medications if my viral load is low."
4. "I am unlikely to develop acquired immune deficiency syndrome (AIDS) if my viral load is high."

The nurse is teaching a client who is scheduled for a 24-hour urine collection.

Which of the following information should the nurse include? **Select all that apply.**

1. "You will be asked to urinate when starting the collection, and the initial urine will be discarded."
2. "A sign will be posted on the bathroom door as a reminder to save your urine."
3. "You will be asked to void at the end of the designated time period to complete the urine collection."
4. "You should discard urine that is dark or pink in color."
5. "The collected urine will be sent to the laboratory at the end of each shift."

The nurse has taught a client with diabetes mellitus (type 2) about foot care.

Which of the following statements by the client would indicate a correct understanding of the teaching? **Select all that apply.**

1. "I will check my shoes for foreign objects prior to putting them on."
2. "I should use a large, coarse file to remove dry skin from a bunion."
3. "I will apply a petroleum-based ointment between my toes after bathing."
4. "I should avoid crossing my legs to prevent decreased circulation to my feet."
5. "I should wear new shoes for a few hours for several days until they fit well."

The nurse is teaching a client who is scheduled for a total hip arthroplasty via a posterior approach.

Which of the following information should the nurse include? **Select all that apply.**

1. "The type of prosthesis used is based on the muscle strength and joint function of your upper extremities."
2. "Do not bend the affected hip more than 90 degrees after surgery."
3. "Skin preparation and cleansing is mandatory before surgery."
4. "Use an elevated toilet seat for at least 6 weeks after surgery."
5. "You can resume sexual intercourse after surgery if your partner is in a dependent position."

The nurse is caring for a client who is receiving an intravenous infusion via a peripheral venous access device (VAD). The client reports sharp pain at the VAD site. The nurse notes the intravenous fluid is infusing more slowly than prescribed.

The nurse should recognize that the client is **most** likely experiencing

1. venous spasm
2. nerve damage
3. septicemia
4. hematoma

The nurse has attended a staff education program about obtaining blood specimens from a central venous access device (VAD).

Which of the following statements by the nurse would require follow-up?

1. “I will use a 3 mL syringe to flush the catheter port.”
2. “The injection cap should be cleansed with antiseptic and allowed to air-dry.”
3. “I will aspirate 5 mL of blood and discard the syringe in the biohazard container before obtaining the specimen.”
4. “The infusion should be turned off for at least 1 minute before the specimen is aspirated.”

The nurse has taught about preventing osteoporosis to a 45-year-old client who has had a hysterectomy and bilateral salpingo-oophorectomy.

Which of the following statements by the client would indicate correct understanding of the teaching?

1. “I will begin to take dancing lessons.”
2. “I will get more rest at night.”
3. “I will take a multivitamin supplement daily.”
4. “I will add more fiber to my diet.”

The nurse is preparing to insert a peripheral venous access device (VAD) for a client.

Which of the following actions should the nurse take?

1. Ask the client to open and close the fist multiple times.
2. Tap the client's vein multiple times to promote dilation.
3. Apply the tourniquet 9 to 10 in (22.5 to 25 cm) above the venipuncture site.
4. Palpate for a vein after cleansing the selected site.

The nurse is assessing a newly admitted client who sustained partial-thickness (second-degree) burns to the anterior thorax in a house fire.

Which of the following findings would require **immediate** follow-up?

1. dizziness and confusion
2. hypoactive bowel sounds and nausea
3. vesicular breath sounds throughout the lung fields
4. pain rated 5 on a scale of 0 (no pain) to 10 (severe pain)

The nurse has taught a client with a hiatal hernia about interventions for the condition.

Which of the following statements by the client would indicate a correct understanding of the teaching?

1. “I will consume 3 regular-sized meals daily.”
2. “Wearing an abdominal binder can help relieve symptoms.”
3. “I should elevate the head of the bed on 6 in (15 cm) blocks.”
4. “Eating foods with a high fat content will increase gastric emptying.”

The nurse is assessing a client with suspected gout.

