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**NCLEX Prep Exam: 265 Questions**

Part 1: 20 Questions on Delegation and Prioritization:

1. The following clients present to a walk-in clinic at the same time. Which should the nurse schedule to be seen first?
   a. 25 year old with high fever, vomiting and diarrhea
   b. 38 year old with sore throat, fever, and swollen lymph glands
   c. 40 year old with severe headache, vomiting and stiff neck
   d. 44 year old limping on a very swollen bruised ankle

2. Of the four clients listed below, which responsibility should the nurse direct the technician to carry out first?
   a. 89 year old with COPD resting quietly on 2 liters of O2 needs morning vitals with O2 sat
   b. 77 year old with gastrointestinal bleeding needs bedside commode emptied
   c. 55 year old diabetic with fasting blood sugar of 75, at 80% of breakfast and needs morning snack
   d. 49 year old with rheumatoid arthritis needs splints reapplied to both hands.

3. The LPN is assigned to care for a client who had a total right hip two days ago. Which observation should the LPN report immediately to the nurse?
   a. incisional pain rated on 6 on a scale of 0-10
   b. reddened incision line with a temperature of 99.6 F
   c. pain and redness in the left lower leg
   d. the client is not tolerating 20lbs of weight bearing on the right leg

4. The nurse just received report on the following clients. Who should the nurse see first?
   a. 35 year old with suspected acute tubular necrosis, urine output totaled 25cc's for the last two hours.
   b. 49 year old with cancer of the breast, 2 days post mastectomy, reported to be having difficulty coping with the diagnosis.
   c. 54 year old with TB in respiratory isolation, requesting pain medication
   d. 36 year old with chest tube insertion after a spontaneous pneumothorax, respirations 16

5. After receiving report on the following clients, who should the nurse assess first?
   a. 25 year old with the hemoglobin level of 15.9
   b. 36 year old on Coumadin with a prothrombin time of 35, 6 seconds
   c. 38 year old with a total calcium level of 9.4

[Contunue Next Page]
d. 45 year old with a BUN of 30 and creatinine of 1.1

6. After completing assessment rounds, which finding would the nurse report to the physician immediately?
   a. client who has not had a bowel movement in 4 days abdomen is firm
   b. client who had a pulse of 89 and regular now has pulse of 100 and irregular
   c. client who is very depressed and has eaten 10% of meals for the last 2 days.
   d. client who has developed a rash around the neck and face who has been on iv penicillin for 2 days.

7. After receiving report on four clients at 7am, what should the nurse complete first?
   a. call physician to report antiemetic for client who has been vomiting
   b. notify family of a clients transfer to ICU for chest pain
   c. call a potassium level of 5.9 to the attention of the physician
   d. begin routine assessment rounds, starting with the sickest client

8. A 62 year old client has a history of coronary heart disease and is brought into the ER complaining of chest pain. What initial action should be taken by the nurse?
   a. give the client ntg gr 1/150 sl now
   b. call the cardiologist about the admission
   c. place the client in a high Fowlers position after loosening the shirt
   d. check blood pressure and note the location and degree of chest pain

9. As a nurse working the ER, which client needs the most immediate attention?
   a. a 3 yr old with a barking cough, oxygen sat of 93 in room air, and occasional inspiratory stridor
   b. a 10 month old with a tympanic temperature of 102, green nasal drainage, and pulling at the ears
   c. an 8 month old with a harsh paroxysmal cough, audible expiratory wheeze and mild retractions
   d. a 3 year old with complaints of a sore throat, tongue slightly protruding out his mouth, and drooling.

10. As the office nurse, you are reviewing client messages for a return call. Which client should the nurse call back first.
    a. client 36 weeks gestation complaining of facial edema
    b. a client 24 weeks gestation complaining of urinary frequency
    c. a client 12 weeks gestation whose had five episodes of vomiting in 36 hours
    d. a client 20 weeks gestation complaining of white, thick vaginal discharge.

11. Which hospital roommate assignment would be most appropriate for a 3 year old
girl with nephrotic syndrome?

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a. 2 year old girl with croup
b. 3 year old girl with impetigo
c. 4 year old boy with tonsillitis
d. 4 year old boy with a fractured femur

12. You are a home health nurse. Which client should you see first?
   a. 7 year old who is recovering from a pelvic fracture
   b. 5 year old who was diagnosed with type 1 diabetes and released from the hospital 2 days ago
   c. an 8 year old with cystic fibrosis who is on 1 l og oxygen via nasal cannula
   d. a 4 year old who has not received any immunizations since 15 months of age

13. The registered nurse is planning the client assignments. Which assignment is an appropriate assignment for the nursing assistant?
   a. assist a 12 year old boy with Down's syndrome, who is profoundly, developmentally disabled, to eat lunch
   b. obtain a temperature of a 29 year old woman receiving the final 30 minutes of a whole blood transfusion
   c. complete initial vital signs on a 51 year old man who has just returned from surgery and PACU for a bowel transfusion
   d. complete a sterile dressing change on a 70 year old woman admitted for skin graft

14. A physician orders MRI's for the following four clients. Select the client that the nurse would send without questioning the order.
   a. 21 year old diabetic with an implanted insulin pump
   b. 18 year old pregnant primigravida
   c. a 72 year old client with CHF and a pacemaker
   d. a 35 year old auto accident victim on life support systems

15. After receiving report, which of the following four clients should the nurse assess first?
   a. client with stage 3 anxiety and disoriented
   b. client with severe agoraphobia and refuses to leave her room
   c. client with paranoid schizophrenia and pacing the halls
   d. client with post-traumatic stress disorder and socially withdrawn

16. A client is admitted with suspected substance abuse. All of the following information was obtained upon admission. Which assessment data is of primary concern to the nurse?
   a. client reports taking a prescription medicine for high blood pressure daily.
b. client exhibiting restlessness, irritability, and has tachycardia

c. client reports taking the substance on a daily basis for six months

d. clients exhibits a cough, slightly elevated temperature and malaise

17. As the office nurse, which client should be assessed first?
a. client with history of drug abuse and diabetes, morning blood sugar 65
b. client with depression and has eaten less than 30% of meals for 24 hours
c. client with anxiety and productive cough of white sputum
d. client with borderline personality exhibiting self-damaging behaviors

18. The charge nurse is apporached by a new graduate nurse who has been assigned four clients: a diabetic with a 4:00 pm blood sugar of 99, a cardiac client with a potassium of 3.3, a client with pyelonephritis with a temperature of 100.8, and an adult client with a 20% second degree burn of the legs. Which client should the change nurse suggest the graduate assess first?
a. the diabetic
b. the cardiac client
c. phlelonephritis client
d. burn client

19. Blood gases were drawn at 7:00 am on four clients. None of the clients were on any type of oxygen and had not received any type of breathing treatment prior to the blood gases being drawn. Which blood gas results should be of greatest concern for the nurse?
a. 24 year old pneumonia client with a ph 7.33, pco2 49, po2 90, hco3 26
b. 35 year old asthma client with a ph of 7.37, pco2 46, po2 95, hco3 29
c. 45 year old with a chest tube and with a ph 7.40, pco2 40, po2 90, hco3 24
d. 65 year old with COPD and ph 7.35, pco2 48, po2 82, hco3 28

20. Which task would be the least appropriate to delegate to a nursing assistant?
a. feed 10 month old a bottle who has crackles bilaterally, harsh, productive cough and in room air
b. help 10 year old with cystic fibrosis, diminished breath sounds int he RLL up to the bathroom
c. obtain vital signs of a 9 year old who was admitted yesterday for an acute asthma exacerbation
d. obtain the respiratory rate of a 6 week old infant who was admitted two hours ago with a respiratory rate of 64

Part 2: 16 New Format Questions:

21. A physician prescribes heparin, 25,000 units in 250 ml of 0.9% sodium chloride solution, to infuse at 600 units/hour for a client who had an acute myocardial infarction. After 6 hours of heparin therapy, the client's partial thromboplastin time is
subtherapeutic. The physician orders an increase in the infusion to 800 units/hour. The nurse should set the infusion pump to deliver how many milliliters per hour?

22. The nurse is assessing a client who reports burning on urination and a low-grade fever. On physical examination, the nurse notes right-sided costovertebral angle tenderness. Identify the area the nurse percussed to elicit this sign.

23. As a nurse is feeding an average-sized client, he begins choking on his food. According to the American Heart Association (AHA), the nurse should intervene using the actions listed below. List the actions in the sequence in which she should perform them.
1. Administer abdominal thrusts until effective or until the client becomes unresponsive.
2. Activate the emergency response team.
3. Ask the client if he can speak.
4. Perform a tongue-jaw lift followed by a finger sweep.
5. Open the airway and attempt to ventilate the client.
6. Give up to five abdominal thrusts.

24. The nurse is performing a cardiac assessment Identify where the nurse places the stethoscope to best auscultate the pulmonic valve.

25. In the ED, a client tells the nurse that he plans to commit suicide and agrees to a voluntary admission to the psychiatric unit Which information will the nurse discuss with the client when he asks, "How long do I have to stay there?" Select all that apply.
1. "You may leave the hospital at any time unless you are suicidal."
2. "Let's talk more after the health team has assessed you."
3. "Once you've signed the papers, you have no say."
4. "Because you could hurt yourself, discharging you wouldn't be safe."
5. "You need a lawyer to help you make that decision."

6. "There must be a court hearing before you leave the hospital."

26. The nurse suspects that her client is in cardiac arrest According to the AHA, she should perform the actions listed below. Order these actions in the sequence that the nurse should do them.
1. Activate the emergency response system.
2. Assess responsiveness.
3. Call for a defibrillator.
4. Provide two slow breaths.
5. Assess pulse.
6. Assess breathing.

