C. Prepare for percutaneous coronary intervention (PCI)
D. Administer morphine sulfate IV

Answer: A
Rationale: For a client with suspected acute myocardial infarction, chewed aspirin is a priority because it rapidly inhibits platelet aggregation and reduces mortality. The 12-lead ECG is already completed (showing ST elevation). PCI and morphine follow after aspirin administration.

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6. A client is receiving heparin IV for a pulmonary embolism. The aPTT is 95 seconds (control 30 seconds). Which action should the nurse take?

A. Increase the heparin infusion rate
B. Maintain the current infusion rate
C. Stop the infusion and notify the provider
D. Administer vitamin K

Answer: B
Rationale: The therapeutic range for aPTT during heparin therapy is 1.5 to 2.5 times the control value (45–75 seconds). An aPTT of 95 seconds is slightly above therapeutic range but not critically elevated. The nurse should maintain the current rate and continue monitoring. Vitamin K is the antidote for warfarin, not heparin.

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7. A nurse is teaching a client about a new prescription for warfarin. Which statement by the client indicates understanding?

A. "I will increase my intake of green leafy vegetables."
B. "I will use a soft toothbrush and electric razor."
C. "I will take aspirin for headaches."
D. "I will stop the medication if I see any bruising."

Answer: B
Rationale: Clients on warfarin are at risk for bleeding. Using a soft toothbrush and electric razor reduces the risk of bleeding. Green leafy vegetables contain vitamin K and should be consumed in consistent amounts, not increased. Aspirin increases bleeding risk. The medication should not be stopped abruptly.

97. A nurse is assessing a client with a new colostomy. Which finding should the nurse report?

A. Stoma is pink and moist
B. Stoma is dusky and cyanotic
C. Small amount of serosanguineous drainage
D. Colostomy output is liquid

Answer: B
Rationale: A dusky or cyanotic stoma indicates inadequate blood supply (ischemia) and requires immediate intervention. A pink, moist stoma is normal. Serosanguineous drainage and liquid output are expected initially.

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98. A client is prescribed sucralfate. Which instruction should the nurse include?

A. "Take this medication 1 hour before meals and at bedtime."
B. "Take this medication with meals."
C. "Take this medication with an antacid."
D. "Take this medication on an empty stomach with grapefruit juice."

Answer: A
Rationale: Sucralfate should be taken 1 hour before meals and at bedtime on an empty stomach. It forms a protective barrier over ulcers. It should not be taken with antacids.

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99. A nurse is caring for a client with acute pancreatitis. Which finding indicates a need for immediate intervention?

A. Serum amylase 200 U/L
B. Serum lipase 150 U/L
C. Blood glucose 250 mg/dL
D. Heart rate 110/min and blood pressure 88/56 mm Hg

Answer: D
Rationale: Tachycardia and hypotension indicate hypovolemic shock, a serious complication of acute pancreatitis. The nurse should initiate fluid resuscitation and notify the provider immediately.

C. "Expect weight gain as a therapeutic effect."
D. "Stop the medication once your thyroid levels normalize."

Answer: A
Rationale: Methimazole can cause agranulocytosis. Clients should report sore throat, fever, or other signs of infection immediately. The medication should not be stopped abruptly.

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125. A client is prescribed levothyroxine. Which instruction should the nurse include?

A. "Take the medication in the morning on an empty stomach."
B. "Take the medication at bedtime with a snack."
C. "Take the medication with calcium supplements."
D. "Stop taking the medication once your energy levels improve."

Answer: A
Rationale: Levothyroxine should be taken in the morning on an empty stomach, 30–60 minutes before breakfast, for optimal absorption. Calcium and iron supplements should be taken at least 4 hours apart.

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126. A nurse is assessing a client with Addison's disease. Which finding should the nurse expect?

A. Hyperglycemia
B. Hypertension
C. Hyperpigmentation of the skin
D. Weight gain

Answer: C
Rationale: Addison's disease (adrenal insufficiency) causes hyperpigmentation of the skin, hypotension, hypoglycemia, weight loss, and hyponatremia. Clients require lifelong corticosteroid replacement.

A. Blood pressure 140/86 mm Hg
B. Heart rate 78/min
C. Muscle cramps and hypotension
D. Weight loss of 1 kg

Answer: C
Rationale: Muscle cramps and hypotension during dialysis may indicate excessive fluid removal or electrolyte imbalance. The nurse should slow the ultrafiltration rate and notify the provider.

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148. A nurse is assessing a client with acute kidney injury (AKI). Which finding should the nurse report?

A. Urine output of 50 mL/hr
B. Serum creatinine 4.2 mg/dL
C. BUN 18 mg/dL
D. Serum potassium 4.0 mEq/L

Answer: B
Rationale: A serum creatinine of 4.2 mg/dL is significantly elevated (normal 0.6–1.2 mg/dL), indicating severe renal impairment. The nurse should notify the provider and monitor for complications.

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149. A client is prescribed furosemide. Which laboratory value should the nurse monitor?

A. Serum potassium
B. Serum calcium
C. Serum magnesium
D. Serum sodium

Answer: A
Rationale: Furosemide is a loop diuretic that causes potassium loss (hypokalemia). The nurse should monitor serum potassium levels closely.