Chapter 1, Introduction to Nursing

1. An oncology nurse with 15 years of experience, certification in the area of oncology nursing, and a master's degree is considered to be an expert in her area of practice and works on an oncology unit in a large teaching hospital. Based upon this description, which of the following career roles best describes this nurse's role, taking into account her qualifications and experience?

A) Clinical nurse specialist

B) Nurse entrepreneur

C) Nurse practitioner

D) Nurse educator

Ans: A

Feedback:

A clinical nurse specialist is a nurse with an advanced degree, education, or experience who is considered to be an expert in a specialized area of nursing. The clinical nurse specialist carries out direct patient care; consultation; teaching of patients, families, and staff; and research. A nurse practitioner has an advanced degree and works in a variety of settings to deliver primary care. A nurse educator usually has an advanced degree and teaches in the educational or clinical setting. A nurse entrepreneur may manage a clinic or health-related business.

2. What guidelines do nurses follow to identify the patient's health care needs and strengths, to establish and carry out a plan of care to meet those needs, and to evaluate the effectiveness of the plan to meet established outcomes?

A) Nursing process

B) ANA Standards of Professional Performane

C) Evidence-based practice guidelines

D) Nurse Practice Acts

Ans: A

Feedback:

The nursing process is one of the major guidelines for nursing practice. Nurses implement their roles through the nursing process. The nursing process is used by the nurse to identify the patient's health care needs and strengths, to establish and carry out a plan of care to meet those needs, and to evaluate the effectiveness of the plan to meet established outcomes.

3. Which of the following organizations is the best source of information when a nurse wishes to determine whether an action is within the scope of nursing practice?

A) American Nurses Association (ANA)

B) American Association of Colleges in Nursing (AACN)

C) National League for Nursing (NLN)

D) International Council of Nurses (ICN)

Ans: A

Feedback:

The ANA produces the 2003 *Nursing: Scope and Standards of Practice*, which defines the activities specific and unique to nursing. The AACN addresses educational standards, while the NLN promotes and fosters various aspects of nursing.

The four concepts listed are all common in nursing theory, but the most important—and the focus of nursing—is the person (client).

16. What is the ultimate goal of expanding nursing knowledge through nursing research?

A) Learn improved ways to promote and maintain health.

B) Develop technology to provide hands-on nursing care.

C) Apply knowledge to become independent practitioners.

D) Become full-fledged partners with other care providers.

Ans: A

Feedback:

The ultimate goal of expanding nursing's body of knowledge through nursing research is to learn improved ways to promote and maintain health. Ongoing practice-based research reflects the nursing profession's commitment to meet the ever-changing demands of health care consumers. While doing research also facilitates the development of technology, helps produce independent practitioners, and provides partnerships with other providers of care, those are not the ultimate goals of nursing research.

17. What was significant about the promotion of the National Center for Nursing Research to the current National Institute of Nursing Research (NINR)?

A) Increased numbers of articles are published in research journals.

B) NINR gained equal status with all other National Institutes of Health.

C) NINR became the major research body of the International Council of Nurses.

D) It decreased emphasis on clinical research as an important area for nursing.

Ans: B

Feedback:

The National Center for Nursing Research was promoted to the National Institute of Nursing Research (NINR) in 1993, gaining equal status with all other National Institutes of Health.

18. Which of the following is a responsibility of an institutional review board (IRB)?

A) Secure informed consent for researchers

B) Review written accuracy of research proposals

C) Determine risk status of all studies

D) Secure funding for institutional research

Ans: C

Feedback:

Federal regulations require that institutions receiving federal funding, or conducting studies of drugs or medical devices regulated by the Food and Drug Administration establish IRBs. The IRB reviews all studies conducted in the institution to determine risk status and to ensure that ethical principles are followed. The IRB does not secure informed consent, review the accuracy of proposals, or secure funding.

19. Before developing a procedure, a nurse reviews all current research-based literature on insertion of a nasogastric tube. What type of nursing will be practiced based on this review?

Ans: B

Feedback:

Eye contact is one of the most culturally variable forms of communication. Although Americans emphasize eye contact while speaking, Hispanics look downward in deference to age, gender, social position, economic status, and authority.

11. An older adult woman of Chinese ancestry refuses to eat at the nursing home, stating, “I’m just not hungry.” What factors should the staff assess for this problem?