27. When teaching an antepartal client about the passage of the fetus through the birth canal during labor, the nurse describes the cardinal mechanisms of labor. Place these events in the proper sequence in which they occur.
1. flexion
2. external rotation
3. descent
4. expulsion
5. internal rotation
6. extension

28. A critically ill 4-year-old is in the pediatric ICU. Telemetry monitoring reveals functional tachycardia. Identify where this arrhythmia originates.

29. A 14-day-old infant is admitted for aspiration pneumonia. The results of a barium swallow confirm a diagnosis of gastroesophageal reflux with resulting aspiration pneumonia. Identify the weakened area of the stomach that is contributing to the reflux.
30. A 53-year-old client returns to his room from the postanesthesia care unit after undergoing right hemicolectomy. The physician orders 1 liter of dextrose 5% in 0.45% sodium chloride solution to infuse at 125 ml/hour. The drip factor of the available I.V. tubing is 15 gtt/ml. What is the drip rate in drops per minute?_________________

31. Assessing a client progressing through labor reveals the following findings. Order them in the most likely sequence in which they would have occurred.
1. uncontrollable urge to push
2. cervical dilation of 7 cm
3. 100% cervical effacement
4. strong Braxton Hicks contractions
5. mild contractions lasting 20 to 40 seconds

32. A nurse is preparing a teaching plan for a client who was prescribed enalapril maleate (Vasotec) to treat his hypertension. Which of the following instructions should she include in the teaching plan? Select all that apply.
1. Instruct the client to avoid salt substitutes.
2. Tell the client that light-headedness is a common adverse effect that he doesn't need to report.
3. Inform the client that he may have a sore throat for the first few days of therapy.
4. Advise the client to report facial swelling or difficulty breathing immediately.
5. Tell the client that blood tests will be necessary every 3 weeks for 2 months and periodically after that.
6. Advise the client not to change position suddenly to minimize orthostatic hypotension.

33. A physician prescribes I.V. normal saline solution to be infused at a rate of 150 mL/hour for a client admitted with dehydration and pneumonia. How many liters of solution will the client receive during an 8-hour shift? ________________

34. A nurse is caring for a terminally ill client. In which order is she likely to observe the following five stages of death and dying, as described by Elisabeth Kubler-Ross?
1. bargaining
2. denial and isolation
3. acceptance
4. anger
5. depression

35. A nurse is caring for a client in the fourth stage of labor. Based on the nurse's note
below, which postpartum complication has the client developed?

6/7/06 1745 Pt.'s 24-hour blood loss is 600 mL. Uterus is soft and relaxed on palpation and pt. has a full bladder. Assisted pt. in emptying bladder and notified Dr. G. McMann of findings. Vital signs stable at present. See graphic sheet for ongoing assessments and perineal pad weights.----S. Jones, RN  {Continue Next Page}

36. Which nonpharmacologic interventions should a nurse include in the care plan for a client who has moderate rheumatoid arthritis? Select all that apply.

1. massaging inflamed joints
2. avoiding range-of-motion exercises
3. applying splints to inflamed joints
4. using assistive devices at all times
5. selecting clothing that has hook-and-loop (Velcro) fasteners
6. applying moist heat to joints

Part 3: 10 questions on Critical Thinking Delegation Questions

37. Sue, RN, and Anna, certified nurse assistant (an unlicensed assisting personnel) are on duty at 0530 when a pediatrician arrives to the newborn nursery to perform a circumcision. Sue delegates to Anna to get baby boy Smith and bring him to the treatment room. Anna obtains baby boy Matthews and the physician performs the procedure on the baby. Sue joins the physician and assists with the procedure. It is not until the procedure is complete that the error is discovered. Who is held accountable for the error?

The RN, Sue.
Sue, RN and the Physician.
The Certified Nurses Aide.
All three because they all have a license.

38. Jane, RN, and Joe, LPN, are on duty and one of Jane's patients is scheduled for a dressing change to a recent below-knee amputation. Jane received a new patient so Joe agreed to change the dressing, as he is experienced in postoperative dressing. Jane explained the particular technique. However, on the following day, Jane discovered that Joe did not change the dressing--Jane's initials were still on the old dressing. Of the four As of delegation, which was not completed?
39. You are the Registered Nurse working in a hospital, working with 2 LPN's and 3 CNA's. Which patient can be delegated to the LPN:  

An older adult is being treated for diabetes.
Mr. Smith needs information about how to prevent high cholesterol.
Jane Doe, age 42, is in stable condition and is being discharged.
John, transferred from the ICU, is admitted to your floor for the 4th time.

40. You are the LPN working in a LTC facility. You are the supervisor on the night shift. You can't do everything! You decide to enlist the help of your CNA. The Aide can do all of the following except:
Draw up an insulin BUT NOT ADMINISTER IT!
You give them Balmex to put on an irritated buttocks.
Take all of the Vital signs on the floor that you need.
The Aide can not do any of these.

41. The _______________ rules usually dictate the approved activities that can be safely performed by personnel under the supervision of a registered nurse.
State Regulations and Boards of Nursing.
The Nurse Practice Act.
Decision Making Model for Delegations of Selected Nursing Tasks.
The administration of your particular facility.

42. You are the triage nurse in the ER, which patient needs immediate attention.
A 55-year-old man presented to the ED complaining of abdominal pain. He stated that he thought his condition was secondary to eating too much greasy fast food too rapidly. His vital signs were blood pressure, 150/100 mm Hg; pulse, 100 bpm; respiration, 22 bpm; and temperature, 98°F. His color is pale but is skin is warm and dry. Within minutes, his blood pressure dropped to 100/60. Stated he felt fine.
A 36-year-old man with dizziness. His vital signs were blood pressure, 140/90 mm Hg; pulse, 120 beats per minute (bpm); respiration, 20 breaths per minute (bpm); and temperature, 99°F. Although the patient’s pulse was 120, his respiratory rate was normal, and he looked well.
A 43-year-old woman presented to the ED, complaining of a headache. The patient had normal vital signs except for a temperature of 101.2°F.
A 65-year-old man presented to the ED complaining of groin pain. He said the pain was severe and he did not feel well. His vital signs were blood pressure, 150/95 mm Hg;
pulse, 108 bpm; respiration, 22 bpm even and unlabored; and temperature, 99°F.

43. Legislation can regulate all except:
safe, competent individual practice by health care professionals
the maximum number of hospital beds available in a facility
the type of procedures that can be done
the amount the facility can charge for a specific item (procedure)

44. The nurse is caring for an elderly patient suffering from diarrhea. When caring for the patient, which assessment should receive priority in his care?
Auscultation of bowel sounds
Dietary history
Urinary output
Stool guiac

45. You are a telephone triage nurse. If a patient calls for help after having handled a suspicious substance, you should:
Tell the patient to call 911
Ask the patient to collect a sample of the substance and bring it in for analysis
Send the patient to the emergency room
Call the CDC.

46. A nurse gave a patient the wrong medication. The patient was seriously injured and sued. Who will most likely be held liable?
the nurse
no one, since it was an accident
the hospital
the nurse and the hospital

Part 4: 20 Questions on Critical Thinking NCLEX Questions

47. Initial drug therapy in the management of Lyme disease includes:
Tetracycline
Steroids
Salicylic Acid
Nonsteroidal anti-inflammatory agents

48. A patient has ingested a non corrosive poison and you cannot reach a poison control center. Your first act of care is to:
Induce vomiting with Syrup of Ipecac
Dilute the ingested poison with milk or water
Attempt to neutralize the poison
have them eat a cracker

49. A patient is suffering from chemical burns to the skin caused by dry lime. Your first step in care should be to:
Wash the area with running water
Remove the lime with phenol
Remove the lime with alcohol
Brush away the lime

50. You are caring for someone of Filipino decent. What is the important thing to remember about their diet?
They believe that eating rice cleanses the system
Spicy foods help prepare their soul for God.
Food is tasty but not spicy
The eat spicy foods because they believe it help them stay healthy.

51. A priority nursing diagnostic category for the client with hypertension would be
Pain
Fluid Volume Deficit
Impaired Skin Integrity
Health Management

52. After 12 hours of experiencing regular contractions, the nurse determines the client is still in the latent stage and should be monitored closely for signs of
exhaustion
hypotension
fluid overload
bradycardia

53. You are the home health nurse of a family of Haitian decent, what is the most important thing to remember when caring for the elderly?
As the family member becomes older, medicines are rejected and replaced by prayer. Haitian family members place great value in caring for their elderly at home.
The nurse should be aware that they view her/him as a gift from the gods.
The nurse should be aware that she/he will be viewed as an "outsider".

54. What are the 5 rights of medication administration?
Right dose, right pt, right route, right time, right MD
right dose, right pt, right route, right time, right frequency
Right dose, right pt, right route, right time, right strength
Right dose, right pt, right route, right time, right medication
55. A patient just had a seizure, all of the following are important data to collect except:
- A full set of vital signs
- Apical Pulse
- Level of consciousness in post ictal state
- A rectal check

56. Which of the following clients is at risk of developing hyponatremia?
- A client with a potassium level of 5.7 mmol/L
- The febrile client with copious watery diarrhea
- The client with massive systemic infection
- A client who is taking high doses of steroids.

