

HESI FUNDAMENTALS

1. A policy requiring the removal of acrylic nails by all nursing personnel was implemented 6 months ago. Which assessment measure best determines if the intended outcome of the policy is being achieved.
 - a. Number of staff induced injury
 - b. Client satisfaction survey
 - c. **Health care-associated infection rate.**
 - d. Rate of needle-stick injuries by nurse.
2. The nurse is preparing to assist a newly admitted client with personal hygiene measures. The client...the client's gag reflex. Which action should the nurse include?
 - A. Offer small sips of water through a straw
 - B. **Place tongue blade on back half of tongue**
 - C. Use a penlight to observe back of oral cavity
 - D. Auscultate breath sounds after client swallows
3. The nurse explains to an older adult male the procedure for collecting a 24-hour urine specimen for creatinine clearance.
 - A. Assess the client for confusion and reteach the procedure
 - B. Check the urine for color and texture
 - C. **Empty the urinal contents into the 24-hour collection container**
 - D. Discard the contents of the urinal
4. A 54-year-old male client and his wife were informed this morning that he has terminal cancer. Which nursing intervention is likely to be most
 - A. Ask her how she would like to participate in the client's care
 - B. Provide the wife with information about hospice
 - C. Encourage the wife to visit after painful treatments are completed
 - D. **Refer her to support group for family members of those dying of cancer**
5. A client who has a body mass index (BMI) of 30 is requesting information on the initial approach to a weight loss plan. Which action should the nurse recommend?
 - A. Plan low carbohydrate and high protein meals
 - B. Engage in strenuous activity for an hour daily
 - C. **Keep a record of food and drinks consumed daily**
 - D. Participated in a group exercise class 3 times a week
6. The nurse assesses a client who has a nasal cannula delivering oxygen at 2 L/min. To assess for skin damage related to the cannula, which areas should the nurse observe?
 - A. **Tops of the ear**
 - B. Bridge of the nose
 - C. **Around the nostrils**
 - D. **Over the cheeks**
 - E. Across the forehead
7. The nurse observes an unlicensed assistive personnel (UAP) who is providing a total bed bath for a confused and lethargic client. The UAP is soaking the client's foot in a basin of warm water placed on the bed. What action should the nurse take?
 - a. Remove the basin of water from the client's bed immediately
 - b. **Remind the UAP to dry between the client's toes completely**
 - c. Advise the UAP that this procedure is damaging to the skin
 - d. Add skin cream to the basin of water while the foot is soaking
8. The nurse in the emergency department observes a colleague viewing the electronic health record (EHR) of a client who holds an elected position in the community. The client is not a part of the colleague's assignment. Which action should the nurse implement?
 - a. **Communicate the colleague's actions to the unit charge nurse**
 - b. Send an email to facility administration reporting the action
 - c. Write an anonymous complaint to a professional website
 - d. Post a comment about the action on a staff discussion board
9. At 0100 on a male client's second postoperative night, the client states he is unstable to sleep and plans to read until feeling sleepy. What action should the nurse implement?
 - a. Leave the room and close the door to the client's room
 - b. Assess the appearance of the client's surgical dressing
 - c. **Bring the client a prescribed PRN sedative-hypnotic**
 - d. Discuss symptoms of sleep deprivation with the client
10. The nursing staff in the cardiovascular intensive care unit are creating a continuous quality improvement project on social media that addresses coronary artery disease (CAD). Which action should the nurse implement to protect client privacy?
 - a. **Remove identifying information of the clients who participated**
 - b. Recall that authored content may be legally discoverable
 - c. Share material from credible, peer reviewed sources only
 - d. Respect all copyright laws when adding website content
11. A male client with unstable angina needs a cardiac catheterization, so the healthcare provider explains the risks and benefits of the procedure, and then leaves to set up for the procedure. When the nurse presents the consent form for signature, the client hesitates and asks how the wires will keep his heart going. Which action should the nurse take?
 - a. Answer the client's specific questions with a short understandable explanation
 - b. **Postpone the procedure until the client understands the risks and benefits**
 - c. Call the client's next of kin and ask them to provide verbal consent
 - d. Page the healthcare provider to return and provide additional explanation
12. The nurse is teaching a client how to do active range of motion (ROM) exercises. To exercise the hinge joints, which action should the nurse instruct the client to perform?
 - a. Tilt the pelvis forwards and backwards

tube. What is the best client position for administration of the bolus tube feedings?

