Option A (administering an IV fluid bolus) is an important supportive measure to maintain maternal blood pressure and uteroplacental perfusion, but it does not relieve the mechanical compression of the cord, which is the immediate threat to fetal life. Option B (calling for assistance and preparing for cesarean delivery) is a critical action, but it is not the first action. The nurse should call for help while simultaneously positioning the client and relieving cord compression. If the nurse leaves the client to call for help, the cord compression will continue and the fetus may suffer irreversible damage. The nurse should use the call light or delegate someone to call for help while remaining with the client. Option D (increasing the epidural infusion rate) is inappropriate because the client's pain is not the priority, and increasing epidural anesthesia could worsen maternal hypotension and further compromise uteroplacental perfusion.

This question tests the nurse's ability to recognize an obstetric emergency, prioritize immediate interventions to relieve cord compression, and coordinate care with the interprofessional team. The correct answer reflects the principle that in a cord prolapse, manual elevation of the presenting part and positioning are the most immediate and effective interventions to prevent fetal death or permanent neurologic injury.

Question 15

A nurse is caring for a 34-year-old client who was admitted to the psychiatric unit 3 days ago with a diagnosis of major depressive disorder and a recent suicide attempt by overdosing on acetaminophen. The client has been started on fluoxetine 20 mg PO daily and is participating in individual and group therapy. During a one-on-one session with the nurse, the client states, "I feel a little better today. I think the medication is starting to work. I'm not thinking about killing myself anymore." The nurse observes that the client's affect is brighter, and the client is making eye contact and engaging in conversation more than on previous days.

Which of the following responses by the nurse is most appropriate?

A. "That's wonderful news. I'm so glad the medication is helping you."
B. "You seem to be feeling better, but it's important to remember that the first few weeks on fluoxetine are the highest risk period for suicide."
C. "You should not rely on medication alone. Therapy is equally important for your recovery."
D. "Let's focus on the present moment and not worry about the future."

Correct Answer: B

A. Administer the phenytoin through the existing IV line with 0.9% sodium chloride.
B. Administer the phenytoin through the existing IV line with lactated Ringer's.
C. Flush the IV line with dextrose before administering phenytoin.
D. Administer the phenytoin orally instead.

Correct Answer: A

Expert Rationale:

The nurse should administer the phenytoin through the existing IV line with 0.9% sodium chloride. Phenytoin is compatible with 0.9% sodium chloride (normal saline) but is incompatible with dextrose solutions because dextrose can cause phenytoin to precipitate, forming crystals that can embolize and cause serious harm. The nurse should ensure that the IV line is flushed with 0.9% sodium chloride before and after administering phenytoin to prevent precipitation. The nurse should also administer phenytoin slowly (typically no faster than 50 mg/min in adults) to prevent hypotension and cardiac dysrhythmias. The nurse should monitor the client's vital signs and ECG during administration.

Option B (administering through lactated Ringer's) is not appropriate because phenytoin is also incompatible with lactated Ringer's. Option C (flushing with dextrose) is contraindicated because dextrose causes phenytoin precipitation. Option D (administering phenytoin orally) is not appropriate for a client who is already receiving IV phenytoin for an acute seizure condition. Oral phenytoin has a slower onset of action and is not suitable for acute seizure management.

This question tests the nurse's ability to apply knowledge of medication compatibility, prioritize safe medication administration, and prevent adverse drug events. The correct answer reflects the principle that IV phenytoin must be administered with 0.9% sodium chloride to prevent precipitation.

Question 40

A nurse is caring for a 68-year-old client who is admitted to the medical unit with a diagnosis of acute gout. The provider has ordered colchicine 0.6 mg PO every hour for 4 doses, then 0.6 mg every 12 hours. The nurse is preparing to administer the first dose. The client's most recent laboratory results are: WBC 8,000/mm^3, creatinine 1.8 mg/dL, and liver function tests within normal limits.

