Foundations and Adult Health Nursing 8th Edition Test Bank Kim Cooper Kelly Gosnell

Unit I: Fundamentals of Nursing

Chapter 1: The Evolution of Nursing

Foundations and Adult Health Nursing 8th Edition Kim Cooper Kelly Gosnell

MULTIPLE CHOICE

1. What is a nursing program considered when certified by a state agency?

a.	Accredited
b.	Approved
c.	Provisional
d.	Exemplified

ANS: B

Approved means certified by a state agency for having met minimum standards; *accredited* means certified by the NLN for having met morecomplex standards. Provisional and exemplified are not terms used in regard to nursing program certification.

DIF: Cognitive Level: Knowledge REF: Page 13 OBJ: 5
TOP: Nursing programs KEY : Nursing Process Step: N/A
MSC: NCLEX: N/A

2. Which of the following must the nurse recognize regarding the healthcare delivery system?

a.	It includes all states.
b.	It affects the illness of patients.
c.	Insurance companies are not involved.
d.	The major goal is to achieve optimal levels of health care.

ANS: D

The ability to listen and assist those who are newly grieving through the use of silence and a quiet presence is very effective. Stating "You need to be strong for your children" is a cliché. Asking if there is anyone the widow needs to have notified and stating "You are feeling overwhelmed about your husband's death" are not therapeutic in this immediate grieving time.

DIF: Cognitive Level: Application REF: 73 OBJ: 5
TOP: Communication KEY: Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

11. A nurse is assessing a patient with a patient problem of impaired verbal communication. What is the lowest number of defining characteristics for this diagnosis?
    a. One
    b. Two
    c. Three
    d. Four

    ANS: A
    If one or more of the defining characteristics is present, a patient problem of impaired verbal communication can be determined.

    DIF: Cognitive Level: Comprehension REF: 74 OBJ: 9
    TOP: Communication KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Psychosocial Integrity

12. What communication technique should the nurse use when communicating with an unresponsive patient?
    a. Avoid speaking directly to the patient.
    b. Assume verbal stimuli are heard.
    c. Speak in a loud voice.
    d. Use simple words.

    ANS: B
    A person interacting with an unresponsive patient should assume all sounds and verbal stimuli have the potential of being heard by the patient.

    DIF: Cognitive Level: Application REF: 76 OBJ: 10
    TOP: Communication KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Psychosocial Integrity

13. If in response to the patient statement, "I am upset about all this lab work" the nurse responds, "You're upset?" What is this is an example of?
    a. An open-ended question
    b. Reflecting
    c. Restating
    d. Paraphrasing

    ANS: C
    Restating is one of the most effective methods of therapeutic communication to encourage the patient to offer more information.

c. Prodromal
d. Incubation

ANS: C
The prodromal stage progresses from onset of nonspecific signs and symptoms to more specific signs and symptoms.

DIF: Cognitive Level: Knowledge REF: 125 OBJ: 4 | 6
TOP: Infection KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

27. What is the most dependable and practical method to use when sterilizing instruments for the operating room?
a. Chemical solution
b. Boiling water
c. Steam under pressure
d. Dry heat

ANS: C
Steam under pressure is the most practical and dependable method for destruction of all microorganisms.

DIF: Cognitive Level: Comprehension REF: 153 OBJ: 12
TOP: Sterilization KEY: Nursing Process Step: N/A MSC: NCLEX: N/A

28. What contribution did Joseph Lister introduce to medical practice?
a. Isolation of infected patients
b. Iodine and alcohol use as disinfectants
c. The autoclave
d. Aseptic technique

ANS: D
Joseph Lister contributed to medical practice through the introduction of the aseptic technique.

DIF: Cognitive Level: Knowledge REF: 117 OBJ: 1
TOP: Joseph Lister KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

29. The nurse is providing instruction to an anxious mother of a child with Rocky Mountain spotted fever. When discussing this diagnosis, what information will the nurse relay about this disease?
a. It is extremely contagious among humans.
b. It is contracted from handling unvaccinated animals.
c. It is a hemolytic B *Streptococcus* infection spread by droplet transmission.
d. It is a serious disease contracted from the bite of a tick.