- A. Prone.
- B. Fowler's.
- C. Sims'.
- D. Supine.

Correct Answer: B

29) A 73-year-old female client had a hemiarthroplasty of the left hip yesterday due to a fracture resulting from a fall. In reviewing hip precautions with the client, which instruction should the LPN/LVN include in this client's teaching plan?

- A. In 8 weeks you will be able to bend at the waist to reach items on the floor.
- B. Place a pillow between your knees while lying in bed to prevent hip dislocation.
- C. It is safe to use a walker to get out of bed, but you need assistance when walking.
- D. Take pain medication 30 minutes after your physical therapy sessions.

Correct Answer: B

30) A client with pneumonia has a decrease in oxygen saturation from 94% to 88% while ambulating. Based on these findings, which intervention should the LPN/LVN implement first?

- A. Assist the ambulating client back to the bed.
- B. Encourage the client to ambulate to resolve pneumonia.
- C. Obtain a prescription for portable oxygen while ambulating.
- D. Move the oximetry probe from the finger to the earlobe.

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1. When turning an immobile bedridden client without assistance, which action by the nurse best ensures client safety?
 - A. Securely grasp the client's arm and leg.
 - B. Put bed rails up on the side of bed opposite from the nurse.
 - C. Correctly position and use a turn sheet.
 - D. Lower the head of the client's bed slowly.

Rationale:

Because the nurse can only stand on one side of the bed, bed rails should be up on the opposite side to ensure that the client does not fall out of bed. Option A can cause client injury to the skin or joint. Options C and D are useful techniques while turning a client but have less priority in terms of safety than use of the bed rails.

2. The nurse identifies a potential for infection in a client with partial-thickness (second-degree) and full-thickness (third-degree) burns. What intervention has the highest priority in decreasing the client's risk of infection?
 - A. Administration of plasma expanders
 - B. Use of careful handwashing technique
 - C. Application of a topical antibacterial cream
 - D. Limiting visitors to the client with burns

Rationale:

Careful handwashing technique is the single most effective intervention for the prevention of contamination to all clients. Option A reverses the hypovolemia that initially accompanies burn trauma but is not related to decreasing the proliferation of infective organisms. Options C and D are recommended by various burn centers as possible ways to reduce the chance of infection. Option B is a proven technique to prevent infection.

3. The nurse is aware that malnutrition is a common problem among clients served by a community health clinic for the homeless. Which laboratory value is the most reliable indicator of chronic protein malnutrition?

- B. Determine if the client has a family history of suicide attempts.
- C. Inquire about whether the life partner was suffering from AIDS.
- D. Consult with the health care provider about the client's need for antidepressant medications.

Rationale:

The client is exhibiting normal grieving behaviors, so referral to a grief counselor is the most important intervention for the nurse to implement. Option B is indicated but is not a high-priority intervention. Option C is irrelevant at this time but might be important when determining the client's risk for contracting the illness. An antidepressant may be indicated, depending on further assessment, but grief counseling is a better action at this time because grief is an expected reaction to the loss of a loved one.

65. An older adult who recently began self-administration of insulin calls the nurse daily to review the steps that should be taken when giving an injection. The nurse has assessed the client's skills during two previous office visits and knows that the client is capable of giving the daily injection. Which response by the nurse is likely to be most helpful in encouraging the client to assume total responsibility for the daily injections?

- A. "I know you are capable of giving yourself the insulin."
- B. "Giving yourself the injection seems to make you nervous."
- C. "When I watched you give yourself the injection, you did it correctly."
- D. "Tell me what you want me to do to help you give yourself the injection at home."

Rationale:

The nurse needs to focus on the client's positive behaviors, so focusing on the client's demonstrated ability to self-administer the injection is likely to reinforce his level of competence without sounding punitive. Option A does not focus on the specific behaviors related to giving the injection and could be interpreted as punitive. Option B uses reflective dialogue to assess the client's feelings, but telling the client that he is nervous may serve as a negative reinforcement of this behavior. Option D reinforces the client's dependence on the nurse.

66. After receiving written and verbal instructions from a clinic nurse about a newly prescribed medication, a client asks the nurse what to do if questions arise about the medication after getting home. How should the nurse respond?

peripheral IV catheter. After which of the following observations should the nurse remove the IV catheter?