Which of the following actions should the nurse take first?

answer reflects the fundamental principle that airway, breathing, and circulation take precedence over all other assessments and interventions in a critically ill client.

Question 47

A nurse is caring for a 58-year-old client who is admitted to the medical unit with a diagnosis of acute myocardial infarction (MI). The client is receiving continuous cardiac monitoring. The nurse notes that the client's cardiac rhythm has changed from normal sinus rhythm to ventricular tachycardia. The client is unresponsive and has no palpable pulse.

Which of the following actions should the nurse take first?

A. Administer amiodarone 300 mg IV push.
B. Begin cardiopulmonary resuscitation (CPR).
C. Defibrillate at 200 joules.
D. Administer epinephrine 1 mg IV push.

Correct Answer: B

Expert Rationale:

The nurse should first begin cardiopulmonary resuscitation (CPR). This client is in pulseless ventricular tachycardia (VT), which is a shockable rhythm. However, the first action in any cardiac arrest is to ensure high-quality CPR. CPR provides circulation to vital organs until defibrillation can be performed. The nurse should immediately start chest compressions at a rate of 100–120 per minute and a depth of at least 2 inches, allowing for complete chest recoil. After initiating CPR, the nurse should call for help and prepare for defibrillation. Defibrillation is the definitive treatment for pulseless VT, but CPR must be started first to maintain perfusion.

Option A (administering amiodarone) is an antiarrhythmic that is used in the treatment of VT, but it is not the first action. CPR and defibrillation take precedence. Option C (defibrillating at 200 joules) is the definitive treatment for pulseless VT, but the nurse should first ensure that CPR is in progress. The defibrillator should be applied as soon as it is available, but CPR should not be delayed. Option D (administering epinephrine) is a vasopressor used in cardiac arrest, but it is not the first action. CPR and defibrillation are the priorities.

This question tests the nurse's ability to recognize a life-threatening dysrhythmia, prioritize interventions according to advanced cardiac life support (ACLS) guidelines,

Option A (administering metoprolol as ordered) is unsafe given the client's bradycardia and asthma history. Option C (administering metoprolol and monitoring for bronchospasm) is also unsafe. The nurse should not administer a medication that could cause serious harm when there are clear contraindications. Option D (administering metoprolol and encouraging inhaler use) is unsafe. The nurse should not rely on a rescue inhaler to mitigate the risks of a medication that could cause bronchospasm.

This question tests the nurse's ability to recognize medication contraindications, assess vital signs and history, and prioritize patient safety. The correct answer reflects the principle that beta-blockers should be used with caution in clients with asthma and bradycardia.

Question 59

A nurse is caring for a 45-year-old client who is receiving IV morphine for pain management following surgery. The nurse is preparing to administer the next dose. The client's most recent assessment reveals: respiratory rate 10 breaths/min, oxygen saturation 92% on room air, and sedation level 3 (drowsy but easily aroused). The client reports pain at a level of 6 on a 0–10 scale.

Which of the following actions should the nurse take?

A. Administer the morphine as ordered.
B. Hold the morphine and notify the provider.
C. Administer half the dose of morphine.
D. Administer morphine and monitor the client closely.

Correct Answer: B

Expert Rationale:

The nurse should hold the morphine and notify the provider. The client's respiratory rate of 10 breaths/min is below the normal range (12–20 breaths/min), and the oxygen saturation of 92% is at the lower end of normal. These findings indicate that the client is experiencing respiratory depression, which is a serious adverse effect of opioid therapy. Additionally, the client's sedation level of 3 (drowsy but easily aroused) suggests that the client is overly sedated. Administering more morphine would worsen the respiratory depression and could lead to respiratory arrest. The nurse should hold the medication, notify the provider, and monitor the client's respiratory status closely. The provider may order a reduced dose, a different analgesic, or naloxone if the respiratory depression worsens.

