Medical-Surgical Nursing (Ignatavicius) 7th Edition test bank

Chapter 1: Introduction to Medical-Surgical Nursing

MULTIPLE CHOICE

Which action demonstrates that the nurse understands the purpose of the Rapid Response Team?

a. Monitoring the client for changes in postoperative status such as wound infection

b. Documenting all changes observed in the client and maintaining a postoperative flow sheet

c. Notifying the physician of the client's change in blood pressure from 140 to 88 mm Hg systolic

d. Notifying the physician of the client's increase in restlessness after medication change

The Joint Commission focuses on safety in health care. Which action by the nurse reflects The Joint Commission's main objective?

a. Performing range-of-motion exercises on the client three times each day

b. Ensuring that the client is eating 100% of the meals served to him or her

c. Assessing the client's respirations when administering opioids

d. Delegating to the nursing assistant to give the client a complete bath daily

b. "If you cook the fruit first, that lowers the potassium."
c. "Berries, cherries, apples, and peaches are low in potassium."
d. "Fresh fruit is higher in potassium than dried fruit."

A client is being discharged and needs to self-monitor for the development of hyperkalemia. Which intervention is most important for the nurse to teach the client?

a. Weighing self daily at the same time of day
b. Assessing radial pulse for a full minute twice a day
c. Ensuring an oral intake of a least 3 L of fluids per day
d. Restricting sodium as well as potassium intake

A client is admitted with hyponatremia. Four hours after the initial assessment, the nurse notes that the client has new hyperactive bowel sounds in all four quadrants. What analysis about the client's condition is correct?

a. The hyponatremia is worse.
b. The hyponatremia is the same.
c. The hyponatremia is better.
d. The client now has hypernatremia.

One hour after admission to the postanesthesia care unit (PACU), the postoperative client has become very restless. What is the nurse's first action?

a. Assess for bladder distention.
b. Assess the oxygen saturation level.
c. Call the surgeon to assess the client.
d. Administer pain medication as ordered.

The nurse is caring for a client in the postanesthesia care unit (PACU) 2 hours after abdominal surgery. The nurse auscultates the client's abdomen and notes that there are no bowel sounds. What action does the nurse take?

a. Position the client on the left side with the bed flat.
b. Insert a nasogastric tube to low intermittent suction.
c. Palpate the bladder and measure abdominal girth.
d. Document the finding and continue to monitor.

The nurse is teaching a seminar about preventing the spread of HIV. Which statement by a student indicates that additional teaching is required?

a. "A woman can still get pregnant if she is HIV positive."
b. "I won't get HIV if I only have oral sex with my partner."
c. "Showering after intercourse will not prevent HIV transmission."
d. "People with HIV are still contagious even if they take HAART drugs."

The nurse is teaching a client who has AIDS how to avoid infection at home. Which statement indicates that additional teaching is needed?

a. "I will wash my hands whenever I get home from work."
b. "I will make sure to have my own tube of toothpaste at home."
c. "I will run my toothbrush through the dishwasher every evening."
d. "I will be sure to eat lots of fresh fruits and vegetables every day."

The nurse is teaching a postmenopausal client about the risk of acquiring HIV infection. The client states, "I'm an old woman! I cannot possibly get HIV." What is the nurse's best response?

a. Administer a laxative.
b. Document the finding.
c. Prepare to insert a nasogastric (NG) tube.
d. Reposition the client on the right side.

A client has experienced an electrical injury of the lower extremities. Which priority assessment data should be obtained from this client?
a. Range of motion in all extremities
b. Heart rate, rhythm, and electrocardiogram (ECG)
c. Respiratory rate and pulse oximetry
d. Orientation to time, place, and person

A client is receiving fluid resuscitation after a burn. Which finding indicates that fluid resuscitation is adequate for this client?
a. Hematocrit = 60%
b. Heart rate = 130 beats/min
c. Increased peripheral edema
d. Urine output = 50 mL/hr

The nurse is caring for a client who has had a recent myocardial infarction involving the left ventricle. Which assessment finding is expected?

a. Faint S1 and S2 sounds
b. Decreased cardiac output
c. Increased blood pressure
d. Absent peripheral pulses

The nurse is caring for a client with coronary artery disease. What assessment finding does the nurse expect if the client's mean arterial blood pressure decreases below 60 mm Hg?