ANS: D
Rocky Mountain spotted fever is contracted through the bite of a tick vector. It is not contagious among humans.

DIF: Cognitive Level: Comprehension REF: 120 OBJ: 2 | 3

21. A nurse assesses a patient's dorsalis pedis pulse. The pulse is easily felt but not palpable when moderate pressure is applied. How should the nurse document this finding?

a.	Weak pulse
b.	Normal pulse
c.	Thready pulse
d.	Bounding pulse

ANS: B

A normal pulse is easily felt but not palpable when moderate pressure is applied. A thready pulse is difficult to feel and is not palpable when only slight pressure is applied. A weak pulse is somewhat stronger than a thready pulse but not palpable when light pressure is applied. A bounding pulse feels full and springlike even under moderate pressure.

22. A nurse assesses a patient's dorsalis pedis pulse. The pulse feels full and springlike even under moderate pressure. How should the nurse document this finding?

a.	Weak pulse
b.	Normal pulse
c.	Thready pulse
d.	Bounding pulse

ANS: D

A bounding pulse feels full and springlike even under moderate pressure. A thready pulse is difficult to feel and is not palpable when only slight pressure is applied. A weak pulse is somewhat stronger than a thready pulse but not palpable when light pressure is applied. A normal pulse is easily felt but not palpable when moderate pressure is applied.

2. If a spinal injury is suspected, before the rescuer starts CPR, the trachea should be opened with a jaw_____maneuver.

   ANS:
   thrust

   The jaw-thrust maneuver does not hyperextend the neck.

   DIF: Cognitive Level: Application REF: 397 OBJ: 14
   TOP: Cardiopulmonary resuscitation (CPR)
   KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

3. When two nurses perform two-person CPR, there should be two slow breaths for every 30 _____.

   ANS:
   compressions

   Two slow breaths are given after every 30 compressions.

   DIF: Cognitive Level: Application REF: 398 OBJ: 4
   TOP: Two-person CPR KEY: Nursing Process Step: Implementation
   MSC: NCLEX: Physiological Integrity

4. The acronym RICE directs the nurse in the care of a sprain. The "C" in the acronym stands for_____.

   ANS:
   compression

   The acronym stands for Rest, Ice, Compression, and Elevation.

   DIF: Cognitive Level: Knowledge REF: 415-416 OBJ: 13
   TOP: Sprain KEY: Nursing Process Step: Application
   MSC: NCLEX: Physiological Integrity

5. When performing_____on an infant, the breastbone is depressed approximately one-third of the chest diameter or $1\frac{1}{2}$ in.

   ANS:
   CPR

   The breastbone is depressed one-third the chest diameter or $1\frac{1}{2}$ in when doing CPR on an infant.

   DIF: Cognitive Level: Application REF: 399 OBJ: 4
   TOP: Cardiopulmonary resuscitation (CPR)
   KEY: Nursing Process Step: Implementation

5. Saw palmetto

6. Chaparral

1. ANS DIF:Apply (application)REF:697

OBJ: Describe safe and unsafe herbal therapies. TOP: Teaching/Learning
MSC:Health Promotion and Maintenance
2. ANS:ADIF:Apply (application)REF:697

OBJ: Describe safe and unsafe herbal therapies. TOP: Teaching/Learning
MSC:Health Promotion and Maintenance
3. ANS:EDIF:Apply (application)REF:697

OBJ: Describe safe and unsafe herbal therapies. TOP: Teaching/Learning
MSC:Health Promotion and Maintenance
4. ANS:BDIF:Apply (application)REF:697

OBJ: Describe safe and unsafe herbal therapies. TOP: Teaching/Learning
MSC:Health Promotion and Maintenance
5. ANS:CDIF:Apply (application)REF:697

OBJ: Describe safe and unsafe herbal therapies. TOP: Teaching/Learning
MSC:Health Promotion and Maintenance
6. ANS:FDIF:Apply (application)REF:697

OBJ: Describe safe and unsafe herbal therapies. TOP: Teaching/Learning
MSC:Health Promotion and Maintenance

a. Activity theory
b. Autoimmunity theory
c. Wear-and-tear theory
d. Disengagement theory

ANS: A
According to the activity theory, the older person who is more active socially is more likely to adjust well to aging.