- A) Small air bubbles are in the IV tubing.**
- B) IV flow stops when the client bends her arm.**
- C) Swelling and coolness are observed at the IV site.**
- D) Blood is visible in the IV catheter and tubing.**

Swelling and coolness are observed at the IV site.

Swelling and coolness are indications of IV infiltration, which warrant removing the catheter and restarting the IV infusion with a new catheter at a different site.

- 86. A client who is nonambulatory notifies the nurse that his trash can is on fire. After the nurse confirms the fire, which of the following actions should the nurse take next?**

- A) Activate the emergency fire alarm.**
- B) Extinguish the fire.**
- C) Evacuate the client.**
- D) Confine the fire.**

Evacuate the client.

According to the RACE mnemonic, the first action in response to a fire is to rescue the clients, moving them to a safe area.

- 87. A nurse in a provider's office is obtaining the health and medication history of a client who has a respiratory infection. The client tells the nurse that she is not aware of any allergies, but that she did develop a rash the last time she was taking an antibiotic. Which of the following information should the nurse give the client?**

- A) "Rashes are very common, especially if you have dry skin. Did it go away on its own?"**
- B) "Virtually all medications have adverse effects. It sounds like this could have been an adverse effect of the antibiotic."**
- C) "It's unlikely that your doctor will prescribe an antibiotic for what seems to be a minor viral infection, so we shouldn't be concerned about that rash."**
- D) "We need to document the exact medication you were taking because you might be allergic to it."**

"We need to document the exact medication you were taking because you might be allergic to it."

If there is any possibility that a client had an allergic reaction to a medication, it is imperative that the provider be aware and does not prescribe that same medication again. Subsequent allergic reactions could be life-threatening.

- 88. A home health nurse who has attended a training session for the therapeutic**

b. "I will insert the tablet between my cheek and teeth."

- c. "I will place the tablet under my tongue."- this is sublingual
- d. "I will chew the tablet."- this is oral

36. A nurse is admitting a client who is malnourished. The client states my wedding ring is loose and I'm worried I will lose it if it falls off. Which of the following is an appropriate response by the nurse?

- a. "I can pin it to your hospital gown, so you won't lose it."
- b. "I will place it in your drawer, so it won't get lost."
- c. "I will hold onto it until a family member can take it home."

d. "I can put it in a locked storage unit for you."

37. A nurse is changing a client's colostomy pouch and notices peristomal skin irritation. Which of the following actions should the nurse take?

- a. Change the pouch once every 24 hour.
- b. Apply the pouch while the skin Barrier is still damp.(no)
- c. Rub the peristomal skin dry after cleaning. (No it will irritate skin more)

d. Ensure the pouch is 0.32 cm (1/8 in) larger than the stoma.

rationale : ATI FUNDA PG 241

38. A nurse is preparing change of shift report after the night shift using one sbar communication tool. which of the following data should the nurse include when reporting **background** information?

- a. "Blood pressure 160/92 mm Hg"- part of ASSESSMENT
- b. "Start first dose of penicillin at 1200"-
- c. "Pain rating of 5 on a scale from 0 to 10"

d. "Code status: do-not-resuscitate"

39. A nurse is caring for a client who has extracellular fluid volume deficit. Which of the following findings should the nurse expect? **Chapter 57 fluid volume imbalances page 343.**

- a. Postural hypotension**
- b. Distended neck veins
- c. Dependent edema
- d. **Bradycardia** - would be TACHY since SNS system kicks in when detects low blood volume
TACHYCARDIA is for fluid overload.

Isn't wherever the water goes the sodium follows. The lady on ati gave me a remediation hw about manifestation of hypernatremia: hyperthermia, tachycardia, and orthostatic hypotension. Therefore it's opposite→ bradycardia. TBC by the group

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1. A nurse is teaching a group of older adults about expected changes of aging. Which of the following statements by a group member indicates that the teaching has been effective?

"I should expect my heart rate to take longer to return to normal after excessive as I get older."

2. A nurse is caring for a client who is postoperative and has paralytic ileum. Which of the following abdominal assessments should the nurse expect?

Absent bowel sounds with distention

3. A nurse is planning care for a client who reports abdominal pain. An assessment by the nurse reveals the client has a temperature of 39.2 degrees C (102 degrees F), heart rate of 105/min, a soft contender abdomen, and census overdue by 2 days. Which of the following findings should be the nurse's priority?