57. You are the only nurse on the floor, all of the following can be delegated to unlicensed personnel except:
- You may delegate a client that is being discharged because they have a clean bill of health.
- You may delegate a task to a UAP that is frequently occurring
- You may delegate a task that has predictable results
- You may delegate tasks that are considered standard and unchanging

58. When delegating to other personnel, it is important to remember the 4 A's of delegation. These are all of the following except:
- Assessment
- Authority
- Assigning
- Actions

59. You are the triage nurse at a fire scene, all of the following are considered emergent except:
- Excessively high temperatures (over 105°F or 40.5°C)
- Obviously mortal wounds where death appears reasonably certain
- Open chest or abdominal wounds
- Obvious multiple injuries

60. When caring for an ethnic minority, you as the charge nurse need to be sensitive to needs and cultures. The most important thing to understand is:
- Try to understand their diets and work with dietary in order to insure proper nutrition.
- The language barrier. If present, work with a family member.
- Remember that many families have basic fears about speaking out or being perceived as speaking out.
What is their illness? It may have an impact on quality of care.

61. The 5 Rights of Delegation include all of the following except:
   Right work environment
   Right Circumstances
   Right Direction
   Right Task

62. The nurse knows the specific expected and desired outcomes for clients with a particular diagnosis are:
   Established by legislation as law. {Continue Next Page}
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   Mandated by federal regulatory agencies.
   Based on predetermined standards of care.
   Governed by the state in which they live.

63. When a minor has the legal right to consent to medical treatment, he or she also has the right to control disclosure of information related to that treatment.
   true
   false

64. When caring for an ethnic minority who speaks a language unknown to you the nurse should not use
   Another nurse working on the same floor
   A paid professional
   A member of the custodial department
   A family member

65. To which document should the nurse refer when information is needed regarding issues of client's right to information and explanations regarding treatment costs?
   code for nurses
   hospital billing department policies
   patient's bill of rights
   a durable power of attorney

66. A mother expresses concern about her 4 year old be hyperactive and always bumping into things and spilling things. The most appropriate intervention at this time would be:
   Determine if there has been any changes at home.
   Explain that this is not unusual
   Explore the possibility of abuse
   Suggest he see a pediatric neurologist
Part 5: 10 questions on Disaster Triage

67. Internal disaster refers to a disaster of any kind that strikes only inside of a building. True or False?

68. Is an external and natural disaster the same thing. Yes or No?

69. In an external disaster, whom would you triage first?

A. The most traumatized.
B. The least traumatized.

70. In an internal disaster, such as a hospital, whom do you triage first?

A. The most traumatized.
C. The least traumatized.

71. One must prioritize in a disaster. What does the acronym T-R-I-A-G-E

72. Using the acronym T-R-I-A-G-E, whom do you treat first and last?

73. When you are triaging in at the scene of a disaster and you notice someone is unconscious and you can’t feel a pulse, you do what you were trained to do and do the obvious, CPR. True or False?

74. You triage using the metatag system, what are the different colors for?

A. Green
75. When determining who is dead or non-salvageable, use the RPM system. What is the meaning of this acronym?

A. R: ____________________________________________________________

B. P: ____________________________________________________________

C. M: ____________________________________________________________

76. Anyone who fails one of the RPM’s gets what color tag?

A. Green
B. Yellow
C. Red
D. Black

Part 6: 10 Questions on Prioritizing Care of a Cardiac Client

77. A 60 year old male is admitted to the ER with chest pain that radiates to the shoulder, jaw and left arm. Following MD orders, the nurse should FIRST....
   Administer the morphine
   Obtain a 12 lead EKG
   Obtain blood work

78. The purpose of administering a thrombolytic drug to a pt with an MI is to
   Help keep them hydrated
   Disolve clots they may have
   Prevent kidney failure

79. A PRIORITY nursing diagnosis for the first 24 hours of a MI is
   Impaired Gas Exchange
   High Risk for Infection
   Fluid Volume Deficit

80. A PRIORITY nursing diagnosis related to the administering of TPA is
Observe for chest pain
Monitor for increased atrial dysrhythmias
Monitor the 12 lead EKG

81. A 69 year old male is admitted to the ER with heart failure complicated by pulmonary edema. A PRIORITY assessment at admission would be
Blood Pressure
Skin breakdown
Serum Potassium

82. Which of the following would be a PRIORITY nursing diagnosis for this heart failure pt?
High risk for infection related to stasis of secretion in alveoli.

83. Digoxin is administered intravenously to this client primary because the drugs acts to:
Dilate coronary arteries.
Increase myocardial contractility
Decrease cardiac dysrhythmias

84. Metoprolol tartrate, may be administered the a client with heart failure because it acts to
reduce peripheral vascular resistance
increase peripheral vascular resistance
reduce fluid volume

85. Furosemide is administered intravenously. How soon after should the nurse begin to see the desired effect?
5 to 10 minutes
30 minutes to 1 hour
2 to 4 hours

86. The nurse teaches the client to take oral furosemide in the morning. The primary reason for this is to help
decrease gastrointestinal irritation
retard rapid drug absorption
excrete fluids accumulated during the night
Part 7: 120 questions From Peer to Peer NCLEX- like

87. Multiple Sclerosis is characterized by which of the following:
1. A progressive neurological disorder characterized by the degeneration of basal ganglia in the cerebrum
2. A progressive demyelinating disease which affects fibers brain and spinal cord
3. A progressive and sometimes fatal disease which results in degeneration of the motor neurons
4. A progressive disease involving neuro-muscular transmission of impulses of voluntary muscle

88. You are assigned to care for a client diagnosed with Bell's Palsy. Which of the following would be an INCORRECT nursing action or intervention?:
1. Offer small frequent feedings of soft foods
2. Apply a facial sling to support facial muscles
3. Teach the patient to close the lid(s) of the affected eye(s) periodically, and to instill artificial tears
4. Vigorously massage muscles of the affected side at least twice daily, to restore circulation and muscle tone

89. In caring for a client with ALS (Amyotrophic Lateral Sclerosis), the nursing diagnosis with the HIGHEST priority would be:
1. Impaired Physical Mobility
2. Altered Role Performance
3. Potential for Ineffective Airway Clearance
4. Potential for Impaired Verbal Communication

90. A client is admitted to your unit with a diagnosis of COPD. The client tells you that the 2L/min of 02 that he is now receiving are not adequate, and requests that you increase the liter flow to 6-8L/min. The nurse's FIRST RESPONSE or INTERVENTION in this situation would be to:
1. Increase the liter flow to 6-8L/min, as per patient's request
2. Not increase the liter flow knowing it will likely result in atelectasis
3. Maintain the liter flow as ordered
4. Contact the patient's physician to get an order to increase the liter flow

91. A patient is on Respiratory Isolation for Tuberculosis (TB). Which of the following would be an indicator for removal of Isolation Precautions?
1. Absence of adventitious breath sounds
2. Patient has been on Anti-Tubercular Drug Therapy with INH for one month's time
3. Patient has no infiltrates on chest x-ray
4. Sputum Culture is negative for AFB, following a course of INH and PAS

92. You are assigned to work in the Endocrine Clinic. A teenage patient with Type I Diabetes comes for monthly evaluation. Her serum glucose is 175mg/dl and the Glycosylated Hgb is 25%. Based on these lab values, which of the following determinations can the nurse make about the patient's control of her diabetes?
1. That it is in good control
2. That it is being poorly controlled and further evaluation is warranted
3. Serum Glucose is within an acceptable range. Glycosylated Hgb is not significant
4. That lab values likely reflect the fact that teenagers usually do not comply with diet at all times, and therefore control is unlikely

93. A client is being seen in the Emergency Room. A diagnosis of Congestive Heart Failure is made. Upon auscultating the client's lungs the nurse hears crackling sounds bilaterally at the bases. In documenting these findings, the nurse would state that which of the following was heard:
1. Rhonchi
2. Wheezing
3. Rales
4. Atelectasis

94. A client with Congestive Heart Failure is placed on several medications including the Beta Blocker Atenolol. The nurse understands that Beta Blockers exert their influence by:
1. Reducing myocardial Oxygen demand
2. Cause vasodilation of coronary vessels
3. Increase heart rate and force of contraction
4. Decrease heart rate and force of contraction

95. A patient in CCU (Coronary Care Unit) is receiving Digoxin (Lanoxin) and Furosemide (Lasix). In assessing the patient's lab values, which of the following might the nurse expect to see?
1. Increase specific gravity of urine
2. Hyperkalemia
3. Hypokalemia
4. Hypernatremia

96. A patient in CCU is diagnosed as having Third Degree (3 deg. A-V Block). Which of the following is NOT an EKG finding in this dysrhythmia?
1. No relationship between P wave and QRS complex
2. Widening QRS complex greater than 0.10 sec.
3. Normal configuration of P waves
4. Heart rate of 60-100 bpm

97. You are caring for a client just diagnosed with 3 degree A-V Block. Which of the following should the nurse be prepared to do?
1. Assist in possible insertion of a pacemaker
2. Administer Digoxin
3. Administer Lidocaine
4. Assist in doing CPR

98. A client has a demand pacemaker inserted. The nurse knows that which of the following is true concerning such:
1. It is unaffected by spontaneous heart beat
2. Only fires when heart rate falls below pre-set minimum rate
3. Uses a sending and pacing electrode in the atria
4. It is always a temporary modality to provide electrical stimuli to the heart

99. A client is discharged on Digoxin (Lanoxin) following hospitalization for Atrial Fibrillation. In preparing a Discharge Teaching Plan, the nurse would NOT include which of the following?
1. Take pulse correctly and count for one full minute
2. Report any signs and/or symptoms such as ocular disturbances, anorexia, etc., to M.D. promptly
3. Take another dose of medication if first dose is vomited
4. Withhold drug if heart rate falls below 60 bpm