DIF: Cognitive Level: Knowledge REF: 726 OBJ: 14
TOP: Theories of aging KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

48. Which theory of aging suggests that previously developed coping abilities and the ability to maintain previous roles and activities are critical to adjustment to old age?
a. Continuity theory
b. Autoimmunity theory
c. Wear-and-tear theory
d. Disengagement theory

ANS: A
Supporters of the continuity theory suggest that the critical factors in adjustment to old age are previously developed coping abilities and the ability to maintain previous roles and activities.

DIF: Cognitive Level: Knowledge REF: 726-727 OBJ: 14
TOP: Theories of aging KEY: Nursing Process Step: N/A
MSC: NCLEX: N/A

49.49. Which of the following measures would be included in a teaching plan to instruct new parents on reducing the incidence of sudden infant death syndrome?
a. Bottle-feed an infant at night.
b. Place infants on their stomach to sleep.
c. Keep an infant's room well ventilated.
d. Place soft bedding and pillows in an infant's crib.

ANS: C
Steps to reduce the incidence of sudden infant death syndrome include placing infants on their back to sleep, avoiding exposure to cigarette smoke, avoiding using soft bedding or pillows, keeping rooms well ventilated, breastfeeding if possible, and maintaining regular medical checkups for infants.

DIF: Cognitive Level: Application REF: 707 OBJ: 4
TOP: Safety KEY: Nursing Process Step: Implementation
MSC: NCLEX: N/A

50. A nurse instructing a group of parents about safety rules for infants and young children should include which of the following measures in the teaching plan?
a. Remove plants from the child's reach.
b. Provide the infant with a pillow at night.
c. Use a plastic covering on the infant's mattress.
d. Keep the crib sides up and set the mattress at the highest setting.

DIF: Cognitive Level: Comprehension REF: 898 OBJ: 5
TOP: Diabetes KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

18. Why is the fetus dependent on the mother for glucose control?
    a. The insulin requirements are higher.
    b. Insulin is destroyed by the placenta.
    c. Insulin does not cross the placenta.
    d. Insulin is absorbed by the fetus.

    ANS: C
    Insulin will not cross the placenta, but high glucose levels do. Therefore, it is imperative that the mother control glucose levels.

    DIF: Cognitive Level: Analysis REF: 901 OBJ: 5
    TOP: Diabetes KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Physiological Integrity

19. A patient with a history of rheumatic heart disease is being admitted to the labor and delivery unit. To prevent further stress on the heart, what should the nurse anticipate to be ordered?
    a. Oxygen administration
    b. Administering large amount of IV fluids
    c. Positioning the patient on her back
    d. Encouraging activity between contractions

    ANS: A
    Oxygen is administered to increase blood oxygen saturation and decrease the stress on the heart. IV fluid administration is kept to a minimum to prevent fluid overload. The patient would be positioned in a semi-Fowler's position to improve circulation. The patient should be encouraged to rest between contractions to conserve energy.

    DIF: Cognitive Level: Application REF: 901 OBJ: 12
    TOP: Cardiovascular defects KEY: Nursing Process Step: Planning
    MSC: NCLEX: Health Promotion and Maintenance

20. A 14-year-old pregnant adolescent arrives at the hospital in early labor. The nurse should recognize that the adolescent is at a greater risk for which problem?
    a. Calcium deficit
    b. Cephalopelvic disproportion
    c. Bleeding tendency
    d. Low hemoglobin levels

    ANS: B
    There are several physiologic concerns for pregnant adolescents, including cephalopelvic disproportion.