A) The woman does not like to eat with other residents of the home.

B) The woman is using this as a means of going home.

C) The food served may not be culturally appropriate.

D) The food served may violate religious beliefs.

Ans: C

Feedback:

Residents in long-term care settings often do not have much choice of foods. As a result, they may not be able to select cultural food preferences. When assessing the cause of decreased appetite in clients, the nurse should determine whether the problem may be related to culture.

12. All of the following are factors to consider when caring for clients with limited income. Which one is the **most** important?

A) Basic human needs may go unmet

B) Limited access to reliable transportation

C) Decreased access to health care services

D) Risk for increased incidence of disease

Ans: A

Feedback:

Poverty prevents many people from consistently meeting their basic human needs. Limited means of transportation, decreased access to health care services, and an increased incidence of disease are also influenced by limited income, but meeting one’s basic human needs is the most important factor.

13. The nurse is providing home care for a client who traditionally drinks herbal tea to treat an illness. How should the nurse respond to a request for the herbal tea?

A) We do not allow our clients to drink herbal tea.

B) Why in the world would you want to drink that stuff?

C) Let me check with the doctor to make sure it is okay to drink the tea with your medicines.

D) I have to fill out a lot of forms that you will have to sign before I can do that.

Ans: C

Feedback:

Herbs are a common method of treatment in many cultures. If a client traditionally drinks an herbal tea to alleviate symptoms of an illness, there is no reason why both the herbal tea and the prescribed medications cannot be used as long as the tea is safe to drink and does not interfere with, or exaggerate, the action of the medications. Asking why the

A) Common law

B) Public law

C) Civil law

D) Criminal law

Ans: C

Feedback:

Civil laws regulate the practice of nursing. A law is a standard or rule of conduct established and enforced by the government, chiefly to protect the rights of the public. Private law, also called civil law, regulates relationships among people and includes laws related to the practice of nursing.

8. What is the legal source of rules of conduct for nurses?

A) Agency policies and protocols

B) Constitution of the United States

C) American Nurses Association

D) Nurse Practice Acts

Ans: D

Feedback:

Nurse Practice Acts are examples of statutory law, enacted by a legislative body in keeping with both the federal constitution and the applicable state constitution. They are the primary source of rules of conduct for nurses. Standards of practice, which differ from rules of conduct, are made by agency policies and protocols and by the American Nurses Association.

9. A nurse moves from Ohio to Missouri. Where can a copy of the Nurse Practice Act in Missouri be obtained?

A) Ohio State Board of Nursing

B) Missouri State Board of Nursing

C) Federal government nursing guidelines

D) National League for Nursing

Ans: B

Feedback:

Each state has a Nurse Practice Act that protects the public by broadly defining the legal scope of nursing practice. A copy of the Nurse Practice Act for the state in which a nurse practices can be obtained from that state's board of nursing. Neither the federal government nor the National League for Nursing has copies of nurse practice acts.

10. Which of the following best describes voluntary standards?

A) Voluntary standards are guidelines for peer review, guided by the public's expectation of nursing.

B) Voluntary standards set requirements for licensure and nursing education.

C) Voluntary standards meet criteria for recognition, specified area of practice.

D) Voluntary standards determine violations for discipline and who may practice.

A) So, you feel that you are not ready to start a program this week…?

B) Why do you feel that you are not ready to start rehabilitation?

C) I understand that you are afraid to start rehabilitation; where do you see yourself in a week?

D) Remember we discussed what needs to be done to get you back on your feet…How do you feel about getting started?

Ans: A

Feedback:

Four skills have proved effective in motivational interviewing. These include: (answer A) reflective listening (restates the client's response back to him or her), (answer B) asking open questions (encourages discussion of the reason for making desired changes), (answer C) affirming (supports the client's efforts and encourages further exploration), and (answer D) summarizing (links and reinforces material that has been discussed).

20. At completion of the health education for a client, the nurse documents the details of the health education in the client's medical record. What can be determined by this documentation?

A) Proof of compliance with education standards

B) Client's response to the health education

C) Self-administration of medications

D) Dietary instructions for the client

Ans: A

Feedback:

The information about who was taught, what was taught, the education method, and the evidence of learning is the best proof of compliance with education standards. These are entered in the client's medical record. The client's response to the health education cannot be determined by this document. Self-administration of medications and dietary instructions for the client are not implied from who was taught, what was taught, the education method, and the evidence of learning.