a. Increased cardiac output
b. Hypertension
c. Chest pain
d. Decreased heart rate

The nurse is assessing a client following a myocardial infarction. The client is hypotensive. What additional assessment finding does the nurse expect?

a. Heart rate of 120 beats/min
b. Cool, clammy skin
c. Oxygen saturation of 90%
d. Respiratory rate of 8 breaths/min

The nurse is teaching a client who is receiving sodium warfarin (Coumadin). Which topics does the nurse include in the teaching plan? (Select all that apply.)
Foods high in vitamin K
Using acetaminophen (Tylenol) for minor pain
Daily exercise and weight management
Use of a safety razor and soft toothbrush
Blood testing regimen

Chapter 42: Care of Patients with Hematologic Problems

Test Bank

MULTIPLE CHOICE

The registered nurse is assigning a practical nurse to care for a client who has leukemia. Which instruction does the registered nurse provide to the practical nurse when delegating this client's care?
a. Evaluate the amount of protein the client eats.
b. Assess the client's roommate for symptoms of infection.
c. Perform effective hand hygiene frequently.
d. Wear a mask when entering the room.

hearing will be affected permanently. Which is the nurse's best response?

a. "Possibly. The eardrum usually heals in 1 to 2 weeks. Any persistent hearing problem should be evaluated."

b. "No. Antibiotics will help resolve the infection and cure your hearing impairment."

c. "Yes. It will be important for you to be fitted with a hearing aid as soon as possible."

d. "Yes. Any time the eardrum is ruptured it will form a scar, which will cause some degree of permanent hearing loss."

The nurse is caring for a client with Ménière's disease. The client asks the nurse how to prevent another acute episode from occurring. Which is the nurse's best response?

a. "Stop or reduce cigarette smoking."

b. "Use aspirin rather than acetaminophen (Tylenol) for pain."

c. "Reduce the quantity of saturated fats in your diet."

d. "Avoid crowds and people with upper respiratory infection."

When performing a client's physical assessment, the nurse notes that the client has conductive hearing loss. Which finding does the nurse expect to see in the client's medical history?

a. History of diabetes with peripheral neuropathy

b. Frequent episodes of otitis media during childhood

c. History of frequent impactions of cerumen in the ear canals

A client is undergoing diagnostic testing for gastroesophageal reflux disease (GERD). Which test does the nurse tell the client is best for diagnosing this condition?

a. Endoscopy
b. Schilling test
c. 24-Hour ambulatory pH monitoring
d. Stool testing for occult blood

A client has Barrett's esophagus. Which client assessment by the nurse requires consultation with the health care provider?

a. Sleeping with the head of the bed elevated
b. Coughing when eating or drinking
c. Wanting to eat several small meals during the day
d. Chewing antacid tablets frequently during the day

The nurse is teaching a client about self-management of gastroesophageal reflux. Which statement by the nurse is most appropriate?

a. "Eat four to six small meals each day."
b. "Eat a small evening snack 1 to 2 hours before bed."
c. "No specific foods or spices need to be cut from your diet."
d. "You may include orange or tomato juice with your breakfast."

A client has irritable bowel syndrome. Which menu selections by this client indicate good understanding of dietary teaching?

a. Tuna salad on white bread, cup of applesauce, glass of diet cola

b. Broiled chicken with brown rice, steamed green beans, glass of apple juice

c. Grilled cheese sandwich, small ripe banana, cup of hot tea with lemon

d. Grilled steak, green beans, dinner roll with butter, cup of coffee with cream

The nurse is performing a physical examination on a client. Which assessment finding leads the nurse to check the client's abdomen for the presence of an acquired umbilical hernia?

a. Body mass index (BMI) of 41.9

b. Cholecystectomy last year

c. History of irritable bowel syndrome

d. Daily dose of lansoprazole (Prevacid) 30 mg orally

The nurse notes a bulge in a client's groin that is present when the client stands and disappears when the client lies down. Which conclusion does the nurse draw from these assessment findings?

a. Reducible inguinal hernia

b. Indirect umbilical hernia

c. Strangulated ventral hernia

c. "I will take a senna laxative at bedtime to avoid becoming constipated."
d. "I will use my legs rather than my back muscles when I lift heavy objects."