Which of the following findings would support a diagnosis of gout? **Select all that apply.**

1. elevated serum uric acid level
2. a swollen, red joint
3. reports of moderate fatigue
4. distal extremities cool to touch
5. pain associated with movement of the affected extremity
6. intolerance of dairy products

The nurse is assessing a client with suspected endometriosis.

Which of the following findings would support a diagnosis of endometriosis?

1. dyspareunia
2. hot flashes
3. weight gain
4. amenorrhea

The nurse is assessing a client with cirrhosis.

Which of the following findings would be consistent with a diagnosis of cirrhosis?

1. steatorrhea
2. deep vein thrombosis (DVT)
3. high fever
4. spontaneous bruising

The nurse is assessing a male client who has suspected syphilis.

Which of the following findings would support a diagnosis of syphilis?

1. urethritis
2. conjunctivitis
3. chancre lesions
4. penile discharge

The nurse has attended a staff education program about spinal shock following acute spinal cord injury.

Follow-up is required if the nurse states that manifestations of spinal shock include

1. bowel dysfunction
2. bladder dysfunction
3. spastic paralysis below the level of injury
4. loss of sensation below the level of injury

The nurse is planning care for a client who has an arteriovenous (AV) shunt in the left arm.

Which of the following interventions should the nurse include in the client's plan of care?

1. Instruct the client to protect the AV shunt by tucking the left arm under the body while sleeping.
2. Check for a bruit by palpating the AV shunt.
3. Administer prescribed intravenous fluids through the AV shunt.
4. Avoid obtaining blood pressure measurements in the arm with the AV shunt.

The nurse is caring for a client who has a chest tube attached to a closed-chest drainage system.

It would be a **priority** for the nurse to monitor the client for

1. tracheal deviation
2. pain at the insertion site
3. subcutaneous emphysema
4. redness or swelling at the insertion site

The nurse in the psychiatric unit has completed the morning assessment of a client.

Progress Notes | **History and Physical** | **Orders**

Day 2

0830: Withdrawn. Remains in assigned client room. Exhibiting blunted affect and jumbled, illogical speech. Experiencing auditory hallucinations and paranoid delusions.

Which of the following interventions should the nurse take **next**?

1. Encourage the client to attend 1 group session today.
2. Teach the client's family members about how to prevent a relapse.
3. Administer the prescribed dose of risperidone.
4. Prepare to discharge the client to a community treatment program.

The nurse in the psychiatric unit has completed the morning assessment of a client.

Progress Notes | **History and Physical** | **Orders**

Body System	Findings
Psychiatric	third admission this year for acute signs and symptoms of schizophrenia; family history of mental illness

Which of the following interventions should the nurse take **next**?

1. Encourage the client to attend 1 group session today.
2. Teach the client's family members about how to prevent a relapse.
3. Administer the prescribed dose of risperidone.
4. Prepare to discharge the client to a community treatment program.

The nurse in the psychiatric unit has completed the morning assessment of a client.

Progress Notes | **History and Physical** | **Orders**

Day 2

0830:

- attend group sessions when stabilized
- risperidone 4 mg, p.o., daily

Which of the following interventions should the nurse take **next**?

1. Encourage the client to attend 1 group session today.
2. Teach the client's family members about how to prevent a relapse.
3. Administer the prescribed dose of risperidone.
4. Prepare to discharge the client to a community treatment program.

The nurse is caring for the following clients.

The nurse should recommend a referral to an occupational therapist for the client with

1. rheumatoid arthritis (RA) who has a 2-month-old infant
2. an intertrochanteric hip fracture who works as a surgeon
3. mononucleosis who is a college student
4. tendonitis who is a professional tennis player

The nurse is preparing to admit a client who has pleuritic chest pain and is reporting a cough productive of yellow sputum for the past 1 week. The client has a pulse oximetry reading of 90% on room air.

Which of the following infection control precautions should the nurse implement?

1. Use a stethoscope that is designated for use with the client only.
2. Wear sterile gloves when inserting a peripheral venous access device (VAD).
3. Assign the client to a private room with monitored negative air pressure.
4. Place a box of surgical masks inside the client's room.