    DIF: Cognitive Level: Analysis REF: 903 OBJ: 7
    TOP: Adolescent pregnancy KEY: Nursing Process Step:

ANS: B
Nystatin should be given for the full 7 days even if the lesions are no longer present.

DIF: Cognitive Level: Analysis REF: 1042 OBJ: 15
TOP: Skin disorders KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

43. What are early signs of varicella disease?
a. High fever over 101°F (38.3°C)
b. General malaise
c. Increased appetite
d. Crusty sores

ANS: B
Early signs of varicella will develop during the prodromal period and are mainly low-grade fever, malaise, and anorexia. Lesions do not appear until later.

DIF: Cognitive Level: Comprehension REF: 1044 OBJ: 15
TOP: Skin disorders KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

44. The mother of a child who has been diagnosed with varicella asks the nurse when the child can return to school. When is the child no longer contagious?
a. When the fever dissipates
b. After the incubation period
c. When the lesions have healed
d. When the lesions are crusted over

ANS: D
Varicella is no longer contagious when the lesions are dry.

DIF: Cognitive Level: Application REF: 1036 OBJ: 15
TOP: Skin disorders KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

45. A child has developed a diaper rash, and the parents are using zinc oxide to treat it. What does the nurse suggest to aid in the removal of the zinc oxide?
a. Mild soap and water
b. A cotton ball
c. Mineral oil
d. Alcohol swabs

ANS: C
To completely remove ointment, especially zinc oxide, mineral oil should be used.

DIF: Cognitive Level: Application REF: 1042 OBJ: 15
TOP: Diaper rash KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

46. The nurse instructs the parents of a child who has had a myringotomy to place the child in which position?
a. Supine

DIF: Cognitive Level: Application REF: Page 1167 OBJ: 6
TOP: Addiction KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

21. The nurse concludes that a significant goal of the care plan for an alcoholic patient has been met when the patient makes which statement?
    a. "I drink because I'm lonely."
    b. "All my difficulties are related to my drinking."
    c. "I wouldn't need to drink if I had my family back."
    d. "My drinking helps me cope with the stress of my job."

    ANS: B
    A major goal for the successful treatment of alcoholics is to have them express responsibility for their behavior.

    DIF: Cognitive Level: Application REF: Page 1164, NCP
    OBJ: 5 TOP: Addiction KEY: Nursing Process Step: Evaluation
    MSC: NCLEX: Psychosocial Integrity

22. While creating a methadone protocol for a patient rehabilitating from heroin addiction, the nurse explains that the patient will take methadone for what length of time?
    a. Daily for the rest of his life
    b. Daily until stabilized, then gradually reduce the dose to zero
    c. Weekly for at least 6 months, then decrease the dose to once a month
    d. Monthly for 6 to 10 months, then decrease the dose to zero

    ANS: B
    Methadone is given daily until the patient is stabilized. The methadone is reduced gradually until the patient does not need to take any.

    DIF: Cognitive Level: Application REF: Page 1167 OBJ: 5
    TOP: Addiction KEY: Nursing Process Step: Implementation
    MSC: NCLEX: Psychosocial Integrity

23. A 22-year-old patient presents in the emergency department with the characteristics of severe Parkinson disease. The nurse should suspect an overdose of what drug?
    a. Marijuana
    b. Cocaine
    c. Amphetamines
    d. Valium

    ANS: C
    Over time, dopamine depletion in the brain can cause Parkinson-like symptoms to occur in people who abuse amphetamines.

    DIF: Cognitive Level: Comprehension REF: Page 1168 OBJ: 6
    TOP: Addiction KEY: Nursing Process Step: Assessment
    MSC: NCLEX: Physiological Integrity

MSC: NCLEX: Health Promotion and Maintenance

33. The nurse is caring for a victim of post-traumatic stress syndrome. The nurse identifies which techniques asexamples of therapeutic communication? (Select all that apply.)

a. Listening

b. Reframing

c. Characterizing

d. Normalizing responses

e. Working to develop trust

ANS: A, B, D, E

The techniques of therapeutic communication that are important to use with the PTSD patient are listening, re-framing, normalizing responses, and working to develop trust.

PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 1201 OBJ: 9 TOP:

PTSD KEY: Nursing Process Step: ImplementationMSC: NCLEX: Health Promotion and Maintenance **COMPLETION**

34. The rehabilitation nurse assesses localized edema around the knee of a patient with paraplegia. The nursesuspects that this is the first sign of_____.

ANS:

heterotopic ossification

Heterotopic ossification is a bony growth in joints of spinal cord injury patients below the injury that ultimatelylimits range of motion.

PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 1204

ANS: D

The nurse can delegate to the NAP to encourage patients to practice postoperative exercises regularly after instruction and to inform the nurse if the patient is unwilling to perform these exercises. The skills of demonstrating and teaching postoperative exercises and documenting are not within the scope of practice forthe nursing assistant. Doing nothing is not appropriate.

DIF:Apply (application)REF:1297

OBJ: Demonstrate postoperative exercises. TOP: Implementation
MSC:Management of Care

19. The nurse is providing preoperative teaching for the ambulatory surgery patient who will be having a cystremoved from the right arm. Which will be the **best** explanation for diet progression after surgery?

a. "Start with clear liquids, soup, and crackers. Advance to a normal diet as tolerated."

b. "Stay with ice chips for several hours. After that, you can have whatever you want."

c. "Stay on clear liquids for 24 hours. Then you can progress to a normal diet."

d. "Start with clear liquids for 2 hours and then full liquids for 2 hours. Then progress to a normal diet."

ANS: A

Patients usually receive a normal diet the first evening after surgery unless they have undergone surgery on GI structures. Implement diet intake while judging the patient's response. For example, provide clear liquids such as water, apple juice, broth, or tea after nausea subsides. If the patient tolerates liquids without nausea, advance the diet as ordered. There is no need to stay on ice chips for several hours or clear liquids for 24 hoursafter this procedure. Putting a time frame on the progression is too prescriptive. Progression should be adjusted for the patient's needs.

DIF:Apply (application)REF:1295

OBJ:Explain the elements of a typical preoperative teaching
plan.TOP: Implementation MSC: Basic Care and Comfort

20. The nurse explains the pain relief measures available after surgery during preoperative teaching for a surgical patient. Which comment from the patient indicates the need for additional education on this topic?

KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

33. The patient, age 58, is diagnosed with osteoporosis after densitometry testing. She has been menopausalfor 5 years and has been concerned about her risk for osteoporosis because her mother has osteoporosis. Inteaching her about her osteoporosis, which information does the nurse include?

a. Even with a family history of osteoporosis, the calcium loss from bones can be slowed by increased calcium intakeand exercise.

b. Estrogen replacement therapy must be started to prevent rapid progression of her osteoporosis.

c. With a family history of osteoporosis, there is no way to prevent or slow bone reabsorption.

d. Continuous, low-dose corticosteroid treatment is effective in stopping the course of osteoporosis.

ANS: A

To prevent osteoporosis, women are advised to have an adequate daily intake of calcium and vitamin D; exer-cise regularly; avoid smoking; decrease coffee intake; decrease excess protein in the diet; and engage in regu-lar moderate activity such as walking, bike riding, or swimming at least 3 days a week. A contributing factor may be use of steroids.

PTS: 1 DIF: Cognitive Level: Analysis REF: Page 1355
OBJ:11TOP:Osteoporosis
KEY:Nursing Process Step: ImplementationMSC:
NCLEX: Physiological Integrity

34. Certain foods may increase the pain associated with gout. Which foods have the highest concentration ofpurines?

a. Brain, liver, kidney

b. Lettuce, corn, potatoes

c. Beef, pork, chicken

d. Fruits and fruit juices

Jaundice is the discoloration of body tissues caused by abnormally high blood levels of bilirubin.

PTS: 1 DIF: Cognitive Level: Knowledge REF: Page 1466
OBJ: 4 TOP: Jaundice KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

45. The disease that is on the increase because of the growing obesity population and is associated with coronary artery disease and use of corticosteroids is_____.