21. A client 36 years of age is able to understand the health education when she is given the opportunity to put theeducation into practice. The nurse helps the client to self-administer the medication dosage before the client is discharged from the health care facility. Which domain correctly identifies the client's learning style?

A) Cognitive domain

B) Affective domain

C) Psychomotor domain

D) Interpersonal domain

Ans: C

Feedback:

The client's learning style falls into the psychomotor domain, which is a style of processing that focuses on learning by performing what has been learned. The cognitive domain is a style of processing information by listening or reading facts and descriptions. The affective domain is a style of processing, which appeals to a person's feelings, beliefs, or values. The interpersonal domain is a style of processing that focuses on learning through social relationships.

22. When caring for a client, the nurse gives day-to-day examples to explain certain points of the health education. The nurse also notes the client's concentration level and educates when the client is active. Which category does the client fall into?

A) Motivation

After the death of the patient, the hospice nurse continues to care for the client's family during the bereavement period for up to one year. Nurses help the family to work through their loss.

25. One of the newest concepts in providing long-term care is called aging in place. What is the best description of this type of care?

A) Clients move to an independent living apartment or home, then have access to increasing health care services as needed, provided within the health care community where they live.

B) Clients move into the nursing home, and access more and more services as required in the same facility.

C) A long-term-care facility, associated with a hospital, that provides acute care services as needed so the client can return to long term care.

D) Clients are maintained in their own homes with home health care.

Ans: A

Feedback:

The best description of "aging in place" is the type of care where the client moves into an independent living space, and then has access to more services, such as assisted living and/or skilled care, that are part of the health care community in which they live.

26. Health care is constantly changing and becoming more complex. Select the answers that describe clients as health care consumers today. Select all that apply.

A) They often have health information obtained from the Internet.

B) They prefer to control the decisions made about their own health care.

C) Most are less concerned about health care costs as long as they receive good care.

D) They express concern regarding access to care and the quality of service.

E) They have helped develop clients' rights and cost-containment measures.

Ans: A, B, D, E

Feedback:

Health care consumers are increasingly more knowledgeable about health, and prefer to control the decisions about their care. They express concern about access to services, and the cost and quality of care. They question duplication of services, and are actively engaged. They have helped to develop client rights and cost-containment measures as protections for clients in health care settings. Today clients are surveyed regarding their experiences with doctors and nurses in hospitals.

27. The Public Health Service (PHS) is a federal agency of the U.S. Department of Health and Human Services. The professional nurse is aware that the services provided by the PHS include which of the following? Select all that apply.

A) Care to migrant workers

B) Care in federal prisons

C) Veterans Administration (VA) hospitals

D) Indian Health Services

Ans: A, B, D

Feedback:

C) "I am so sick; I am about to throw up."

D) "Unable to palpate femoral pulse in left leg."

Ans: D

Feedback:

Objective data are observable and measurable data that can be seen, heard, or felt by someone other than the person experiencing them. Objective data observed by one person can be verified by another person observing the same client. Objective data are also called signs or overt data. The only objective data in this question would be that the nurse is unable to palpate a femoral pulse.

12. A nurse is collecting information from a client with dementia. The client's daughter accompanies the client. Which of the following statements by the nurse would recognize the client's value as an individual?

A) "Can you tell me how long your father has been this way?"

B) "Sarah, I have to go and read your father's old charts before we talk."

C) "Mr. Koeppe, tell me what you do to take care of yourself."

D) "Mr. Koeppe, I know you can't answer my questions, but it's okay."

Ans: C

Feedback:

Clients such as older adults with dementia, and their children, cannot be relied on to report accurately. However, they should be encouraged to respond to interview questions as best as they can. Bypassing the client communicates that the nurse does not have time or has doubts in the client's ability to communicate.

13. A nurse is collecting data from a home care client. In addition to information about the client's health status, what is another observation the nurse should make?

A) Number of rooms in the house

B) Safety of the immediate environment

C) Frequency of home visits to be made

D) Friendliness of the client and family

Ans: B

Feedback:

The nurse should also observe the safety of the immediate environment. Observation is the conscious and deliberate use of the five senses to gather data. Each time a client is observed, the nurse observes current responses, ability to provide self-care, the immediate environment, and the larger environment.