100. You are caring for a client s/p cardiac catheterization. Which of the following signs/symptom(s) that the patient may experience DO NOT necessarily indicate a possible serious complication requiring intervention by the nurse?
1. Mild pain at the insertion site
2. Decrease in pedal pulses on affected side
3. Development of an expanding hematoma at the insertion site
4. Development of bradycardia

101. A client with a history of Polycystic Kidney Disease is admitted to the Renal Unit for evaluation for dialysis. Which of the following lab values would be MOST significant in determining renal function?
1. Creatinine 8.7 mg/dl
2. BUN 90 mg/dl
3. Serum K+ 7.0 MEq/l
4. Uric Acid 7.5

102. A 2 year old diagnosed with Hirschsprung's disease is being interviewed by the nurse. During data collection, the parents described the child's stools as "strange". Which of the following stool types would most likely fit the parents description?
1. Light yellow, frothy and foul smelling
2. Currant jelly-like
3. Narrow and ribbon-like
4. Green liquid

103. A mother calls the clinic and asks to speak to the nurse regarding her 6 month old daughter who has been vomiting for the past 24 hours. The mother states that the baby is on Digoxin for a congenital heart defect and she is concerned that this may be a serious problem. What instructions should the nurse give to the mother over the phone?
1. Check the infant's pulse for a HR <100 BPM
2. Increase the infant's fluid intake
3. Check the infant for a wet diaper
4. Redose the digoxin

104. Which of these statements made to the nurse by a 9 year old with acute appendicitis would require immediate action?
1. "I am afraid to have surgery."
2. "I feel hot and thirsty."
3. "I feel better with my legs up towards my chest."
4. "My pain has gone away."

105. A nurse assigned to a child with Acute Glomerulonephritis is picking up doctor's orders to put in the Kardex. Which of the orders should the nurse question?
1. Bed rest
2. Daily weights
3. Daily blood pressure
4. Strict I & O

106. A 4 year old with Celiac Disease is in the hospital with an exacerbation of Celiac Crisis due to improper dietary intake. When teaching the mother the dietary restrictions for her child, which of the following foods must be completely eliminated from the child's diet?
1. Whole milk, ice cream and cheese
2. Rice, corn and soybeans
3. Bread, oatmeal and pretzels
4. Beef, liver and veal

107. A breast feeding mother develops mastitis in the left breast and is put on an antibiotic for seven days. She asks the nurse if she can continue breast feeding. The nurse's best answer would be:
1. "Only breast feed from the right breast."
2. "Do not breast feed or stimulate the breasts until the infection is resolved."
3. "Continue breast feeding, this is not a contraindication."
4. "Pump the breasts and discard the milk until the infection resolves."

108. On a tour of the labor and delivery suite, a prospective couple asks the nurse when do you put the erythromycin ointment in the baby's eyes. The correct response would be:
1. "It is only done if the mother has a chlamydia infection at the time of delivery."
2. "It is only used if the baby has signs or symptoms of an eye infection."
3. "It is placed in the eyes immediately after the delivery."
4. "It is placed in the eyes after the parents have had a chance to hold the baby."

109. A woman has been in labor for 13 hours and is 4 cm dilated, 50% effaced. She is on a Pitocin drip. The nurse is aware to discontinue the Pitocin if:
1. The woman complains of pain
2. The contractions are 90 seconds in duration
3. The contractions are 3 minutes apart
4. The contractions are not causing cervical dilation

110. When teaching a 36 week primigravida signs of true labor, the nurse would be sure to include:
1. When she feels pain that radiates from the lower back to the abdomen
2. When the contractions are felt more in the abdomen
3. When there is loss of the mucous plug
4. When she experiences lightening

111. A woman who is 12 hours post partum has the following findings: Temperature = 100.4, Pulse = 94, Respirations = 20, BP = 100/60. An appropriate nursing intervention would be to:
1. Call the doctor
2. Get her up and ambulating
3. Offer her fluids to drink
4. Prepare her for a blood transfusion

112. A patient on a locked psychiatric unit asks the nurse if he may have a razor to
shave. The nurse is aware that razors are considered sharps and therefore must be:
1. Used under the direct supervision of a nurse each time used
2. Only given to patients who are extremely responsible
3. Only given if a suicide assessment has been performed first
4. Signed out to responsible patients and signed in when returned

113. A patient being treated for schizophrenia is started on Thorazine 200mg qid. The doctor has ordered Cogentin for this patient. The nurse is aware that the Cogentin is given:
1. To decrease the incidence of seizures
2. To reduce side effects of the Thorazine
3. To potentiate the action of Thorazine
4. To improve and stabilize mood

114. A patient diagnosed with antisocial personality is admitted to the psychiatric unit. She is told that all meals are served in the dining room and patients are expected to be dressed in street clothes when they come in to eat. She complies with the rule for lunch and dinner but demands that she be served breakfast in bed. What action should the nurse take?
1. Bring the breakfast tray as requested
2. Warn her that her behavior will be reported to the doctor
3. Tell her that you will do it once and then she must promise to comply with the rules
4. Tell her that the rules apply to everyone

115. An important aspect of planning care for patients with a conversion disorder is the nurses awareness that:
1. Reality testing is often severely impaired
2. The symptoms are ego-syntonic
3. Secondary gains can interfere with achieving desired treatment goals
4. The disorder originates in problems occurring during toilet training

116. A patient with major depression has been placed on Parnate. The nurse teaches the patient the dietary restrictions required while taking an MAO inhibitor. The following statement made by the patient indicates the patient needs more teaching:
1. "I should avoid stimulants like caffeine and any drugs with epinephrine."
2. "I can't have smoked fish or pickled vegetables."
3. "I should eat fresh foods and keep my lunch refrigerated when I go to work."
4. "I should use over the counter cold remedies when I get sick."

117. A young woman has been seeing a therapist for about a year following the sudden death of her husband. Which behavior would indicate that the woman has achieved
reorganization following this major crisis in her life?
1. She keeps all her dead husband's things in the same place they were and keeps a candle lit next to his picture every day
2. She feels comfortable talking about her husband and how they fell in love
3. She begins to explore work options and moving to a smaller place that she can afford on her income
4. She is no longer angry that her husband has left her

118. A patient is on special observation for signs of delirium from alcohol withdrawal. What physical changes would the nurse note first?
1. Hypotension and delusions
2. Temperature elevation and tremulousness
3. Runny nose and stomach cramps
4. Angina and confabulation

119. A patient is admitted to the Psychiatric Unit for chronic alcoholism. The treatment team diagnoses the patient with Wernicke's encephalopathy. The team is concerned that if this syndrome is left untreated, the patient will develop which one of the following irreversible syndrome with the cardinal symptoms of confusion and amnesia?
1. HIV encephalopathy
2. Delirium Tremens
3. Korsakoff's syndrome
4. Down's syndrome

120. An elderly man is admitted to the Geriatric Unit for his forgetfulness and severe behavioral changes. He is diagnosed with Alzheimer's Disease. Which of the following should be the primary goal of nursing intervention?
1. Keep him away from problems of daily living
2. Keep his capacity for self care activities to the optimum
3. Keep him isolated
4. Keep all available resources to increase his dependency

121. A patient on the psychiatric unit has been in an acute manic state for several days. She is very active, rarely sleeps and never appears to be hungry. The nurse's goal of highest priority based on these observations would be:
1. Slow the patient's rate and quantity of speech
2. Improve self esteem and self worth
3. Maintain optimal rest and hydration
4. Remain in areas with low stimulation

122. Which of the following is an INCORRECT statement regarding diet therapy for a
patient in renal failure?
1. Limit dietary protein
2. Provide a diet high in carbohydrates
3. Limit Sodium (NA) intake
4. Provide a diet high in Potassium rich food

123. A patient with Chronic Renal Failure is being maintained on Peritoneal Dialysis. Which of the following is NOT an indication that the patient is developing possible Peritonitis?
1. Slightly blood tinged drainage after the first exchange
2. Rigid abdomen with abdominal pain
3. Decreased rate of fluid return
4. Nausea and vomiting

124. A patient with a bowel obstruction has a Salem Sump Tube (N/G) tube) in place. You are to irrigate this tube q. shift. Which of the following solutions should the nurse use?
1. Tap Water
2. D5%W
3. Sterile Water
4. Normal Saline

125. A patient has a Salem Sump Tube. When the nurse goes to irrigate the tube she notices that the gastric drainage is dark brown. Which of the following is the FIRST intervention the nurse should take upon noticing this?
1. Check the pH of the gastric contents
2. Perform a Hemoccult Test on the contents
3. Irrigate the tube and then check the returns
4. Remove the tube from suction

126. You are assigned to speak to a group of High School students about HIV and AIDS. In discussing transmission the nurse knows that the highest concentration of the HIV virus in infected patients is in the:
1. Saliva
2. Semen
3. Blood
4. Cerebrospinal Fluid

127. In teaching High School students about health practices that promote the prevention of spread of the HIV virus, the nurse should include which of the following:
1. Use a latex condom and water soluble lubricant during intercourse
2. Abstain from intercourse if the female is menstruating
3. Following oral intercourse, use an over-the-counter mouthwash so to destroy the HIV virus
4. Shower immediately with an antibacterial soap after intercourse, so to destroy the HIV virus

128. You are assigned to care for a patient with SIADH (Syndrome of Inappropriate Secretion of Antidiuretic Hormone). In developing a nursing care plan, which of the following needs would have the HIGHEST PRIORITY:
1. Oxygenation
2. Nutrition
3. Activity Intolerance
4. Safety