Temperature

4. A nurse is caring for a child who is postoperative following a tonsillectomy. Which of the following actions should the nurse take?

Administer analgesics to the child on a routine schedule throughout the day and night.

5. A nurse is assessing the heart sounds of a client who has developed chest pain that becomes worse with inspiration. The nurse auscultates a high-pitched scratching sound during both systole and diastole with the diaphragm of the stethoscope positioned at the left sternal border. Which of the following heart sounds should the nurse document?

Pericardial friction rub

6. A nurse is teaching an assistive personnel (AP) about proper hand hygiene. Which of the following statements by the AP indicates an understanding of the teaching?

"There are times I should use soap and water rather than alcohol based hand rub to clean my hands."

7. A nurse is caring for a client who is unstable and has vital signs measured every 15 minutes by an electronic blood pressure machine. The nurse notices the machine begins to measure the blood pressure at varied intervals and the readings are inconsistent. Which of the following actions should the nurse take?

Discontinue the machine, and measure the blood pressure manually every 15 min.

40. A nurse is planning care for a client who has had a stroke, resulting in aphasia and dysphagia. Which of the following tasks should the nurse assign to an assistive personnel (AP)?
- a. **Assist the client with a partial bed bath**
 - b. **Measure the client's BP after the nurse administers an antihypertensive medication**
 - c. **Use a communication board to ask what the client wants for lunch**
41. A charge nurse is observing a newly licensed nurse prepare a sterile field. Which of the following actions should the charge nurse identify as contaminating the sterile field?
- a. **The nurse opens the sterile field on a wet surface.**
42. A nurse is performing a skin assessment of a client who has a lesion on his anterior thigh and expresses concern about skin cancer. Which of the following findings should the nurse report to the provider as a possible indication of a skin malignancy?
- a. **An uneven shape**
43. A nurse is caring for a client who has an aggressive form of prostate cancer. The provider briefly discusses treatment options and leaves the client's room. When the nurse asks if the client would like to discuss any concerns, the client declines. Which of the following statements should the nurse make?
- a. **"I am available to talk if you should change your mind."**
44. A nurse is admitting a client who has been having frequent tonic-clonic seizures. Which of the following actions should the nurse add to the client's plan of care?
- a. **Wrap blankets around all four sides of the bed.**
45. A nurse is caring for a client who has a sodium level of 125mEq/L. Which of the following findings should the nurse expect?
- a. **Abdominal cramping**
 - b. The client has hyponatremia, manifestations include abdominal cramping, weakness, headache, and nausea.
46. A nurse is caring for a group of clients on a medical-surgical unit. In which of the following situations does the nurse demonstrate the ethical principle of veracity?
- a. **A client unaware of her recent cancer diagnosis asks the nurse if she has cancer, and the nurse responded affirmatively.**
 - b. Following the ethical principle of veracity, the nurse must tell the truth at all times and never deceive others.
47. A nurse is auscultating the anterior chest wall of a client newly admitted to a medical-surgical unit. Identify the type of breath sounds.
- a. **Normal breath sounds**
48. A nurse is providing home care for a client who is receiving tube feedings and medication through a gastrostomy tube. The family member providing the feedings reports that the client has begun to have diarrhea. For which of the following practices should the nurse intervene?
- a. **The family member washes out the feeding bag with warm water once every 24 hours.**

- c. **Instructions for diet and medications.**
 - d. Most recent vital sign data.
 - e. **Contact information for the home health care agency.**
5. **As part of the admission process, a nurse at a long-term care facility is gathering a nutrition history for a client who has dementia. Which of the following components of the nutrition evaluation is the priority for the nurse to determine from the client's family?**
- a. Body mass index
 - b. Usual times for meals and snacks
 - c. Favorite foods
 - d. **Any difficulty swallowing**