A nurse is caring for a 62-year-old client who is admitted to the surgical unit following a total knee arthroplasty. The client has a history of type 2 diabetes mellitus, hypertension, and obesity. The provider has ordered enoxaparin 40 mg subcutaneously daily for venous thromboembolism (VTE) prophylaxis, and the nurse is preparing to administer the first dose. The client's most recent laboratory results are: platelet count 145,000/mm³, hemoglobin 11.8 g/dL, hematocrit 35%, and creatinine 1.1 mg/dL.

Which of the following findings should the nurse identify as a contraindication to administering enoxaparin?

A. Platelet count of 145,000/mm³
B. History of type 2 diabetes mellitus
C. History of hypertension
D. Creatinine of 1.1 mg/dL

Correct Answer: A

Expert Rationale:

The nurse should identify the platelet count of 145,000/mm³ as a potential contraindication to administering enoxaparin. Enoxaparin is a low-molecular-weight heparin (LMWH) that works by inhibiting factor Xa, thereby preventing clot formation. One of the most serious adverse effects of heparin products is heparin-induced thrombocytopenia (HIT), a condition in which the immune system attacks platelets, leading to a rapid and severe drop in platelet count. While a platelet count of 145,000/mm³ is within the normal range (typically 150,000–450,000/mm³), it is at the low end of normal. The nurse should assess the client's baseline platelet count and monitor for any signs of bleeding or a further drop in platelets. In some protocols, a platelet count below 100,000/mm³ is an absolute contraindication to heparin products, and a count below 150,000/mm³ may warrant caution. The nurse should verify the client's baseline platelet count and consider whether the count is stable or declining.

Option B (history of type 2 diabetes mellitus) is not a contraindication to enoxaparin. Diabetes is a risk factor for VTE, which is precisely why prophylaxis is indicated. Option C (history of hypertension) is not a contraindication. Hypertension is a common comorbidity in surgical patients and does not preclude the use of enoxaparin. Option D (creatinine of 1.1 mg/dL) is within the normal range (typically 0.6–1.2 mg/dL for men) and is not a contraindication. However, the nurse should note that enoxaparin is renally excreted, and dose adjustments may be necessary for clients with severe renal impairment (creatinine clearance < 30 mL/min). This client's creatinine is normal, so no dose adjustment is needed.

Expert Rationale:

The nurse should stop the magnesium sulfate infusion and notify the provider. This client is exhibiting signs of magnesium toxicity, which is a life-threatening complication of magnesium sulfate therapy. The key assessment findings include diminished deep tendon reflexes (1+), respiratory rate of 10 breaths/min (below the normal range of 12–20 breaths/min), and drowsiness. Magnesium sulfate is a central nervous system depressant, and toxicity can lead to respiratory depression, loss of deep tendon reflexes, cardiac arrest, and death. The nurse's first action is to stop the infusion to prevent further worsening of toxicity. The nurse should then notify the provider immediately and prepare to administer the antidote, calcium gluconate, if ordered. The nurse should also continue to monitor the client's respiratory status, deep tendon reflexes, and urine output closely.

Option A (continuing the infusion and reassessing in 1 hour) is unsafe. The client is already showing signs of toxicity, and continuing the infusion would worsen the condition. Option C (administering calcium gluconate IV) is the appropriate antidote for magnesium toxicity, but it should be administered after stopping the infusion and notifying the provider. The nurse should not administer calcium gluconate without a provider's order. Option D (increasing the magnesium sulfate infusion rate) is contraindicated. Increasing the rate would worsen toxicity and could be fatal.

This question tests the nurse's ability to recognize magnesium toxicity, prioritize immediate interventions, and apply knowledge of the antidote. The correct answer reflects the principle that when signs of toxicity are present, stopping the offending agent is the first priority.