129. A patient is admitted to the Surgical Intensive Care Unit following a motorcycle accident in which severe head trauma was obtained. Which of the following signs would be indicative of increased intracranial pressure?
1. Increased pulse, increased respirations, increased BP
2. Increased pulse, decreased respirations, increased BP
3. Decreased pulse, decreased respirations, increased BP
4. Decreased pulse, decreased respirations, decreased BP

130. A patient is being monitored for signs of increased intracranial pressure. An Intraventricular catheter has been placed. Which of the following would indicate normal intracranial pressure?
1. An ICP of less than 20mmHg and CPP of 10mmHG
2. An ICP of 30mmHg and a CPP of 20mmHg
3. An ICP of more than 20mmHg and a CPP of 30mmHg
4. An ICP of less than 20mg and a CPP of 60mmHg or more

131. Of the following signs/symptoms, which is the EARLIEST sign of increasing ICP (Intracranial Pressure)?
1. Papilledema
2. Lethargy
3. Change in vital signs (ie: Increased BP)
4. Absence of reflexes

132. A homeless individual is brought to the Emergency Room after having been out in subfreezing temperatures for three to four days. The toes of the patient's right foot appear hard and cold with mottling, and are unresponsive to touch. Which of the following would NOT be included in the initial management of this patient by the Emergency Room nurse:
1. Rewarm the extremity with controlled and rapid rewarming until the injured part flushes
2. Wrap the affected extremity in a blanket and apply moist heat
3. Place sterile gauze between the affected digits
4. Elevate the affected extremity

133. In caring for a patient with a tracheostomy which of the following would be an INCORRECT ACTION by the nurse when providing tracheostomy care?
1. Checking the cuff pressure
2. Provide humidified oxygen
3. Remove the outer cannula for cleaning q. shift
4. Place sterile gauze between the outer wings of the tube before tying strings or tape to secure it

134. You are assigned to teach a nursing student how to suction an adult patient with a tracheostomy. Which of the following actions by the nursing student would be INCORRECT?
1. Pre-oxygenation of the patient with a Resusibag at 100% 02 several times before suctioning
2. Maintains wall suction pressure at 110-150mmHG
3. Does not suction for greater than 10-15 seconds at a time
4. Applies gentle intermittent pressure and rotates catheter during insertion phase of suctioning

135. Following a Vasectomy, a patient complains of pain and discomfort. Which of the following measures can be safely employed by the patient to aid in the relief of this discomfort?
1. Use an ice bag intermittently
2. Apply a heating pad to the scrotal area
3. Have the patient take a warm sitz bath
4. Give ASA grains X, q4h

136. Following a Vasectomy, a patient notices discoloration of the scrotal area and becomes alarmed. In responding to the patient's concern the nurse should:
1. Explain to the patient that this is a normal finding and usually responds to warm sitz baths
2. Note this is an abnormal finding and notify M.D. to see the patient
3. Know that this is not a likely occurrence, and is probably in the patient's imagination
4. Note that this is an indication of adequate blood flow to the area, and no intervention is necessary.
137. A woman who is one day post partum tells the nurse she doesn't have any milk yet. The nurse instructs her to:
1. Supplement the formula until the let down reflex occurs
2. Continue breast feeding
3. Place ice packs on her chest
4. Discontinue breast feeding and choose a commercially prepared formula

138. On a first prenatal visit, a woman has an alphafetoprotein test. The nurse is going to explain the reason for this test. The nurse would be sure to include:
1. The test detects Down's Syndrome
2. The test detects congenital heart defects
3. The test detects neural tube defects
4. The test detects the baby’s sex

139. During the neonatal assessment, the nurse notes the baby has a cephalohematoma. Which type of delivery would be most likely to have caused this?
1. NSVD
2. C-Section
3. Vacuum extraction
4. Breech

140. A mother who has just delivered is a known cocaine abuser. During the neonatal assessment, the nurse would assess the baby for the following complications:
1. Drowsiness, respiratory depression, sluggish reflexes
2. Irritability, jitterness, tachycardia
3. Fever, irritability, difficulty breathing
4. Poor muscle tone, persistent peripheral cyanosis, sleepiness

141. A breast feeding mother has begun to complain that her nipples have become sore. The nurse would instruct her to:
1. Discontinue breast feeding until they improve
2. Put olive oil on her nipples
3. Utilize different positions for the baby during breast feeding
4. Pump the breasts and give the baby the expressed milk

142. A newborn is admitted to a special care nursery awaiting surgery for a myelomeningocele. Which of the following nursing diagnoses would be the priority in the plan of care for this baby?
1. Altered parenting
2. Altered skin integrity
3. Potential for infection
4. Potential altered elimination

143. The nurse has just admitted a 4 month old infant to the Recovery Room after a repair of a cleft lip. In transferring the infant from the stretcher to the bed, the nurse would position the infant in the following position:
1. Trendelenburg
2. Prone with the head turned to the right
3. Supine with head of bed elevated 30 degrees
4. Prone with head elevated slightly

144. The parents of a child with Tetralogy of Fallot have been given discharge instructions. Which of the following situations would the parents be instructed to avoid?
1. All infant contact with persons outside the home
2. Infant contact with persons who have mild colds
3. Infant contact with persons who have severe allergies
4. Routine immunizations

145. A nurse's teaching plan for a family with a child with Sickle Cell Anemia includes information on prevention of Sickle Cell Crisis. Which of the following situations would the nurse instruct avoiding in order to prevent a crisis?
1. Weight loss without dehydration
2. Midrange altitudes
3. Exposure to respiratory infections
4. Overhydration

146. A 14 year old girl has been hospitalized with Sickle Cell Anemia in vasoocclusive crisis. Which of these nursing diagnoses should receive priority in the nursing plan of care:
1. Impaired social interaction
2. Alteration in body image
3. Pain
4. Alteration in tissue perfusion

147. A patient with an Antisocial Disorder has a long history of arrests related to drugs and petty theft. This patient is admitted to the hospital for evaluation. The nursing staff should assume the following approach:
1. Authoritarian
2. Punitive
3. Unified
4. Flexible
148. A patient has been placed on Prozac [Fluoxetine] to treat a major depression. The nurse is aware that Prozac is an SSRI which is different from a tricyclic antidepressant. Two advantages of Prozac related to side effects would be:
1. Facilitates weight loss and doesn't potentiate seizures
2. Improves sleep and builds bone density
3. Strengthens immune system and improves sleep
4. Improves mood and stabilizes mood swings

149. A patient attends a medication class on Lithium. The following statement made by the patient indicates she needs additional medication teaching:
1. "I will need to have my Lithium blood level monitored."
2. "I should have salt in my diet."
3. "I should take a diuretic if I feel bloated."
4. "I should tell the nurse if I have diarrhea and vomiting."

150. A schizophrenic patient has been placed on Prolixin. He complains that he hates having to take medication because it reminds him that he's ill. The nurse reports this to the treatment team and recommends the doctor prescribe Prolixin Decanoate. The advantage of Prolixin Decanoate is:
1. The dose is minimal with few side effects
2. It is given by injection once every 1-2 weeks
3. It is given by injection once every 3-4 weeks  {Continue Next Page}

151. An elderly patient has been living in a nursing home for several years. The nursing staff has begun to notice a change in her behavior. All of the following are symptoms of depression except:
1. Changes in sleep patterns
2. Changes in eating patterns with weight loss
3. Excessive fatigue and increased concern with bodily functions
4. Hyperorality

152. A patient is brought to the Psychiatric Emergency Room by the police for threatening neighbors to blow up their car for stealing his secret formula. The patient is very agitated and paranoid. He is diagnosed with Paranoid Schizophrenia. The doctor orders Haldol for this patient over Thorazine because:
1. Haldol works faster in violent patients
2. Haldol has less side effects than Thorazine
3. Haldol is less sedating than Thorazine
4. Haldol is more sedating than Thorazine
153. A manic patient is exuberant and restless. He has been on medication for a few days but he continues to be somewhat agitated. The nurse recommends which of the following activities as most therapeutic at this time:
1. Playing a card game with the nurse
2. Volleyball
3. Jigsaw puzzle alone
4. Jazz dance group

154. A patient suffering from major Depression has done poorly on medication. The decision to give her ECT [electroconvulsive therapy] is made with her consent. All of the following are priorities in teaching her about this therapy to help her make an informed decision except:
1. ECT may cause death and memory loss
2. ECT may take several treatments
3. ECT may cause a manic episode
4. ECT involves having a seizure

155. A patient has been acting out on the Psychiatric Unit for days, being verbally abusive and threatening to staff. The following observation made by the nurse indicates he is improving:
1. The patient approaches each staff member and apologizes
2. The patient offers to help the staff clean up the living room
3. The patient begins to verbalize feelings
4. The patient states he feels better and is ready for a pass home

156. A young woman is admitted to the Psychiatric Unit. She had made a serious cut to her abdomen following her boyfriend threatening to terminate their relationship. Upon admission she began verbally abusing one nurse while being extremely sweet to a mental health worker. The patient's diagnosis is Borderline Personality Disorder. The primary defense mechanism used by this borderline patient with the nursing staff is:
1. Regression
2. Splitting
3. Inflation
4. Depression

157. A patient has Alzheimer's Disease and keeps the nurse in the room for extended periods of time while reminiscing about the past. Which of the following interventions by the nurse would be MOST therapeutic?
1. Keep the patient focused on the present and future only
2. Take the patient to group therapy with others in a similar age group
3. Set aside time in planning care in which you can let the patient reminisce about the past.
4. Offer diversionary activities that will free you to do your work, and reduce patient's talking about past.