Chapter 10

1. **When entering a client's room to change a surgical dressing, a nurse notes that the client is coughing and sneezing. Which of the following actions should the nurse take when preparing the sterile field?**
- a. Keep the sterile field at least 6 ft away from the client's bedside.
 - b. Instruct the client to refrain from coughing and sneezing during the dressing change.
 - c. **Place a mask on the client to limit the spread of microorganisms into the surgical wound.**
 - d. Keep a box of facial tissue for the client to use during the dressing change.
2. **A nurse has removed a sterile pack from its outside cover and placed it on a clean work surface in preparation for an invasive procedure. Which of the following flaps should the nurse unfold first?**
- a. The flap closest to the body
 - b. The right side flap
 - c. The left side flap
 - d. **The flap farthest from the body**
3. **A nurse is wearing sterile gloves in preparation for performing a sterile procedure. Which of the following objects can the nurse touch without breaching sterile technique? (Select all that apply.)**
- a. A bottle containing a sterile solution
 - b. The edge of the sterile drape at the base of the field
 - c. **The inner wrapping of an item on the sterile field**
 - d. **An irrigation syringe on the sterile field**
 - e. **One gloved hand with the other gloved hand**

1. A nurse is a provider's office is preparing to test a client's cranial nerve function. Which of the following should the nurse include when testing cranial nerve V? (Select all that apply.)
 - a. "Close your eyes."
 - b. "Tell me what you can taste."
 - c. **"Clench your teeth."**
 - d. "Raise your eyebrows."
 - e. **"Tell me when you feel a touch."**

2. A nurse is assessing a client's thyroid gland as part of a comprehensive physical examination. Which of the following findings should the nurse expect? (Select all that apply.)
 - a. **Palpating the thyroid in the lower half of the neck.**
 - b. Visualizing the thyroid on inspection of the neck.
 - c. Hearing a bruit when auscultating the thyroid.
 - d. **Feeling the thyroid ascend as the client swallows.**
 - e. **Finding symmetric extension off the trachea on both sides of the midline.**

3. A nurse is assessing an adult client's internal ear canals with an otoscope as part of a head and neck examination. Which of the following actions should the nurse take? (Select all that apply.)
 - a. Pull the auricle down and back.
 - b. **Insert the speculum slightly down and forward.**
 - c. Insert the speculum 2 to 2.5 cm (0.8 to 1 in)
 - d. **Make sure the speculum does not touch the ear canal.**
 - e. **Use the light to visualize the tympanic membrane in a cone shape.**

4. A nurse is caring for a client who asks what their Snellen eye test results mean. The client's visual acuity is 20/30. Which of the following responses should the nurse make?
 - a. **"Your eyes see at 20 feet what visually unimpaired eyes see at 30 feet."**
 - b. "Your right eye can see the chart clearly at 20 feet, and your left eye can see the chart clearly at 30 feet."
 - c. "Your eyes see at 30 feet what visually unimpaired eyes see at 20 feet."
 - d. "Your left eye can see the chart clearly at 20 feet, and your right eye can see the chart clearly at 30 feet."

5. A nurse is performing a head and neck examination for an older adult client. Which of the following age-related findings should the nurse expect? (Select all that apply.)
 - a. Reddened gums

4. A nurse on the IV team is conducting an in-service education program about the complications of IV therapy. Which of the following statements by an attendee indicates an understanding of the manifestations of infiltration? (Select all that apply.)
- a. "The temperature around the IV site is cooler."
 - b. "The rate of the infusion increases."
 - c. "The skin at the IV site is red."
 - d. "The IV dressing is damp."
 - e. "The tissue around the venipuncture site is swollen."
5. A nurse is caring for a client receiving dextrose 5% in 0.9% sodium chloride IV at 120 mL/hr. Which of the following statements by the client should alert the nurse to suspect fluid overload? (Select all that apply.)
- a. "I feel lightheaded."
 - b. "I feel as though my heart is racing."
 - c. "I feel a little short of breath."
 - d. "The nurse technician told me that my blood pressure was 150 over 90."
 - e. "I think my ankles are less swollen."

Chapter 50

1. A nurse is collecting data from a client who takes haloperidol to treat schizophrenia. Which of the following findings should the nurse document as extrapyramidal symptoms (EPSs)? (Select all that apply.)
- a. Orthostatic hypotension
 - b. Tremors
 - c. Acute dystonia
 - d. Decreased level of consciousness
 - e. Restlessness
2. A nurse is teaching a client who has a new prescription for oxybutynin about managing the medication's anticholinergic effects. Which of the following instructions should the nurse include? (Select all that apply.)
- a. Take sips of water frequently.
 - b. Wear sunglasses when outdoors in sunlight.
 - c. Use a soft toothbrush when brushing teeth.
 - d. Take the medication with an antacid.