ANS:
nonalcoholic fatty liver disease (NAFLD)
nonalcoholic fatty liver disease
NAFLD

NAFLD is a disease that is on the rise due to the increasing population of obese persons. The disease is also associated with CAD and the use of corticosteroids.

PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 1465
OBJ: 2 TOP: NAFLD KEY: Nursing Process Step: N/A
MSC: NCLEX: Physiological Integrity

46. The tumor marker that is elevated in patients with pancreatic cancer is_____.

ANS:
CA19-9

The tumor marker CA19-9 is elevated in the presence of pancreatic cancer.

PTS: 1 DIF: Cognitive Level: Knowledge REF: Page 1484
OBJ: 1 TOP: CA19-9 KEY: Nursing Process Step: N/A
MSC: NCLEX: Physiological Integrity

47. Hepatitis D is usually seen as a co-infection with_____.

ANS:
hepatitis B
Hepatitis D is usually seen as a coinfection with hepatitis B.
PTS: 1 DIF: Cognitive Level: Knowledge
REF: Page 1473, Box 54-1 OBJ: 6 TOP: Hepatitis
KEY: Nursing Process Step: N/A MSC: NCLEX: Physiological Integrity

48. A_____occurs when the body encapsulates the autodigestive debris in the pancreatic tissue, frequently becoming an abscess.

ANS:
pseudocyst

c. Thallium scan

d. PET

ANS: A

Because of the large magnets in the MRI cabinet, the pacemaker may be reset to a fixed mode and interferewith the functioning of the pacemaker.

PTS: 1 DIF: Cognitive Level: Application REF: Page 1551
OBJ: 10 TOP: Pacemaker KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

32. Which assessment would lead the nurse to examine the leg closely for evidence of a stasis ulcer?

a. Cool dry lower limb

b. Edematous, red scaly skin on medial surface of the leg

c. Lack of hair and shiny appearance of the lower leg

d. Lack of a pedal pulse

ANS: B

Suggestion of a stasis ulcer in the making is an edematous, dry scaly area on the medial surface of the lower leg that has a darker pigmentation (rubor). Cool hairless limbs with absent or weak pedal pulses are indicativeof arterial insufficiency.

PTS: 1 DIF: Cognitive Level: Application REF: Page 1582

OBJ: 21 TOP: Medications KEY: Nursing Process Step: Assessment
MSC: NCLEX: Physiological Integrity

33. What is the patient goal of the walking exercise program designed for the rehabilitation of a post-MIpatient?

b. Increase intake of dairy products

c. Restrict his protein intake

d. Take one baby aspirin daily

ANS: A

Fluid intake should be encouraged to at least 2000 mL of fluid in 24 hours, unless contraindicated.PTS: 1 DIF: Cognitive Level: Application REF: Page 1682

OBJ: 8 TOP: Urolithiasis KEY: Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

12. The nurse notes the amount and color of the urine the patient with urolithiasis has voided. While usingStandard Precautions, what should be the nurse's next action?

a. Discard the urine

b. Add the urine to a 24-hour collector

c. Send the urine to the laboratory

d. Strain the urine

ANS: D

All urine should be strained. Because stones may be any size, even the smallest speck must be saved for as-sessment by the laboratory.

PTS: 1 DIF: Cognitive Level: Application REF: Page 1697
OBJ: 8 TOP: Urolithiasis KEY: Nursing Process Step: Planning
MSC: NCLEX: Physiological Integrity

13. The nurse assessing a patient who is taking furosemide (Lasix) finds an irregular pulse. This is likely a signof:

REF: Page 1822, Nursing Care Plan OBJ: 12 TOP: Ovarian cancer
KEY:Nursing Process Step: Implementation
MSC: NCLEX: Psychosocial Integrity

4.A patient, age 41, has had a total abdominal hysterectomy and bilateral salpingo-oophorectomy for en- dometriosis. She asks the nurse if she will have "hot flashes." What knowledge will guide the nurse's response?

a. Only the uterus was removed, and the ovaries are still producing estrogen and she will not have hot flashes.

b. The patient is too young to have hot flashes associated with menopause.

c. The uterus, ovaries, and fallopian tubes were removed, and she will have surgically induced menopause and mayhave hot flashes.

d. The uterus and fallopian tubes were removed, and she will not experience "hot flashes."