The nurse is planning a staff education program about infection control guidelines.

Which of the following information about alcohol-based hand rub should the nurse include?

1. “Use before touching medical equipment that will come in direct contact with the client.”
2. “Avoid using when moving your hands from a contaminated body site to a clean body site during client care.”
3. “Avoid using before caring for clients who have severe neutropenia.”
4. “Use after contact with body excretions that do not cause your hands to be visibly soiled.”

The nurse is assessing a client with suspected mononucleosis.

Which of the following findings would support a diagnosis of mononucleosis?

1. polyarthralgia
2. costovertebral pain
3. cervical lymphadenopathy
4. left lower quadrant (LLQ) tenderness

The nurse and unlicensed assistive personnel (UAP) are caring for assigned clients.

It would be **most** appropriate for the nurse to assign UAP to

1. apply a continuous passive motion (CPM) device to the affected extremity of a client who had a total knee replacement
2. change the bed linens for a client who was admitted 1 hour ago following a closed-head injury and is comatose
3. reposition a client with hydrocephalus who has a headache and is vomiting
4. place in the prone position a client who had an above-the-knee amputation (AKA) 1 day ago

The nurse in the inpatient psychiatric unit is leading a support group for clients.

It would be a **priority** for the nurse to intervene if the client with

1. bipolar I disorder is experiencing a manic episode, is moving the legs, and is looking around the room restlessly
2. borderline personality disorder is saying that another group member is too disturbed to be attending the session
3. major depressive disorder is sitting quietly with the eyes downcast
4. schizophrenia is rocking in place and copying the gestures of another client in the group

The nurse has observed a staff member tell a client with bipolar disorder that there will be consequences for making negative comments about conditions in the facility.

When the nurse meets privately with the staff member, which of the following statements would be **most** appropriate for the nurse to make to the staff member?

1. "Threatening a client can result in the immediate dismissal of a staff member."
2. "Staff members who have difficulty with control issues often seek power over clients."
3. "Clients have a right to provide feedback about services without fear of punishment."
4. "Staff should set limits with clients in a nonjudgmental manner."

The nurse has been made aware of the following client situations.

The nurse should **first** assess the client

1. with chronic obstructive pulmonary disease (COPD) who is using pursed-lip breathing after ambulating in the hallway
2. with pericarditis who has a systolic blood pressure that is 20 mm Hg higher during expiration than during inspiration
3. who had a total abdominal hysterectomy (TAH) 12 hours ago and has saturated 1 perineal pad in the past 5 hours
4. who has Guillain-Barré syndrome and has had an increase in the vital capacity over the past 4 hours

The nurse in the psychiatric unit is administering medications when a client with a borderline personality disorder approaches and asks to talk. The nurse suggests having a talk in 1 hour. The client shouts, “I’ll wait, but you will be sorry!” and then picks up a pitcher of water and throws it onto the floor.

Which of the following actions should the nurse take?

1. Offer to listen to the client while continuing to administer the medications.
2. Suggest that the client take a p.r.n. prescribed medication for agitation.
3. Ask another nurse to finish administering the medications, and talk with the client.
4. Request assistance from several nearby staff members with controlling the client’s behavior.

The nurse is talking with a client who has a positive laboratory test result for human immunodeficiency virus (HIV) infection.

Which of the following statements by the client would require follow-up?

1. "I try to eat a well-balanced diet."
2. "I avoid crowds when I go outside the house."
3. "I am taking a vitamin C tablet daily to help prevent infections."
4. "I take echinacea every day to help improve my immune system."

The nurse is planning a staff education program about informed consent.

Which of the following information should the nurse include? **Select all that apply**.

1. "An individual designated by a power of attorney for health care can provide informed consent despite the competency of the client."
2. "The nurse has a duty to insist that the client repeat what has been said about a procedure for which consent is necessary."
3. "The primary health care provider must disclose the risks if the client declines a recommended procedure."
4. "The client should sign the consent form prior to receiving prescribed opioids."
5. "Informed consent is not needed for emergency procedures that are in the client's best interest."