14. A nurse is preparing to conduct a health history for a client who is confined to bed. How should the nurse position herself?

A) Standing at the end of the bed

B) Standing at the side of the bed

C) Sitting at least six feet from the beside

D) sitting at a 45-degree angle to the bed

Ans: D

A) The UAP is responsible and accountable for his or her own actions.

B) Nurses do not have authority to delegate interventions.

C) The nurse transfers responsibility but is accountable for the outcome.

D) The UAP can function in an independent role for all interventions.

Ans: C

Feedback:

UAPs are trained to function in an assistive role to the RN in client activities as delegated and supervised by the RN. Delegation is the transfer of responsibility of an activity to another individual while retaining accountability for the outcome.

19. A nurse on duty finds that a client is anxious about the results of laboratory testing. Which intervention by the nurse reflects a supportive intervention?

A) Sitting with the client to encourage her to talk

B) Telling the laboratory technician to speed up the results

C) Calling the physician for an order for an anxiolytic

D) Educating the client about reducing risk factors

Ans: A

Feedback:

Supportive interventions include recognizing the need for encouragement, unconditional acceptance of behaviors, and the positive effects of being present for clients during stress or crisis. To support the anxious client, the nurse should sit with her and encourage her to talk. Telling the laboratory technician to speed up the results, or calling the physician and taking orders for anxiolytics are inappropriate supportive interventions. Educating the client about reducing risk factors is an educational intervention.

20. Educating clients on their diabetic regimen of administering insulin is the implementation of which skill?

A) Intrinsic

B) Technical

C) Interpersonal

D) Visual

Ans: B

Feedback:

The administration of insulin is a technical skill. Technical competence means being able to use equipment, machines, and supplies in a particular specialty.

21. A registered nurse who provides care in a subacute setting is responsible for overseeing and delegating to unlicensed assistive personnel (UAP). Which of the following principles should the nurse follow when delegating to UAP? Select all that apply.

A) Ensure that UAPs closely follow the nursing process when providing care.

B) Audit the client documentation that UAPs record after they perform interventions.

C) Take frequent mini-reports from UAPs to ensure changes in client status are identified.

D) Aging

Ans: A

Feedback:

Development is an orderly pattern of changes in structure, thoughts, feelings, or behaviors resulting from maturation, experiences, and learning. It is a dynamic and continuous process as one proceeds through life, characterized by a series of ascents, plateaus, and declines. Growth is an increase in body size or changes in body cell structure, function, and complexity.

11. As the fetus develops, certain growth and development trends are regular and predictable. The first trend is cephalocaudal growth. What does this mean?

A) Legs and feet develop first.

B) Both sides of the body develop equally.

C) Head and brain develop first.

D) Gross motor skills are learned last.

Ans: C

Feedback:

Cephalocaudal (proceeding from the head to the tail) development is the first trend, followed by proximodistal (progressing from gross motor to fine motor movements), and finally by symmetric (both sides of the body developing equally).

12. Many different factors affect growth and development. For example, why does one child have blonde hair and blue eyes while another child has brown hair and green eyes?

A) Childhood illnesses

B) Genetic inheritance

C) Prenatal influences

D) Maternal nutrition

Ans: B

Feedback:

At conception, every human receives an equal number of chromosomes from each parent. Physical characteristics, such as height, bone size, and eye and hair color, are inherited from our family of origin.

13. According to Erikson, normal adolescent behavior includes trying on new roles and possibly even rebelling. What is the purpose of this behavior in adolescents?

A) To establish a sense of security

B) To establish a sense of identity

C) To gain autonomy

D) To avoid inferiority

Ans: B

Feedback:

An infection is a disease state that results from the presence of pathogens (disease-producing microorganisms) in or on the body.

3. A client who has had abdominal surgery develops an infection in the wound while still hospitalized. Which of the following agents is most likely the cause of the infection?

A) Virus

B) Bacteria

C) Fungi

D) Spores

Ans: B

Feedback:

Some of the more prevalent agents that cause infection are bacteria, viruses, and fungi. Bacteria are the most significant and most commonly observed infection-causing agents in health care institutions.

4. A nurse caring for a client who has gas gangrene knows that this infection originated in which of the following reservoirs?