158. Which of the following measures would be MOST EFFECTIVE to prevent disorientation in a minimally confused, elderly, hospitalized patient?
1. Orient to the room nightly prior to the patient going to sleep
2. Leave a small night light on in the room
3. Make rounds q1h to ensure that the patient is safe
4. Put the side rails up and call bell within reach

159. Following Gastric Resection, patients are prone to developing Dumping Syndrome. Which of the following types of dietary intake by the patient would be MOST helpful to either reduce or prevent this syndrome from developing?
1. Moderate fat, low carbohydrate
2. High fat, high carbohydrate
3. Low fat, low carbohydrate
4. Moderate fat, high carbohydrate

160. Following Total Gastrectomy patients will require vitamin replacement. Of the following, which vitamin is ESSENTIAL and MUST be given throughout life:
1. Vitamin C
2. Vitamin B6
3. Vitamin D
4. Vitamin B12

161. A patient with Pseudomonas is placed on Gentamycin Sulfate (Garamycin). Which of the following assessment parameters is NOT indicative of a potential serious adverse/toxic effect of this pharmacological agent?
1. Patient complains of decreased hearing or hearing loss
2. Elevation of serum BUN and/or Creatinine
3. Urine output of less than 600ml daily
4. Nausea and vomiting

162. You are taking care of a patient on Amphotericin-B. Which of the following electrolyte disturbances should the nurse be alert for:
1. Changes in Serum Potassium and Serum Sodium
2. Changes in Serum Potassium and Serum Magnesium
3. Changes in Serum Sodium and BUN
4. Changes in BUN and Creatinine
163. You are assigned to work in the Infectious Disease Clinic. A patient is diagnosed as having Second Stage Syphilis. Which of the following signs/symptoms is NOT a clinical manifestation of Second Stage Syphilis?
1. Low grade fever and malaise
2. Macular type rash
3. Chancre
4. Arthralgia

164. A patient presents to the Rheumatology Clinic where a diagnosis of Rheumatoid Arthritis is made. Which of the following would NOT be an assessment finding by the nurse:
1. Presence of Heberden's Nodes
2. Warm, tender, painful joints
3. Serum RF, and elevated ESR
4. Pt. c/o increased pain and stiffness in the morning

165. Following amputation of a lower extremity, a patient with prosthesis should be educated by the nurse to:
1. Wear the prosthesis daily, but remove immediately when discomfort is experienced
2. Adjust the fit of the prosthesis by wearing a heavier sock to insure a tight fit
3. To put the prosthesis on immediately upon arising in the morning and keep it on all day
4. To apply oil or lotion to the stump before applying the prosthesis

166. You are assigned to care for a patient with a Below the Knee Amputation (BKA). Among the patient's orders is one which states that the patient should be placed in the prone position twice daily. The nurse knows that the reason for this is:
1. Changing the patient's position will help to prevent skin breakdown
2. To observe the stump for signs of infection
3. To assist the patient in doing ROM (Range of Motion) exercises
4. To stretch the flexor muscles and prevent flexion contractures

167. A young athlete injures his knee in football practice. The team doctor prescribes Ibuprofen (Advil) for pain, and to reduce inflammation. Following three weeks of therapy the patient develops petechiae, and a blood test reveals a Platelet Count of 9,000. The nurse can expect that:
1. The patient will be able to continue therapy with this medication
2. That the dosage will be reduced from 6 to 3 tablets daily
3. That the medication will be discontinued, and an alternative therapy will be prescribed
4. That the doctor will order repeat lab studies, as they are likely in error

168. You are caring for a patient who is s/p Colostomy. In preparing a teaching plan for this patient which of the following would be an INCORRECT statement?
1. Irrigation is not necessary since the fecal contents are liquid
2. That the stoma should be dark pink to red in appearance
3. That the bag should be checked when starting new medication to be sure that it is completely dissolved
4. That the bag/appliance should be changed q 2-3 days

169. You are caring for a patient receiving Hyperalimentation (Total Parenteral Nutrition). The flow rate ordered is 60cc/hr. After two hours the patient complains of feeling extremely nauseous, and of having a bad headache. Which of the following would be the MOST APPROPRIATE intervention by the nurse?
1. Stop the infusion immediately
2. Increase the flow rate as the patient is likely hypoglycemic
3. Decrease the flow rate and observe the patient
4. Check the patient's glucose level and urinary output

170. In caring for a patient with DVT (Deep Vein Thrombosis), which of the following nursing interventions would be INAPPROPRIATE?
1. Elevate the foot of the bed
2. Apply elastic stockings to both lower extremities
3. Apply warm, moist heat to the affected extremity
4. Teach patient to use a heel-toe gait when ambulating

171. You are providing care for a patient with Arterial Occlusive Disease, and writing a Nursing Care Plan. One of your interventions is to position the patient's legs below the level of the heart. From which of the following Nursing Diagnoses is the above intervention MOST LIKELY derived from:
1. Potential for Activity Intolerance
2. High risk for pain
3. Potential for Altered Respiratory Function
4. Altered Tissue Perfusion

172. A 4 year old with advanced HIV disease is anorexic from oral candidiasis. Administration of antifungal medications will help to resolve the Candida. Which of the following nursing interventions will help to promote optimal nutrition:
1. Offer favorite foods several times a day
2. Give foods in liquid form
3. Give the child rewards for eating
4. Provide high calorie, protein meals and snacks

173. An 8 year old girl is admitted with R/O Acute Glomerulonephritis. Considering the usual prescribed treatment for this diagnosis which would be the earliest clinical manifestation of a response to treatment:
1. Decreased blood pressure
2. Increased urine output
3. Decreased edema
4. Increased serum protein

174. During a well baby check up, the nurse would expect the mother of a 7 month old to report that the baby:
1. Walks while holding on to things
2. Sits alone for brief periods
3. Pulls himself to a standing position in the crib
4. Just began to hold his head erect while sitting with support

175. A child in the Emergency Room is diagnosed with an acute episode of Croup (Acute laryngotracheo - bronchitis). During the initial assessment, which of the following finding would the nurse expect to find?
1. Diffuse expiratory wheezing
2. Inspiratory stridor with a brassy cough
3. Decreased aeration in lung fields
4. Shallow respirations

176. A 7 month old with congenital hip dysplasia had a spica cast applied. Which of the following instructions should be given to the parents in caring for their child.
1. Do not diaper the baby.
2. Feed only in prone position.
3. Observe the child's respiratory patterns.
4. Apply baby powder to the edges of the cast.

177. A woman delivered a set of twins 2 hours ago via C-Section and is now in the Recovery Room. The following fundal assessment findings would be expected:
1. Fundus at umbilicus, hard and midline
2. Fundus 1-2 finger breadths above umbilicus, hard and midline
3. Fundus 1-2 finger breadths below umbilicus, hard and midline
4. Fundus would not be assessed because of the C-Section
178. A woman is admitted to the Labor Room in preterm labor. She is 30 weeks pregnant and having contractions. Her cervix is 5 cm dilated, 50% effaced. The doctor orders Celestine (Betamethasone) to be administered stat. The patient asks why this drug is being given to her. The nurses’ best explanation for this order would be:
1. To stop her contractions
2. To relieve pain
3. To increase maturity of the baby
4. To prevent infection.

179. A woman was admitted to the Labor Room in the active phase of labor. Which of the following assessment findings would confirm that she is in the active phase of labor?
1. Cervical dilation of 3cm, contractions lasting for 45-50 seconds with a frequency of 20 minutes apart
2. Cervical dilation of 4cm, contractions lasting for 60 sec. with a frequency of 10 minutes apart
3. Cervical dilation of 8cm, contractions lasting for 50 seconds with a frequency of 3 minutes apart
4. Cervical dilation of 6cm, contractions lasting for 45 seconds with a frequency of 3 minutes apart

180. The nurse is assessing a patient who is on a fetal monitor. On the last tracing, 2 late decelerations have occurred. The nurse is aware that late decelerations are:
1. Not worrisome and indicate head compression
2. Not worrisome and indicate cord compression
3. Worrisome and indicate uteroplacental insufficiency
4. Worrisome and indicate head compression

181. During the transitional phase of labor, the patient begins to scream and grabs the nurse with each contraction. The most appropriate nursing intervention would be to:
1. Look for the patient's coaching partner and get them to assist the patient
2. Establish eye contact and breathe with the patient
3. Give the patient pain medication
4. Tell the patient to begin pushing

182. The nurse is caring for a 9 month old in Bryant's Traction. When the nurse enters the room she observes that the baby is in the crib with the buttocks elevated slightly off the bed and the hips are flexed at a 90 degree angle. The appropriate nursing action to take would be to:
1. Call the Orthopedic Department to adjust the traction
2. Reposition the patient to the correct position
3. Chart the observation
4. Loosen the traction so that the buttocks rest on the bed

183. A toddler with Cystic Fibrosis is admitted with Pneumonia. Which of the findings in the child's history is directly related to the diagnosis of Cystic Fibrosis:
1. Developmental delay in walking
2. Tripling birth weight at one year
3. Meconium ileus
4. Two previous admissions for dehydration.