Question 80

A nurse is caring for a 28-year-old client who is at 38 weeks of gestation and has been admitted to the labor and delivery unit in active labor. The client's prenatal history is significant for gestational diabetes mellitus (GDM) controlled with diet and exercise, and a previous cesarean delivery at 39 weeks for breech presentation. The client has been in active labor for 6 hours and has received an epidural for pain management. The nurse notes the following findings: cervical dilation 6 cm, effacement 90%, station −1, and fetal heart rate (FHR) baseline 145 beats/min with moderate variability. Suddenly, the client reports a gush of fluid and a feeling of something coming through the vagina. The nurse performs a sterile vaginal examination and visualizes the umbilical cord protruding through the cervix. The FHR tracing now shows a prolonged deceleration to 90 beats/min that lasts for 2 minutes.

Correct Answer: B

Expert Rationale:

The nurse should first teach the client to ensure the baby's mouth covers the areola. Sore nipples are a common problem in breastfeeding, and one of the most common causes is improper latch. When the baby only covers the nipple and not the areola, the nipple is not drawn deeply enough into the baby's mouth, leading to friction and pain. The nurse should teach the client to position the baby so that the baby's mouth covers a large portion of the areola, not just the nipple. The nurse should also assess the baby's positioning and the client's comfort during feeding. Proper latch is the key to preventing and resolving sore nipples.

Option A (recommending formula feeding) is not appropriate. The nurse should support the client's breastfeeding goals and help troubleshoot issues. Option C (applying a nipple shield) may be helpful in some cases, but it does not address the underlying issue of improper latch. Option D (advising the client to pump and bottle-feed) is not the first-line intervention for sore nipples. The nurse should first attempt to correct the latch.

This question tests the nurse's ability to assess breastfeeding technique, identify the cause of sore nipples, and provide appropriate education and support. The correct answer reflects the principle that proper latch is essential for successful breastfeeding.

Question 95

A nurse is caring for a 32-year-old client who is at 36 weeks of gestation and has been diagnosed with severe preeclampsia. The provider has ordered magnesium sulfate IV infusion. The nurse is monitoring the client for signs of magnesium toxicity. The client's most recent assessment reveals: deep tendon reflexes 1+ (diminished), respiratory rate 10 breaths/min, urine output 25 mL/hr, and oxygen saturation 94% on room air. The client is drowsy but arousable.

Which of the following actions should the nurse take first?

A. Continue the magnesium sulfate infusion and reassess in 1 hour.
B. Stop the magnesium sulfate infusion and notify the provider.
C. Administer calcium gluconate IV.
D. Increase the magnesium sulfate infusion rate.

Correct Answer: B

widespread transmission among customers. This is the most likely explanation for an outbreak concentrated among food-service workers across multiple restaurants. The other antecedents are less likely: undercooked pork is associated with hepatitis E, not hepatitis A; contaminated municipal water is a possible source but less common in developed countries with treated water supplies; and recent flooding could contribute to contamination but is not the most direct or significant risk factor in this scenario.

The most significant consequence is secondary transmission to household contacts and customers. Hepatitis A has an incubation period of approximately 28 days (range 15–50 days), and infected individuals are most contagious during the 2 weeks before the onset of symptoms. This means that food-service workers may have unknowingly transmitted the virus to customers and household contacts before they became symptomatic. Secondary transmission can lead to a much larger outbreak than the initial 24 cases, potentially affecting hundreds of people. The other consequences are less significant: restaurant closure is an economic consequence but not a health outcome; chronic liver disease is not a typical consequence of hepatitis A (unlike hepatitis B and C, hepatitis A does not cause chronic infection); and increased vaccination rates may occur as a public health response but is not a direct consequence of the outbreak itself.

This question tests the nurse's ability to apply epidemiologic principles to a community outbreak, identify the most likely mode of transmission, and predict the most significant public health consequence. The correct answer reflects the nurse's understanding of hepatitis A transmission, the importance of hand hygiene in food safety, and the potential for rapid secondary spread in a susceptible population.