A) Other people

B) Food

C) Soil

D) Animals

Ans: C

Feedback:

The soil can act as a reservoir; the organisms that cause gas gangrene and tetanus are examples of pathogens whose reservoir is soil. Nurses can serve as reservoirs and inadvertently transfer pathogenic organisms to clients. For example, a nurse with artificial nails may harbor a large number and variety of microbes under the nails. Undercooked ground beef, tomatoes, and bagged spinach are reservoirs that have been identified as responsible for recent outbreaks of *E. coli* infections. The rabies virus is an example of a pathogen whose reservoir is various animals, notably dogs, squirrels, bats, and raccoons.

5. A client with an upper respiratory infection (common cold) tells the nurse, “I am so angry with the nurse practitioner because he would not give me any antibiotics.” What would be the most accurate response by the nurse?

A) “Antibiotics have no effect on viruses.”

B) “Let me talk to him and see what we can do.”

C) “Why do you think you need an antibiotic?”

D) “I know what you mean; you need an antibiotic.”

Ans: A

Feedback:

Viruses are the smallest of all microorganisms. Viruses, including the common cold and AIDS, cause many infections. Antibiotics have no effect on viruses.

6. A woman tests positive for the human immunodeficiency virus antibody but has no symptoms. She is considered a carrier. What component of the infection cycle does the woman illustrate?

D) Review of the definition and legal repercussions of IPV with all new female clients

Ans: A

Feedback:

Practices related to the identification of IPV vary, but it is generally agreed that a simple screening tool can be an effective strategy. A focused physical assessment and the involvement of social work are not warranted for all clients. A review of the definition and repercussions of IPV is likely not as effective as a simple and direct screening tool.

3. A nurse is admitting a client to a geriatric medicine unit following the client's recent diagnosis of acute renal failure. Which of the following nursing actions is most likely to reduce the client's chance of experiencing a fall while on the unit?

A) Orient the client to the room and environment thoroughly upon admission.

B) Provide the client with a bedpan to reduce the need to transfer to a commode or washroom.

C) Administer pain medications sparingly in order to minimize cognitive or musculoskeletal side effects.

D) Place the client in a shared room with a client who is stable and oriented.

Ans: A

Feedback:

A person who is familiar with his or her surroundings is less likely to experience an accidental injury. As part of the hospital admission routine, it is important to orient the client to the safety features and equipment in the room. A bedpan should not be used for the sole reason of reducing the risk of falls, and pain medication should be provided in doses sufficient to treat the client's pain. A client should never be charged with supervising the safety of another client.

4. Which of the following clients is most likely to face an increased risk of falls due to his or her medication regimen?

A) A female client age 77 years who has received a benzodiazepine to minimize her anxiety

B) A male client age 79 years whose recent high blood pressure has required a PRN dose of an angiotensin-converting enzyme (ACE) inhibitor

C) A woman age 81 years who has required a blood transfusion to treat a gastrointestinal bleed

D) A man 90 years of age whose venous ulcer has required the administration of intravenous antibiotics

Ans: A

Feedback:

While all drugs carry some risk of adverse effects, the use of benzodiazepines and antiepileptics are more predicative of falls than are other drug families.

5. A girl age 4 years has been admitted to the emergency department after accidently ingesting a cleaning product. Which of the following treatments is most likely appropriate in the immediate treatment of the girl's poisoning?

A) Administration of activated charcoal

B) Inducing vomiting

C) Gastric lavage

D) Intravenous rehydration

Ans: A

Feedback:

Feedback:

Airway/oxygen therapy/pulse oximetry occur in the postanesthesia unit in the postoperative phase. Teaching deep-breathing exercises and reviewing the meaning of p.r.n. orders for medications occur in the preoperative phase. Putting in IV lines and administering fluids occurs in the intraoperative phase.

34. Which statement accurately represents a recommended guideline when providing postoperative care for the following clients?

A) Force fluids for an adult client who has a urine output of less that 30 mL per hour.

B) If client is febrile within 12 hours of surgery, notify the physician immediately.

C) If the dressing was clean but now has a large amount of fresh blood, remove the dressing and reapply it.

D) If vital signs are progressively increasing or decreasing from baseline, notify the physician of possible internal bleeding.