184. An 18 month old with Tetralogy of Fallot has a "tet" spell after having an invasive procedure. To improve the child's cardiac status which of the following interventions should the nurse do initially:
1. Place the child in a knee chest position
2. Begin chest compressions
3. Administer oxygen
4. Position with HOB elevated

185. A 2 1/2 year old who had a cleft palate repair is in the playroom and is crying because she wants the elbow restraints removed. The most appropriate action by the nurse to take would be to:
1. Distract the child with a toy
2. Remove the restraints and supervise the child
3. Remove the child from the playroom
4. Give the child pain medication

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186. Which of the following actions taken by the mother of a 6 month old who is experiencing discomfort associated with teething, indicates that the nurse's teaching plan has been successful:
1. She gives the baby an ice cube to suck on
2. She reports that the baby was less irritable after placing an Aspirin against the erupting tooth
3. She continues to apply a solution made by her grandmother that contains whiskey and sugar on the baby's gums
4. She offers the baby a hard rubber toy to bite on

187. You are caring for a patient with a diagnosis of Sepsis. One of the goals you have set for your patient is that there will be adequate tissue perfusion within the first 24
hours. Which of the following assessment parameters would NOT be indicative that this goal is being met?
1. CVP of 8cm H2O
2. Urinary output of 30ml/hr or more
3. Heart rate of 106 bpm
4. Absence of mental confusion and/or lethargy

188. You are assisting a physician in removing a chest tube from a patient. Which of the following will the patient be asked to do when the physician is ready to remove the tube?
1. Exhale and hold breath, or bear down
2. Inhale and hold breath, or bear down
3. Breathe normally
4. Inhale and cough

189. Which of the following is an ABNORMAL finding when observing Water Sealed Chest Drainage for proper functioning?
1. Bubbling initially with coughing and deep inspiration
2. Continuous bubbling where the water seal is maintained
3. Water level fluctuations with breathing
4. A collection chamber that is less than 1/2 full

190. A 70 year old patient sustained a hip fracture and is placed in Buck's Traction while awaiting a surgical fixation. Of the following, which would be the PRIORITY intervention in providing care for this patient?
1. Turn and change the patient's position q2h
2. Check traction ropes, weights and pulleys q shift
3. Assess neurological/sensory and circulatory status q 2 h
4. Release traction intermittently

191. Following Total Hip Replacement, the nurse should position the patient:
1. Recumbent with the affected extremity in abduction
2. Recumbent with the affected extremity in adduction
3. Recumbent on unoperated side with affected leg straight
4. Recumbent on operated side with unaffected leg at 45 degrees

192. In caring for a patient with Total Hip Replacement the nurse must assess for signs and symptoms of possible joint dislocation. Which of the following symptoms would NOT indicate a possible/probable dislocation of the hip joint:
1. Severe hip pain
2. Inability to move affected extremity
3. Shortening of the extremity
4. Positive Babinski Reflex

193. A patient with Insulin Dependent Diabetes comes to the doctor's office with a chief complaint of fever, a "bad cold" and flu like symptoms. On exam her Temperature is 101.2, Pulse 96 and Respirations 16. Her WBC (White blood count) is 15,000/mm³. Which of the following can the nurse expect in regard to the patient's Insulin dosage:
1. Insulin should be withheld
2. The dose should be decreased
3. No change is necessary
4. The dose should be increased

194. A patient with Insulin Dependent Diabetes (IDDM) is admitted to the hospital following a three day history of productive cough, fever and chills. A diagnosis of Pneumonia is made. VS on admission are Temperature 103.2, Pulse 112, Respirations 32 and are deep and rapid. The nurse's FIRST ACTION should be to:
1. Administer oxygen at 2L/min via nasal cannula
2. Obtain a blood sample for Glucose and Acetone
3. Administer 5U of Regular Insulin
4. Give orange juice with sugar packets added

195. You are changing a dressing on a patient who is s/p Nephrectomy. When assisting the doctor in changing the dressing, you observe the drainage to be thin and light red in color. When documenting this, the nurse would describe the drainage as:
1. Serous
2. Sanguinous
3. Serosanguinous
4. Purulent

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196. You are caring for a patient with a diagnosis of Meniere's Disease. Which of the following would NOT be an appropriate nursing intervention for this patient?
1. Restrict salt intake
2. Give vasodilating drugs such as Priscoline or Banthine
3. Give diuretics
4. Increase carbohydrate intake

197. Which of the following classifications of drugs WOULD NOT be utilized in the treatment of Asthma?
1. Calcium Channel Agonists
2. Beta Agonists
3. Methylxanthines
4. Corticosteroids

198. A patient is receiving Prednisone, a corticosteroid. Which of the following possible changes in lab values should the nurse be alert for?
1. Increased K+, decreased Ca++, increased glucose
2. Decreased K+, increased Ca++, decreased glucose
3. Decreased K+, decreased Ca++, increased glucose
4. Increased K+, increased Ca++, decreased glucose

199. A patient has received thromboembolytic therapy following a Myocardial Infarction with Streptokinase. Which of the following drugs should the nurse have on hand if the patient develops excessive bleeding or hemorrhage?
1. Protamine Sulfate
2. Aminocaproic Acid (Amicar)
3. Vitamin K
4. Heparin

200. A patient is receiving Incentive Spirometry post-operatively. Which of the following would demonstrate misunderstanding on the part of the nurse regarding this treatment modality?
1. The patient should be medicated for pain, p.r.n. prior to beginning the treatment
2. The head of the bed should be elevated to at least 45 degrees
3. The therapy should begin on the second or third post-op day
4. The patient should be taught to hold their breath following inspiration, and then to exhale slowly

201. You are working in the Dermatology Clinic. A patient has a Basal Carcinoma In Situ removed from his left lower leg. When he returns for follow-up in one week, you note that the wound has healed with minimal scarring. Which type of healing process does this represent?
1. Primary intention
2. Secondary intention
3. Tertiary intention
4. Dehiscence

202. A mother has requested that Hepatitis B vaccine be given to her newborn, because all her other children have been vaccinated. The most appropriate response by the nurse would be to:
1. Tell the mother it will be administered
2. Explain to the mother that it is not given until the two month check-up
3. Explain to the mother that Hepatitis B vaccine is not given to infants
4. Tell the mother to ask her Pediatrician what his/her opinion is

203. A woman in labor begins to have variable decelerations on the fetal monitor tracing. The nurse's most appropriate intervention would be to:
1. Decrease IV fluids
2. Increase IV fluids
3. Increase Pitocin
4. Prepare the patient for a C-Section

204. A woman who is 31 weeks pregnant is having contractions that are 5 minutes apart. She has not ruptured membranes. Which of the following interventions should be started first?
1. Give IV fluids
2. Give Ritodrine (Yutopar) to cause uterine muscle relaxation
3. Place her on a fetal monitor
4. Place her in a left lateral recumbent position

205. A woman with placenta previa is being discharged from her prenatal visit. Which of the following instructions should the nurse be sure to include for her?
1. Use condoms during coitus
2. Coitus is contraindicated
3. Only use the missionary position during coitus
4. During coitus do not use any position that puts pressure on the uterus

206. A pregnant woman who is HIV+ is being told about a new treatment to decrease the incidence of transmission of HIV to the baby. The nurse would explain that AZT is:
1. Given only to the mother during the third trimester of the pregnancy
2. Given only to the baby after birth
3. Given in the third trimester, during the delivery and to the baby for the first 6 weeks after birth
4. Given during the entire pregnancy and during the delivery

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Part 8: 20 Question on Infection Control:

207: What did HAI's USED to be known as?
A. Healthcare idiopathic infections
B. Nosocomial infections
C. Healthcare treated infections
D. Healthcare transmitted infections

208: For an infection to be defined as "healthcare acquired" what criteria needs to be
met?
A. The patient has to have had the infection when they were admitted to the hospital
B. The patient had to have been ready for discharge and then an infection was found which delayed their discharge
C. There must have been no evidence an infection present or incubating at the time of admission
D. The infection must be resistant to methicillin

209: According to the Center for Disease Control, what constitutes the single most important procedure in the prevention of infections?
A. Use of germicidal solutions on counters
B. Use of surgical masks
C. Use of sterile technique
D. Handwashing

210: Respiratory and cough etiquette includes:
A. Taking antibiotics
B. Covering the mouth and nose when sneezing and coughing
C. Putting the person in isolation
D. Using Lysol spray on inanimate surfaces

211. VRE, or Vancomycin Resistant Enterococcus:
A. May be spread by direct contact or by indirect contact with surfaces or contaminated equipment
B. Can not be transmitted from one person to another
C. Can not be spread by contaminated equipment
D. Responds to methicillin

212: What has contributed to the increase in the incidence of clostridium difficile?
A. Overuse, misuse and imprudent use of antibiotics
B. The number of hospitalizations per year in a healthcare facility
C. The quick turn-over rate in healthcare facilities
D. The increase in the number of surgical procedures

213: Which is not considered a potentially infectious material?
A. Wound exudate
B. Saliva
C. Blood
D. Sweat

214: If hands are not visibly soiled, which hand cleaner is strongly encouraged by the CDC and JCAHO standards?
A. Alcohol-based hand cleaners  
B. Plain water  
C. Phenol solutions  
D. They wouldn't need cleaned if they aren't visibly soiled

215: If a physician is not available to give an order, a patient can't be placed in isolation.  
A. True  
B. The nurse can place the patient in isolation and notify the physician as soon as possible  
C. The patient can be placed in isolation only with the family's consent.  
D. The patient must wear a mask until the physician's order to place the patient in isolation is obtained. At that time, the patient can be placed in the appropriate isolation.

216: The most frequent HAI is:  
A. Meningitis  
B. Cholecystitis  
C. UTI  
D. Osteomyelitis

True or False Questions:
217. Standard precautions require that masks be worn at all times.  
218. Early isolation theory concentrated on those patients who were diagnosed with or strongly suspected of having an infectious process.  
219. Transmission-based precautions are designed to be used in conjunction with standard precautions.  
220. Standard precautions need only be implemented when blood is visible.  
221. Contact precautions guidelines include the use of gloves when coming into contact with a patient's unbroken skin.  
222. Employees with no formal education in microbiology should receive training in methods of bacterial transmission.  
223. Standard precautions should be followed with all patients.  
224. Airborne bacteria may stay suspended in the air for an extended period of time.  
225. Droplet precautions require the use of a respirator.  