The nurse is caring for a client who has a prescription for an intravenous infusion of 0.45% sodium chloride (half-strength saline). The nurse notes the client is receiving 5% dextrose in water.

Which of the following actions should the nurse take **first**?

1. Change the intravenous fluid to the prescribed fluid.
2. Notify the primary health care provider.
3. Complete an incident report.
4. Assess the client.

The nurse is caring for a client in the first stage of labor and observes that a segment of the umbilical cord is visible in the vaginal opening after rupture of the client's amniotic membranes.

Which of the following actions should the nurse take?

1. Instruct the client to lie on her left side.
2. Attempt to place the umbilical cord back into the uterus.
3. Assist the client into a knee-chest position.
4. Administer an intravenous tocolytic agent.

The nurse in the emergency department (ED) is caring for a 79-year-old female client.

Nurses' Notes | **History and Physical** | **Laboratory Results**

1215: Client presents with right-sided ptosis and facial drooping, right-sided hemiparesis, and expressive aphasia. Client's adult child reports that the client recently had influenza. On assessment, skin is warm and dry. Lung sounds are clear; apical pulse is irregular. Bowel sounds are active in all quadrants. Client is incontinent of urine 2 times in the ED; adult child reports that the client is typically continent of urine. Capillary refill of 3 seconds. Peripheral pulses palpable, 2+. Vital signs: T 97.5° F (36.4° C), P 126, RR 18, BP 188/90, pulse oximetry reading 90% on room air.

The nurse is reviewing the client's assessment data to prepare the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.

Actions to Take	Potential Conditions	Parameters to Monitor
Administer oxygen at 2 L/min via nasal cannula.	Bell's palsy	urine output
Request a prescription for an oral corticosteroid.	hypoglycemia	temperature
Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine specimen for urinalysis and culture and sensitivity (C & S).	urinary tract infection (UTI)	serum glucose level
Request an order for 50% dextrose in water to be administered intravenously.		electrocardiogram (ECG) rhythm

The nurse in the emergency department (ED) is caring for a 79-year-old female client.

Nurses' Notes | **History and Physical** | **Laboratory Results**

Body System	Findings
Neurological	history of a stroke 2 years ago
Cardiovascular	history of hypertension; atrial fibrillation; hyperlipidemia
Gastrointestinal	history of gastrointestinal bleeding 2 months ago
Endocrine	history of diabetes mellitus (type 2) for 30 years
Immunological	influenza 3 weeks ago

The nurse is reviewing the client's assessment data to prepare the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.

Actions to Take	Potential Conditions	Parameters to Monitor
Administer oxygen at 2 L/min via nasal cannula.	Bell's palsy	urine output
Request a prescription for an oral corticosteroid.	hypoglycemia	temperature
Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine specimen for urinalysis and culture and sensitivity (C & S).	urinary tract infection (UTI)	serum glucose level
Request an order for 50% dextrose in water to be administered intravenously.		electrocardiogram (ECG) rhythm

The nurse in the emergency department (ED) is caring for a 79-year-old female client.

Nurses' Notes | **History and Physical** | **Laboratory Results**

Laboratory Test and Reference Range	1215
random serum glucose Elderly 60–90 years: 82–115 mg/dL (4.6–6.4 mmol/L)	76 mg/dL (4.2 mmol/L)

The nurse is reviewing the client's assessment data to prepare the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.

Actions to Take	Potential Conditions	Parameters to Monitor
Administer oxygen at 2 L/min via nasal cannula.	Bell's palsy	urine output
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Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine specimen for urinalysis and culture and sensitivity (C & S).	urinary tract infection (UTI)	serum glucose level
Request an order for 50% dextrose in water to be administered intravenously.		electrocardiogram (ECG) rhythm

The nurse is preparing to administer an aminoglycoside.

Which of the following laboratory test results should the nurse review before administering the medication?

1. serum electrolyte level and serum uric acid level
2. hemoglobin (Hgb) and white blood cell (WBC) count
3. serum ammonia level and serum glucose level
4. blood urea nitrogen (BUN) and serum creatinine

The nurse is talking with a client who is scheduled for endoscopic retrograde cholangiopancreatography (ERCP) in 2 hours in the outpatient department.