Ans: D

Feedback:

A continued decrease in blood pressure or an increase in heart rate could indicate internal bleeding, and the physician should be notified. If an adult client has a urine output of less than 30 mL per hour, the physician should be notified, unless this is expected. If the client is febrile within 12 hours of surgery, the nurse should assist the client with coughing and deep-breathing exercises. When large amounts of fresh blood are present, the dressing should be reinforced with more bandages and the physician notified.

35. A diabetic client is undergoing surgery to amputate a gangrenous foot. This procedure would be considered which of the following categories of surgery based on purpose?

A) Diagnostic

B) Ablative

C) Palliative

D) Reconstructive

Ans: B

Feedback:

Ablative surgery is performed to remove a diseased body part. Diagnostic surgery is performed to make or confirm a diagnosis. Palliative surgery involves relieving or reducing intensity of an illness. Reconstructive surgery restores function to traumatized or malfunctioning tissue.

Chapter 31, Hygiene

1. Which client is most likely to require hospitalization related to problems associated with the feet?

A) A client with peripheral vascular disease

B) A client with osteoporosis

C) A client with asthma

D) A client with diabetes insipidus

Ans: A

Feedback:

The nurse would ask the client to cross the arms across the chest, and cross the legs. This facilitates the turning motion and protects the client's arms during the move. Or, if the client is able, the nurse may ask the client to assist by grasping the bed rail on the side toward which the client is turning.

33. A nurse is assisting in the transfer of a client to a stretcher. The client has casts on both legs. What is the nurse's best choice of transfer equipment for this client who cannot bear weight on either leg?

A) Powered-stand assist

B) Transfer chair

C) Repositioning lift

D) Gait belt

Ans: B

Feedback:

Chairs that can convert into stretchers are available. These are useful with clients who have no weight-bearing capacity, cannot follow directions, and/or cannot cooperate. The back of the chair bends back and the leg supports elevate to form a stretcher configuration, eliminating the need for lifting the client. Powered-stand assist devices and repositioning devices require the client to have weight-bearing capacity in one leg. Gait belts are used to assist clients to ambulate safely.

34. While being measured for anti-embolism stockings, the client asks the nurse why they are necessary. What would be the nurses's best response?

A) They promote venous blood return to the heart.

B) They eliminate peripheral edema.

C) They provide a nonslip foot surface to help prevent falls.

D) They reduce the risk for impaired skin integrity.

Ans: A

Feedback:

Anti-embolism stockings are used to promote venous blood return to the heart and help in preventing blood clots. They often do help with edema in the legs, but they do not eliminate edema (nor is this their main goal). They do not provide a nonslip foot surface. If applied incorrectly they can increase the risk for impaired skin integrity.

35. The nurse and an assistant are preparing to move a client up in bed. Arrange the following steps in the correct order.

1. Adjust the head of the bed to a flat position.
2. Place a friction-reducing sheet under the client.
3. Ask the client to bend legs and place the chin on the chest.
4. Position the assistant on the side opposite you.
5. Remove all pillows from under the client.
6. Grasp the sheet and move the client on the count of 3.

A) 3, 1, 2, 4, 5, 6

A) 500 calories/day

B) 200 calories/day

C) 300 calories/day

D) 400 calories/day

Ans: A

Feedback:

To lose 1 pound (0.45 kg) in a week, daily calorie intake should be decreased by 500 calories a day. One pound of body fat equals about 3,500 calories; 3,500 calories divided by 7 days = 500 calories/day.

4. The nurse caring for a client for several days has assessed that he has been eating poorly during his hospitalization. Which nursing measure should the nurse implement to assist the client in improving his nutritional intake?

A) Encourage his daughter to prepare food at home and bring it to the client.

B) Serve large meals and encourage the client to eat as much as possible.

C) Provide distractions while the client is fed so that he will eat more.

D) Provide bland meals.

Ans: A

Feedback:

The nurse should solicit food preferences and encourage favorite foods from home, when possible. Be sure the foods look attractive and the eating area is free of odors, clutter, and distractions during mealtime. Provide small, frequent meals to avoid overwhelming the client with large amounts of food.

5. Which of the following nutritional guidelines should a nurse provide to a client who is entering the second trimester of her pregnancy?

A) "You'll need to eat more calories and to make sure you eat a balanced diet high in nutrients."

B) "Try to eat your normal number of calories, but aim to eat a diet that's higher in fruits and vegetables."