ANS: C

A total abdominal hysterectomy with bilateral salpingo-oophorectomy is the removal of the uterus, fallopian tubes, and ovaries. If the ovaries are removed in these surgeries, the surgery will induce menopause and hotflashes may occur.

PTS: 1 DIF: Cognitive Level: Analysis REF: Page 1813
OBJ:14TOP:Hysterectomy
KEY:Nursing Process Step: Implementation
MSC: NCLEX: Physiological Integrity

5. On the fourth postoperative day after a modified radical mastectomy, the nurse finds the patient with her back to the nurse. She is crying and tells the nurse she feels ugly and is worried that her husband will not be inlove with her anymore. The nurse bases subsequent nursing interventions on what diagnosis?

a. Disturbed body image related to removal of her breast

b. Deficient knowledge related to inadequate education

PTS: 1 DIF: Cognitive Level: Analysis REF: Page 1950, Table 53-8
OBJ:30TOP:Spinal cord injury
KEY: Nursing Process Step: Assessment MSC: NCLEX: Physiological Integrity

19.A frantic family member is distressed about the flaccid paralysis of her son following a spinal cord injuryseveral hours ago. What does the nurse know about this condition?

a. It is an ominous indicator of permanent paralysis.

b. It is possibly a temporary condition and will clear.

c. It degenerates into a spastic paralysis.

d. It will progress up the cord to cause seizures.

ANS: B

A period of flaccid paralysis following a cord injury is called areflexia, or spinal shock, and may be temporary.PTS: 1 DIF: Cognitive Level: Application REF: Page 1954

OBJ: 20 TOP: Trauma KEY: Nursing Process Step: AssessmentMSC:
NCLEX: Physiological Integrity

20.A patient with a spinal cord injury at T1 complains of stuffiness of the nose and a headache. The nurse notes a flushing of the neck and “goose flesh.” What should be the primary nursing intervention based onthese assessments?

a. Place patient in flat position and check temperature

b. Administer oxygen and check oxygen saturation

c. Place on side and check for leg swelling

d. Sit upright and check blood pressure

ANS: D

a. Reduction of red cells

b. Increase in WBCs

c. Neopterin

d. Increase in T-helper cells increase natural killer (NK) cells

ANS: C

Neopterin is produced in the presence of an inflammatory reaction and is increased in HIV disease.PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 1990, Box 55-2

OBJ: 5 TOP: Neopterin KEY: Nursing Process Step: InterventionMSC: NCLEX: Physiological Integrity

19. For most people who are HIV-positive, marker antibodies are usually present 10 to 12 weeks after exposure.What is the development of these antibodies called?

a. Immunocompetence

b. Seroconversion

c. Opportunistic infection

d. Immunodeficiency

ANS: B

Seroconversion is the development of antibodies from HIV, which takes place approximately 5 days to 3 months after exposure, generally within 1 to 3 weeks. Although the conversion has taken place, the patient isnot yet immunodeficient.

PTS: 1 DIF: Cognitive Level: Analysis REF: Page 1987
OBJ:10TOP:Progression of disease
KEY: Nursing Process Step: Assessment MSC: NCLEX: Health Promotion and Maintenance

MSC:NCLEX: Safe, Effective Care Environment

28. The experienced nurse who assists a novice to learn the skills of the profession is called a(n) _____.

ANS:
mentor

The nurse who guides a novice in the skills of the profession is called a mentor.PTS: 1 DIF: Cognitive Level: Comprehension REF: Page 2043
OBJ: 11 TOP: Mentoring KEY: Nursing Process Step: N/A
MSC:NCLEX: N/A