Which of the following questions would be important for the nurse to ask? **Select all that apply.**

1. "How will you be getting home after the procedure?"
2. "Do you have access to a thermometer after you leave here?"
3. "What allergies do you have?"
4. "Are you wearing dentures?"
5. "Do you have external hemorrhoids?"

The nurse is assessing a client who had cardiac catheterization 2 hours ago.

Which of the following findings would require **immediate** follow-up?

1. blood pressure, 104/70 mm Hg
2. 1+ pedal pulse of the affected extremity
3. heart rate, 98
4. urine output of 100 mL for the past 2 hours

The nurse has taught the parent of a 9-year-old child who has been newly diagnosed with bacterial conjunctivitis.

Which of the following statements by the parent would indicate a correct understanding of the teaching?

1. “The infection produces profuse watery discharge.”
2. “I should clean my child’s eyelids and eyelashes with soap and water prior to instilling the medication.”
3. “My child’s eyes may be sensitive to light until the infection resolves.”
4. “The prescribed corticosteroid eyedrops should be used for 1 week.”

The nurse is talking with a client who has diabetes mellitus (type 1) and is receiving insulin via an infusion pump.

Which of the following statements by the client would require follow-up?

1. "I need a bolus dose of insulin prior to a meal."
2. "I should refill the pump with short-duration insulin."
3. "I can decrease serum glucose monitoring to twice daily."
4. "I will change the infusion needle every 2 to 3 days."

The nurse is caring for a client who is scheduled for a spinal fusion in 1 hour.

Which of the following situations would require follow-up? **Select all that apply.**

1. The nurse notes that the client signed the consent form 1 week ago.
2. The nurse determines that the last analgesia the client received was yesterday afternoon.
3. The client states, “I need to find out why the surgery is needed before I sign the consent form.”
4. The nurse administers the prescribed preoperative sedation after the client signs the consent form.
5. The client states, “I am afraid to sign the consent form because I know I am going to die during the surgery.”
6. The client states, “The surgery may result in some paralysis, but the resolution of the pain is worth the risk to me.”

The charge nurse must transfer a client from a locked psychiatric unit to an unlocked unit in order to make a bed available.

The charge nurse should recommend for transfer the client with

1. depression who has suddenly become more animated and involved in unit activities
2. bipolar I disorder who is experiencing a manic episode, is disrobing, and is laughing with other clients
3. schizophrenia who is withdrawn and requires assistance with activities of daily living (ADL)
4. dementia who is delusional about being poisoned by staff members

The nurse in the emergency department (ED) is caring for a 10-day-old client.

Flow Sheet

	1000	1400	1800
Intake	480 mL (formula)	60 mL (formula)	60 mL (formula)
Output	3 small yellow stools	40 mL (emesis)	40 mL (emesis)

Nurses' Notes

1000: Parent reports that the client has been vomiting after drinking each bottle of formula. Parent estimates the client is vomiting half of each bottle with each feeding. Client triaged. Vital signs: T 97.7° F (36.5° C), P 124, RR 30.

1400: Client experienced projectile vomiting 30 minutes after drinking 60 mL of formula. Anterior fontanel is soft and flat. Bowel sounds are hyperactive.

1800: Client experienced projectile vomiting 30 minutes after drinking 60 mL of formula. Abdomen is distended. Client is crying and inconsolable.

Which of the following diagnostic procedures should the nurse anticipate the physician would order? **Select all that apply.**

1. barium enema
2. abdominal x-ray
3. abdominal ultrasound
4. complete metabolic panel
5. esophagogastroduodenoscopy (EGD)

The nurse in the emergency department (ED) is assessing a client with multiple injuries that occurred as a result of a motor vehicle collision.

Which of the following findings should receive **highest** priority?

1. avulsion injury of the left index finger
2. deep laceration on the right forearm with blood oozing from the surface
3. hematoma on the left side of the neck
4. open fracture of the right tibia and fibula

The nurse has received information about assigned clients.