C) "The more food energy you consume, the greater the chances that you will have a healthy pregnancy."

D) "Maintain your regular calorie intake, but take some supplements and emphasize organic foods."

Ans: A

Feedback:

Nutrient needs during pregnancy increase to support growth and maintain maternal homeostasis, particularly during the second and third trimesters. During the last two trimesters, women of normal weight need approximately 300 extra calories per day. Key nutrient needs include protein, calories, iron, folic acid, calcium, and iodine. It would be inaccurate to encourage the client to maximize calorie intake.

6. The nurse is testing the blood glucose levels of a client with a history of diabetes. The nurse has performed hand hygiene, checked the order, informed the client and turned on the monitor. After removing a test strip from the vial, the nurse should do which of the following?

A) Confirm that the strip and the meter share the same code.

B) Massage the client's finger toward the selected puncture site.

C) Cleanse the client's finger with alcohol.

29. The home care nurse visits a client who has dyspnea. The nurse notes the client has pitting edema in his feet and ankles. What additional assessment would the nurse expect to observe?

A) Crackles in the lower lobes

B) Inspiratory stridor

C) Expiratory stridor

D) Wheezing in the upper lobes

Ans: A

Feedback:

People with chronic congestive heart failure often experience shortness of breath because of excess fluid in the lungs and low oxygen levels. Stridor is associated with respiratory infections such as croup. Wheezing may be heard in individuals who use tobacco products.

30. A nurse is caring for an older adult client who is to be discharged from the health care facility. The client has been prescribed the use of a liquid oxygen unit at home to continue with oxygen therapy. What should the nurse tell the client regarding the potential problems of using a liquid oxygen unit? Select all that apply.

A) Liquid oxygen may leak during warm weather.

B) The unit may give off a bad smell if not cleaned regularly.

C) The unit's outlet may become occluded because of frozen moisture.

D) Portable liquid oxygen is more expensive.

E) The unit may require a secondary source of oxygen.

Ans: A, C, D

Feedback:

The nurse should inform the client who has been prescribed the use of a liquid oxygen unit that the unit may leak during warm weather; frozen moisture may occlude the outlet; and the unit is more expensive when compared with other portable sources of oxygen. Emission of a bad smell if filters are not cleaned, increase in the electric bill, and requirement of a secondary source of oxygen in case of failure are disadvantages of using an oxygen concentrator and are not related to the use of a liquid oxygen unit.

31. A nurse is educating a postoperative client on how to use an incentive spirometer. Which of the following is an accurate step that should be included in the teaching plan?

A) Instruct the client to inhale normally and then place the lips securely around the mouthpiece.

B) Instruct the client to inhale slowly and as deeply as possible through the mouthpiece, without using the nose.

C) When the client cannot inhale anymore, the patient should hold his or her breath and count to 10.

D) Encourage the client to perform incentive spirometry two to three times every one to two hours, if possible.

Ans: B

Feedback:

The client using an incentive spirometer should exhale normally and place the lips around the mouthpiece. He or she should inhale slowly and deeply without using the nose, and when the client cannot inhale anymore, hold the breath and count to 3 before exhaling normally. This should be performed 5 to 10 times every one to two hours, if possible.

The client is stating his stressors and a reaction to the stressor when he states, “I am so tired.” This would support Stress Overload. Defensive Coping would be not appropriate as he can state stressors in his life. He does not express Hopelessness in his statement to the nurse. The nurse needs more data, such as difficulty falling asleep and interrupted sleep, to support Disturbed Sleep Pattern.

35. The nurse walks into the client’s room and finds her sobbing uncontrollably. When the nurse asks what the problem is, the client responds I am so scared. I have never known anyone who goes into a hospital and comes out alive. On this client’s care plan the nurse notes a nursing diagnosis of Ineffective coping related to stress. What is the best outcome you can expect for this client?

A) Client will adapt relaxation techniques to reduce stress.

B) Client will be stress free.

C) Client will avoid stressful situations.

D) Client will start anti-anxiety agent.

Ans: A

Feedback:

Stress management is directed toward reducing and controlling stress and improving coping. The outcome for this diagnosis is that the client needs to adopt coping mechanisms that are effective for dealing with stress, such as relaxation techniques. The other options are incorrect because it is unrealistic to expect a client to be stress free; avoiding stressful situations and starting an anti-anxiety agent are not the best answers as outcomes for ineffective coping.