The nurse has taught self-care measures to a client with an anal fissure. Which action by the client requires the nurse to do additional teaching?

a. Taking warm sitz baths several times daily
b. Administering daily enemas to prevent constipation
c. Using bulk-producing agents to aid elimination
d. Self-administering anti-inflammatory suppositories

A client is brought to the emergency department with an abrupt onset of vomiting, abdominal cramping, and diarrhea 2 hours after eating food at a picnic. Which infectious microorganism does the nurse suspect as the probable cause?

a. Salmonella
b. Giardia lamblia
c. Staphylococcus aureus
d. Clostridium botulinum

The nurse recognizes which client as being at greatest risk for the development of carcinoma of the liver?

a. Middle-aged client with a history of diabetes mellitus
b. Young adult client with a history of blunt liver trauma
c. Older adult client with a history of cirrhosis
d. Older adult client with malnutrition

A client who underwent liver transplantation 2 weeks ago reports a temperature of 101° F (38.3° C) and right flank pain. Which is the nurse's best response?

a. "The anti-rejection drugs you are taking made you susceptible to infection."
b. "You should go to the hospital immediately to have your new liver checked out."
c. "You should take an additional dose of cyclosporine today."
d. "Take acetaminophen (Tylenol) every 4 hours until you feel better."

A client who had a liver transplant a month ago is admitted with fever and tachycardia. Which medication does the nurse prepare to administer to this client?

a. Ceftriaxone (Rocephin)

deficiency. Which foods does the nurse encourage the client to include in the diet?

a. Fortified cereals and tofu
b. Pumpkin seeds and blackstrap molasses
c. Kale, spinach, and whole grain bread
d. Strawberries and sweet red peppers

The nurse is caring for a client who has a new small-bore nasoduodenal tube for feedings. Which intervention most effectively prevents clogging of the tube?

a. Administering medications that have been thoroughly crushed and dissolved in cold water
b. Flushing the feeding tube with 60 mL of cranberry juice or carbonated beverage four times daily
c. Irrigating the tube with water before and after administration of medications using 20 to 30 mL
d. Diluting the tube feeding to half-strength with cold water before infusion into the feeding tube

The nurse is reviewing recent laboratory values for a client who is being treated for malnutrition. Which laboratory finding indicates that the client is not receiving adequate iron supplementation?

a. Hematocrit, 31%
b. Serum albumin, 3.5 g/dL

A client has received vasopressin (DDAVP) for diabetes insipidus. Which assessment finding indicates a therapeutic response to this therapy?

a. Urine output is increased; specific gravity is increased.
b. Urine output is increased; specific gravity is decreased.
c. Urine output is decreased; specific gravity is increased.
d. Urine output is decreased; specific gravity is decreased.

A client with hypercortisolism has an irregular pulse. Which is the nurse's priority intervention?

a. Documenting the finding and reassessing in 1 hour
b. Assessing blood pressure in both arms
c. Administering atropine sulfate
d. Assessing the telemetry reading

The client with adrenal hyperfunction screams at her husband, bursts into tears, and throws her water pitcher against the wall. She then tells the nurse, "I feel like I am going crazy." Which is the nurse's best response?

a. "I will ask your doctor to order a psychiatric consult for you."
b. "You feel this way because of your hormone levels."
c. "Can I bring you information about support groups?"
d. "I will close the door to your room and restrict visitors."

a. Young, muscular white man
b. Young African-American man
c. Middle-aged Asian woman
d. Middle-aged American Indian woman

The nurse is teaching a client about self-monitoring of blood glucose levels. To prevent bloodborne infection, which statement by the nurse is best?

a. "Wash your hands after completing the test."
b. "Do not share your monitoring equipment."
c. "Blot excess blood from the strip."
d. "Use gloves during monitoring."

A client with diabetes has frequent blood glucose readings higher than 300 mg/dL. Which action does the nurse teach the client about self-care?

a. Check urine ketones when blood glucose readings are high.
b. Increase the insulin dose after two high glucose readings in a row.
c. Change the diet to include a 10% increase in protein.
d. Work out on the treadmill whenever glucose readings are high.