The nurse should **first** assess the client

1. with multiple sclerosis (MS) who had an indwelling urethral catheter removed 5 hours ago and has not been able to urinate
2. with an abdominal aortic aneurysm who reports recent onset of low back pain
3. who had coronary artery bypass graft (CABG) surgery 2 days ago and reports sternal pain when coughing
4. who has bacterial pneumonia and is requesting a cough suppressant

The nurse that cared for a client with chronic obstructive pulmonary disease (COPD) who lost more than 10% of ideal body weight has been named in a lawsuit charging negligence.

Which of the following entries in the client's medical record would help **refute** the charge of negligence?

1. The client has been instructed to eat 3 large meals daily.
2. The client has been encouraged to maintain a high-calorie, high-protein diet.
3. The client has been encouraged to drink fluids with meals to promote digestion.
4. The client has been instructed to exercise 30 minutes before eating to improve appetite.

The nurse is documenting care for a client who had a peripheral venous access device (VAD) inserted 10 minutes ago.

Which of the following would be the **best** example of correct documentation for the nurse to include in the client's medical record?

1. 22-gauge catheter inserted into the right hand.
2. Secured the site with paper tape to avoid skin tears.
3. Infusion started slowly due to reports of coolness at the site.
4. Labeled site, tubing, and intravenous fluid bag.

The nurse is caring for assigned clients.

It would be **most** important for the nurse to monitor

1. serum lipase levels for the client with hypercholesterolemia
2. arterial blood gas (ABG) results for the client who has an acid-base imbalance
3. serum glucose levels for the client with diabetes insipidus (DI)
4. adrenocorticotropic hormone (ACTH) levels for the client who has a fluid imbalance

The nurse is planning a staff education program about collaborative conflict resolution strategies.

Which of the following would **best** describe implementation of a collaborative conflict resolution strategy?

1. "A staff nurse is working with the nurse manager and offering suggestions about an upcoming new procedure."
2. "The clinical nurse leader is flattered by being asked to help create a clinical ladder for nursing staff members."
3. "The charge nurse is working with staff nurses and the nurse manager to develop shared goals and a plan for the new staffing format."
4. "A new nurse has offered to work on a holiday in exchange for having the following weekend off."

The nurse is caring for a client who lives with a spouse and 2 adolescent children. The client has been admitted to a hospital for treatment of active pulmonary tuberculosis (TB). The local health department has been notified about the client's diagnosis.

The nurse should recognize that after this notification the local health department will

1. schedule periodic examinations of the client's chest and sputum
2. contact the client's family to arrange for family members to be examined
3. immunize those persons with whom the client has been in contact
4. isolate members of the client's immediate family at home until diagnostic studies rule out TB

The nurse is participating in a community-based disaster drill.

The nurse should give **priority** for treatment to a

1. 2-year-old client with a bleeding scalp laceration and briskly reactive pupils
2. 15-year-old client who is restless and has a distended, firm abdomen
3. 30-year-old client who has a leg wound exposing the femur, a blood pressure of 120/76 mm Hg, and a pulse of 90
4. 60-year-old client with heart failure whose pulse oximetry reading is 92% on room air and whose respirations are 26

The nurse in a community-based setting has received the following telephone messages.

The nurse should **first** return the telephone call to the parent of a

1. 3-year-old child who sustained a concussion and was irritable when awakened every 2 hours during the night
2. 4-year-old child with impetigo contagiosa who has eruptions spreading around the mouth and nose that are draining thin yellow fluid
3. 5-year-old child with Ewing sarcoma who is receiving external radiation and the irradiated area appears reddened
4. 6-year-old child with a right long-leg cast whose toes on the affected extremity are swollen and cool to the touch

The nurse is teaching a client who is receiving newly prescribed clopidogrel.

Which of the following information should the nurse include?

1. “Notify your primary health care provider if you experience unusual bruising.”
2. “Avoid taking over-the-counter (OTC) medications containing acetaminophen.”
3. “Avoid driving your car for a short time until your response to the medication is known.”
4. “Have a blood specimen obtained every 3 months to check your serum albumin level.”