Part 9: 35 questions from Peer to Peer NCLEX - like  
227. A nurse is reviewing a patient’s medication during shift change. Which of the following medication would be contraindicated if the patient were pregnant? Note: More than one answer may be correct.  
A: Coumadin
B: Finasteride  
C: Celebrex  
D: Catapress  
E: Habitrol  
F: Clofazimine

228. A nurse is reviewing a patient’s PMH. The history indicates photosensitive reactions to medications. Which of the following drugs has not been associated with photosensitive reactions? Note: More than one answer may be correct.
A: Cipro  
B: Sulfonamide  
C: Noroxin  
D: Bactrim  
E: Accutane  
F: Nitrodur

229. A patient tells you that her urine is starting to look discolored. If you believe this change is due to medication, which of the following patient’s medication does not cause urine discoloration?
A: Sulfasalazine  
B: Levodopa  
C: Phenolphthalein  
D: Aspirin

230. You are responsible for reviewing the nursing unit’s refrigerator. If you found the following drug in the refrigerator it should be removed from the refrigerator’s contents?
A: Corgard  
B: Humulin (injection)  
C: Urokinase  
D: Epogen (injection)

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231. A 34 year old female has recently been diagnosed with an autoimmune disease. She has also recently discovered that she is pregnant. Which of the following is the only immunoglobulin that will provide protection to the fetus in the womb?
A: IgA  
B: IgD  
C: IgE  
D: IgG
232. A second year nursing student has just suffered a needlestick while working with a patient that is positive for AIDS. Which of the following is the most important action that nursing student should take?
A: Immediately see a social worker
B: Start prophylactic AZT treatment
C: Start prophylactic Pentamidine treatment
D: Seek counseling

233. A thirty-five-year-old male has been an insulin-dependent diabetic for five years and now is unable to urinate. Which of the following would you most likely suspect?
A: Atherosclerosis
B: Diabetic nephropathy
C: Autonomic neuropathy
D: Somatic neuropathy

234. You are taking the history of a 14-year-old girl who has a (BMI) of 18. The girl reports inability to eat, induced vomiting, and severe constipation. Which of the following would you most likely suspect?
A: Multiple sclerosis
B: Anorexia nervosa
C: Bulimia
D: Systemic sclerosis

235. A 24-year-old female is admitted to the ER for confusion. This patient has a history of a myeloma diagnosis, constipation, intense abdominal pain, and polyuria. Which of the following would you most likely suspect?
A: Diverticulosis
B: Hypercalcaemia
C: Hypocalcaemia
D: Irritable bowel syndrome

236. Rho gam is most often used to treat ____ mothers that have a ____ infant.
A: RH positive, RH positive
B: RH positive, RH negative
C: RH negative, RH positive
D: RH negative, RH negative

237. A nurse if reviewing a patient’s chart and notices that the patient suffers from conjunctivitis. Which of the following microorganisms is related to this condition?
A: Yersinia pestis
B: Helicobacter pylori
C: Vibrio cholera
D: Hemophilus aegyptius

238. A nurse if reviewing a patient’s chart and notices that the patient suffers from Lyme disease. Which of the following microorganisms is related to this condition?
A: Borrelia burgdorferi
B: Streptococcus pyogenes
C: Bacillus anthracis
D: Enterococcus faecalis

239. A fragile 87 year-old female has recently been admitted to the hospital with increased confusion and falls over last 2 weeks. She is also noted to have a mild left hemiparesis. Which of the following tests is most likely to be performed?
A: FBC (full blood count)
B: ECG (electrocardiogram)
C: Thyroid function tests
D: CT scan

240. A 84 year-old male has been loosing mobility and gaining weight over the last 2 months. The patient also has the heater running in his house 24 hours a day, even on warm days. Which of the following tests is most likely to be performed?
A: FBC (full blood count)
B: ECG (electrocardiogram)
C: Thyroid function tests
D: CT scan

241. A 20 year-old female attending college is found unconscious in her dorm room. She has a fever and a noticeable rash. She has just been admitted to the hospital. Which of the following tests is most likely to be performed first?
A: Blood sugar check
B: CT scan
C: Blood cultures
D: Arterial blood gases

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245. A 28 year old male has been found wandering around in a confused pattern. The male is sweaty and pale. Which of the following tests is most likely to be performed first?
A: Blood sugar check
B: CT scan
C: Blood cultures
246. A mother is inquiring about her child’s ability to potty train. Which of the following factors is the most important aspect of toilet training?
A: The age of the child
B: The child ability to understand instruction.
C: The overall mental and physical abilities of the child.
D: Frequent attempts with positive reinforcement.

247. A parent calls the pediatric clinic and is frantic about the bottle of cleaning fluid her child drank 20 minutes. Which of the following is the most important instruction the nurse can give the parent?
A: This too shall pass.
B: Take the child immediately to the ER
C: Contact the Poison Control Center quickly
D: Give the child syrup of ipecac

248. A nurse is administering a shot of Vitamin K to a 30 day-old infant. Which of the following target areas is the most appropriate?
A: Gluteus maximus
B: Gluteus minimus
C: Vastus lateralis
D: Vastus medialis

249. A nurse has just started her rounds delivering medication. A new patient on her rounds is a 4 year-old boy who is non-verbal. This child does not have on any identification. What should the nurse do?
A: Contact the provider
B: Ask the child to write their name on paper.
C: Ask a co-worker about the identification of the child.
D: Ask the father who is in the room the child’s name.

250. A 65 year old man has been admitted to the hospital for spinal stenosis surgery. When does the discharge training and planning begin for this patient?
A: Following surgery
B: Upon admit
C: Within 48 hours of discharge
D: Preoperative discussion

252. A child is 5 years old and has been recently admitted into the hospital. According to Erickson which of the following stages is the child in?
A: Trust vs. mistrust
B: Initiative vs. guilt
C: Autonomy vs. shame
D: Intimacy vs. isolation

253. A toddler is 16 months old and has been recently admitted into the hospital. According to Erickson which of the following stages is the toddler in?
A: Trust vs. mistrust
B: Initiative vs. guilt
C: Autonomy vs. shame
D: Intimacy vs. isolation

254. A young adult is 20 years old and has been recently admitted into the hospital. According to Erickson which of the following stages is the adult in?
A: Trust vs. mistrust
B: Initiative vs. guilt
C: Autonomy vs. shame
D: Intimacy vs. isolation

255. A nurse is making rounds taking vital signs. Which of the following vital signs is abnormal?
A: 11 year old male – 90 b.p.m, 22 resp/min, 100/70 mm Hg
B: 13 year old female – 105 b.p.m., 22 resp/min., 105/60 mm Hg
C: 5 year old male- 102 b.p.m, 24 resp/min., 90/65 mm Hg
D: 6 year old female- 100 b.p.m., 26 resp/min., 90/70 mm Hg

256. When you are taking a patient’s history, she tells you she has been depressed and is dealing with an anxiety disorder. Which of the following medications would the patient most likely be taking?
A: Elavil
B: Calcitonin
C: Pergolide
D: Verapamil

257. Which of the following conditions would a nurse not administer erythromycin?
A: Campylobacterial infection
B: Legionnaire’s disease
C: Pneumonia
D: Multiple Sclerosis

258. A patient’s chart indicates a history of hyperkalemia. Which of the following would
you not expect to see with this patient if this condition were acute?
A: Decreased HR
B: Paresthesias
C: Muscle weakness of the extremities
D: Migranes

259. A patient’s chart indicates a history of ketoacidosis. Which of the following would you not expect to see with this patient if this condition were acute?
A: Vomiting
B: Extreme Thirst
C: Weight gain
D: Acetone breath smell

260. A patient’s chart indicates a history of meningitis. Which of the following would you not expect to see with this patient if this condition were acute?
A: Increased appetite
B: Vomiting
C: Fever
D: Poor tolerance of light

261. A new mother has some questions about PKU. Which of the following statements made by a nurse is not correct regarding PKU?
A: A Guthrie test can check the necessary lab values.
B: The urine has a high concentration of phenylpyruvic acid
C: Mental deficits are often present with PKU.
D: The effects of PKU are reversible.

262. A patient has taken an overdose of aspirin. Which of the following should a nurse most closely monitor for during acute management of this patient?
A: Onset of pulmonary edema
B: Metabolic alkalosis
C: Respiratory alkalosis
D: Parkinson’s disease type symptoms

263. A fifty-year-old blind and deaf patient has been admitted to your floor. As the charge nurse your primary responsibility for this patient is?
A: Let others know about the patient’s deficits.    {Continue Next Page}
B: Communicate with your supervisor your patient safety concerns.
C: Continuously update the patient on the social environment.
D: Provide a secure environment for the patient.
264. A patient is getting discharged from a SNF facility. The patient has a history of severe COPD and PVD. The patient is primarily concerned about their ability to breathe easily. Which of the following would be the best instruction for this patient?
A: Deep breathing techniques to increase O2 levels.
B: Cough regularly and deeply to clear airway passages.
C: Cough following bronchodilator utilization
D: Decrease CO2 levels by increase oxygen take output during meals.

265. A nurse is caring for an infant that has recently been diagnosed with a congenital heart defect. Which of the following clinical signs would most likely be present?
A: Slow pulse rate
B: Weight gain
C: Decreased systolic pressure
D: Irregular WBC lab values