Which statement by a client with type 2 diabetes indicates a need for further teaching about diabetic management and follow-up care?

a. "I need to have an annual appointment, even if my glucose levels are in good control."

b. "Because my diabetes is controlled with diet and exercise, I have to be seen only if I am sick."

c. "I can still develop complications, even though I do not have to take insulin at this time."

d. "If I have surgery or get very ill, I may have to receive insulin injections for a short time."

A client recently diagnosed with type 1 diabetes tells the nurse, "I will never be able to stick myself with a needle." Which is the nurse's best response?

a. "Try not to worry about it. We will give you your injections here in the hospital."

b. "Everyone gets used to giving themselves injections. It really does not hurt."

c. "I am not sure how your disease can be managed if you refuse to give yourself the shots."

d. "Tell me what it is about the injections that is concerning you."

by the client indicates a good understanding of this therapy?

a. "I should finish this antibiotic even if I am feeling better."
b. "I need to drink a full glass of water when I take this drug."
c. "My blood will be drawn occasionally for kidney function tests."
d. "This medication may turn my urine bright orange and stain my clothes."

Which type of incontinence is most common after a difficult vaginal delivery?

a. Stress
b. Urge
c. Reflex
d. Overflow

A client has functional urinary incontinence. Which instruction by the nurse to the client and family helps meet an expected outcome for this condition?

a. "You must clean around your catheter daily with soap and water."
b. "Wash the vaginal weights with a 10% bleach solution after each use."
c. "Operations to repair your bladder are available, and you can consider these."
d. "Buy slacks with elastic waistbands that are easy to pull down."

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A client with chronic kidney disease is scheduled to be given the following medications: digoxin (Lanoxin) and epoetin alfa (Epogen). The client reports nausea and vomiting and wishes to wait to take the medications. Which action by the nurse is most appropriate?

a. Administer both medications with soda crackers.
b. Allow the client to wait an hour before taking the medications.
c. Review today's potassium level and notify the health care provider.
d. Call the health care provider to get an order for anti-nausea medication.

A client is receiving continuous arteriovenous hemofiltration (CAVH). Which laboratory value does the nurse monitor most closely?

a. Hemoglobin
b. Glomerular filtration rate
c. Sodium
d. White blood cells

A client who is 2 days post–femoral vein cannulation begins to have

A client is being treated with anastrozole (Arimidex) for breast cancer. The nurse is developing a plan of care for the client. Which intervention is the highest priority?

a. Teach the client to weigh herself each day at the same time.
b. Instruct the client to keep a symptom journal for menopausal symptoms.
c. Monitor the client closely for evidence of osteoporosis.
d. Review the client's dietary habits to prevent weight gain.

A client with a history of breast cancer is admitted through the emergency department with shortness of breath, weakness, fatigue, and new lower extremity edema. The client's oxygen saturation is 88%. After stabilizing the client, which action by the nurse is most important?

a. Obtain a list of the client's medications.
b. Orient her to her room and surroundings.
c. Place the client on intake and output.
d. Assess the client's family cardiac history.

The clinic nurse is preparing a client for a physical and breast examination. The nurse notes the client's breast appears as shown in the

A client with prostate cancer reports pain in his lower back and legs. Which action by the nurse is most appropriate?

a. Discuss medications for arthritis.
b. Perform a bladder scan.
c. Facilitate imaging studies.
d. Encourage weight-bearing exercises.

A client diagnosed with early prostate cancer is confused that surgery has not been planned. Which is the nurse's best response?

a. "The disease is slow-growing. The risks of surgery at your age are not justified by the outcome."
b. "Your disease is so advanced that surgery at this point would not increase your chances of cure."
c. "Your disease is in a very early stage and is slow-growing. Your doctor will monitor you."
d. "This stage indicates that you do not really have cancer, so surgery is not necessary."

The nurse manages a clinic in an area with a high rate of sexually transmitted diseases (STDs). Which strategy best helps decrease the rate of infection?
Start an expedited partner treatment program.
Use a single-dose drug given in the clinic.
Provide referrals to a low-cost pharmacy.
Plan occasional community educational programs.

The nurse assesses a client and finds the manifestation shown in the photograph. Which drug does the nurse prepare to administer to the client?

Doxycycline (Vibramycin)
Ceftriaxone (Rocephin)
Acyclovir (Zovirax)
Podophyllin (Pododerm)