Chapter 43, Loss, Grief, and Dying

1. As decisions related to health care become increasingly complex, nurses need to be familiar with concepts related to advance directives. Which statement regarding advance directives is correct?

A) Hospitals are legally required to inform clients about advance directives.

B) The status of advance directives remains consistent from state to state.

C) Advance directives should be developed with the assistance of a physician or nurse.

D) Nurses can be appointed a surrogate decision maker by the client.

Ans: A

Feedback:

The Patient Self-Determination Act of 1990 requires all hospitals to inform their clients about advance directives. Th status of advance directives varies from state to state. Clients appoint a family member or close friend as a surrogate decision maker, not a nurse or health care professional. Advance directives are developed by the client; nurses and physicians may play a role in providing education related to advance directives, but their role is not essential.

2. A woman has had a breast removed to treat cancer. What type of loss will she most likely experience?

A) Actual loss

B) Perceived loss

C) Maturational loss

D) Anticipatory loss

Ans: A

A helpful way to elicit information about a client's sexual history is to ask, How would you describe the problem?

32. The nurse conducting a class on human sexuality includes which of the following about gender identity?

A) It is opposite of biologic gender.

B) It may be the same as or different from biologic gender.

C) It is determined by male (XY) or female (XX) chromosomes.

D) It is determined by physical characteristics.

Ans: B

Feedback:

Gender sex denotes chromosomal sexual development. Gender identity is the inner sense one has of being male or female, which may be the same or different from biologic gender.

33. When conducting a class on sexuality with teenagers, the nurse includes that sexuality is which of the following?

A) External appearance of one's genitalia as male or female

B) Male or female internal organ structure and function

C) How one experiences maleness or femaleness physically, emotionally, and mentally

D) The pleasure experienced during sexual activity

Ans: C

Feedback:

A critical component of human identity and well-being, sexuality involves how a person exhibits and experiences maleness or femaleness physically, emotionally, and mentally. Sexuality is defined not only by a person's genitalia and hormones, but also by attitudes and feelings.

34. Parents of an infant express concern because the infant is touching his genitals. What should the nurse teach the parents?

A) Self-manipulation of genitals is normal behavior in an infant.

B) Have the child wear clothes that prohibit touching.

C) If this bad behavior continues, seek counseling.

D) Make him have time out every time it happens.

Ans: A

Feedback:

Infants touch their genitals. This is normal behavior for a toddler. Punishment of genital fondling may lead to guilt and shame regarding sexual behavior later in life.

35. Which of the following occurs in the male during the resolution phase of the sexual response cycle?

A) The penis becomes erect due to increased pelvic congestion of blood.

B) Involuntary spasmodic contractions occur in the penis.

C) The male orgasm occurs usually with ejaculation of semen from the penis.

D) Education

E) Automobile makes

Ans: A, B, C

Feedback:

Many religions have significance in regard to daily life. For instance, some religions have dietary requirements and restrictions. The Mormons have special undergarments that are worn by some members. Some religions restrict medical treatments, such as blood products. Education and automobile makes are not restricted by most religions.

33. A client informs the nurse that her physician has planned a procedure that may be in conflict with the client's personal spiritual belief. The client asks the nurse for assistance. The nurse is aware that her role should include assisting the client to do which of the following?

A) Confront the physician and refuse to undergo the procedure.

B) Explore and research alternative medicine therapies.

C) Poll other physicians about alternate treatment options.

D) Obtain accurate information in order to make a good decision.

Ans: D

Feedback:

The nurse's role is to assist the client in obtaining the information needed to make an informed decision, and to support the client's decision making. The nurse should never interfere between a client and the client's physician.

34. A client requests the nurse not touch his lips when administering his oral medications. Based on the nurse's understanding of the major religions, the nurse identifies this request as reflecting which of the following?

A) Judaism

B) Christianity

C) Islam

D) Hinduism

Ans: D

Feedback:

In the Hindu religion, the nurse administering oral medications should avoid touching the client's lips. Judaism, Christianity, and Islam do not require this.

35. The nurse caring for a Native American client should inquire if the client utilizes which of the following?

A) Medicine man or woman

B) Priest

C) Rabbi

D) Preacher

Ans: A

Feedback: