TABLE OF CONTENTS:

Part 1: 20 Delegation and Prioritization Answers........................................Pages 2-3
Part 2: 16 New Format Answers......................................................................Pages 3-5
Part 3: 10 Critical Thinking Technique Answers..........................................Pages 5-6
Part 4: 20 Critical Thinking Technique Answers..........................................Pages 6-8
Part 5: 10 Disaster Triage Answers.................................................................Pages 8-9
Part 6: 10 Prioritizing Care of Cardiac Client Answers.................................Pages 9
Part 7: 120 Peer to Peer NCLEX - like Answers..........................................Pages 10-21
Part 8: 20 Infection Control Answers.............................................................Pages 21-23
Part 9: 36 Peer to Peer NCLEX - like Answers..............................................Pages 23-25
Part 1: 20 questions on Delegation and Prioritization Answers

Question 1. - Actual answer was: c. 40 year old with severe headache, vomiting and stiff neck.
Question 2 - Actual answer was: b. 77 year old with gastrointestinal bleeding needs bedside commode emptied. The nurse will check this first so the aide should carry this out first.
Question 3 - Actual answer was: c. pain and redness in the left lower leg. This could be a sign of infection or DVT.
Question 4 - Actual answer was: a. 35 year old with suspected acute tubular necrosis, urine output totaled 25cc's for the last two hours. Anything less than 30 cc’s an hour should be cause for concern.
Question 5 - Actual answer was: b. 36 year old on Coumadin with a prothrombin time of 35. 6 seconds. Norm HGB levels Men 14-18; Women 12-16; Normal PT is 10 –13 sec; Normal Calcium is 4.5 – 5.5 mEq/L; Normal BUN 7-20 mg/dl; Normal Creatine Male 0.6 – 1-2 mg/dl Femal 0.5 – 1.1 mg/dl
Question 6 - Actual answer was: b. client who had a pulse of 89 and regular now has pulse of 100 and irregular.
Question 7 - Actual answer was: c. call a potassium level of 5.9 to the attention of the physician. A potassium of 5.9 is high (normal being 3.5-5.0) and high potassium levels can cause cardiac arrhythmia which can be life threatening so you need to call that to the attention of the physician before you complete the other things.
Question 8 - Actual answer was: d. check blood pressure and note the location and degree of chest pain.
Question 9 - Actual answer was: d. a 3 year old with complaints of a sore throat, tongue slightly protruding out his mouth, and drooling.
Question 10 - Actual answer was: a. client 36 weeks gestation complaining of facial edema. Could indicate PIH needs more evaluation.
Question 11 - Actual answer was: d. 4 year old boy with a fractured femur. Developmental level appropriate and diagnosis not contagious.
Question 12 - Actual answer was: b. 5 year old who was diagnosed with type 1 diabetes and released from the hospital 2 days ago. This child needs close monitoring because children with type 1 diabetes are prone to wide fluctuations in blood sugar levels because of changes in their diet, activity and emotions. The complexity of the knowledge required by the parents to care for the newly diagnosed diabetic child requires close monitoring and reinforcement of teachings.
Question 13 - Actual answer was: b. obtain a temperature of a 29 year old woman receiving the final 30 minutes of a whole blood transfusion.
Question 14 - Actual answer was: b. 18 year old pregnant primigravida.
Question 15 - Actual answer was: a. client with stage 3 anxiety and disoriented.
Question 16 - Actual answer was: b. client exhibiting restlessness, irritability, and has tachycardia.
Question 17 - Actual answer was: d. client with borderline personality exhibiting self-damaging behaviors.
Question 18 - Actual answer was: b. the cardiac client. due to the low potassium level and the heart condition.
Question 19 - Actual answer was: a. 24-year-old pneumonia client with a pH 7.33, pco2 49, po2 90, hco3 26.
Normal ph 5.0 – 7.5; Normal pco2 35 – 45 mm Hg; Normal po2 80 – 100 mm Hg; Normal Hco3 20-29 mEq/L. Co2 is tested by Hco3 also know as bicarbonate. 95% of Co2 is in Hco3 therefore, Hco3 is tested.

Question 20 - Actual answer was: d. obtain the respiratory rate of a 6 week old infant who was admitted two hours ago with a respiratory rate of 64. While the assistant can technically count respirations per minute, the infant's initial respiratory rate of 64 indicates a need for further respiratory assessment that only the RN can perform.

Part 2: New Format Answers

1. 8. Use the following formula to calculate drug dosages: Dose on hand ÷ quantity on hand = dose desired ÷ X. The nurse should use the following equations: 25,000 units ÷ 250 ml = 800 units/hour ÷ X. Cross multiply to solve for X and divide each side of the equation by 25,000 units: X = 8 ml/hour.

2. To determine whether costovertebral angle tenderness (a sign of glomerulonephritis) is present, the nurse should percuss the costovertebral angle (the angle over each kidney that's formed by the lateral and downward curve of the lowest rib and the vertebral column). The costovertebral angle can be percussed by placing the palm of one hand over the costovertebral angle and striking it with the fist of the other hand.

3. 3,1,2,4,5,6. According to the AHA, the nurse should ask the client if he's choking and if he can speak. Next, she should administer abdominal thrusts or chest thrusts (if the client is obese or pregnant). She should continue thrusts until they're effective or until the client becomes unresponsive. When the latter occurs, the nurse should activate the emergency response team, then perform a tongue-jaw lift followed by a finger sweep to clear visible food. Next, she should open the client's airway and try to ventilate him. If his airway still is obstructed, she should reposition his head and try to ventilate again. Then, she should give up to five abdominal thrusts.

4. The pulmonic area is best heard at the second intercostal space, just left of the sternum.

5. 1, 2, 4. A person who's admitted to a psychiatric hospital on a voluntary basis may sign out of the hospital unless the health care team determines that he's a danger to himself or others. Members of the health care team evaluate the client's condition before discharge. If they have reason to believe that he's a danger to himself or others, a hearing can be held to determine if the admission status should be changed from voluntary to involuntary. Option 3 is incorrect because it denies the client's rights, option 5 is incorrect because the client doesn't need a lawyer to leave the hospital, and option 6 is incorrect because a hearing isn't mandated before discharge. A hearing is held only if the client remains in danger and requires further treatment.
6. According to the AHA, the nurse should first assess responsiveness. If the client is unresponsive, she should activate the emergency response system, then call for a defibrillator. Next, she should assess breathing by opening the airway and then looking, listening, and feeling for respirations. If respirations aren't present, she should administer two slow breaths, then assess the carotid pulse. If no pulse is present, she should start chest compressions.

7. As the fetus moves through the birth canal, she goes through position changes to ensure that the smallest diameter of her head always presents to the smallest diameter of the birth canal. Termed the cardinal mechanisms of labor, these position changes occur in the following sequence: descent, flexion, internal rotation, extension, external rotation, and expulsion.

8. In junctional tachycardia, the atrioventricular node fires rapidly.

9. Gastroesophageal reflux is a neuromotor disturbance in which the cardiac sphincter located between the stomach and the esophagus is not functioning effectively. This allows easy regurgitation of gastric contents into the esophagus, causing possible aspiration into the lungs.

10. The flow rate is 125 ml/hour or 125 ml/60 minutes. Use the following equation: Drip rate = 125 ml/60 minutes × 15 gtt/1 ml. The drip rate is 31.25 gtt/minute (31 gtt/minute).

11. Strong Braxton Hicks contractions typically occur prior to the onset of true labor and are considered a preliminary sign of labor. During the latent phase of the first stage of labor, contractions are mild, lasting about 20 to 40 seconds. As the client progresses through labor, contractions increase in intensity and duration, and cervical dilation occurs. Cervical dilation of 7 cm indicates that she has entered the active phase of the first stage of labor. Cervical effacement also occurs, and effacement of 100% characterizes the transition phase of the first stage of labor. Progression into the second stage of labor is noted by the client's uncontrollable urge to push.

12. Rationale: When teaching a client about enalapril maleate, the nurse should tell him to avoid salt substitutes because they may contain potassium, which can cause light-headedness and syncope. He should report facial swelling or difficulty breathing immediately because they may be signs of angioedema, which would trigger his prescriber to discontinue the drug. The client should also be advised to change position slowly to minimize orthostatic hypotension. The nurse should tell the client to report light-headedness, especially in the first few days of therapy, so his dosage can be adjusted. The client should also report signs of infection, such as a sore throat and fever, because the drug may decrease his white blood cell (WBC) count. Because this effect is generally seen within 3 months, the WBC count and differential should be monitored periodically.
13.1.2 L Rationale: The ordered infusion rate is 150 mL/hour. The nurse should multiply 150 mL by 8 hours to determine the total volume in milliliters the client will receive during an 8-hour shift (1,200 mL). Then she should convert milliliters to liters by dividing by 1,000. The total volume in liters that the client will receive in 8 hours is 1.2 L.

14.2,4,1,5,3 Rationale: According to Kubler-Ross, the five stages of death and dying are denial and isolation, anger, bargaining, depression, and acceptance.

15 1 Rationale: Blood loss from the uterus that exceeds 500 mL in a 24-hour period is considered postpartum hemorrhage. If uterine atony is the cause, the uterus feels soft and relaxed. A full bladder can prevent the uterus from contracting completely, increasing the risk of hemorrhage. Puerperal infection is an infection of the uterus and structures above; its characteristic sign is fever. Two major types of deep vein thrombosis occur in the postpartum period: pelvic and femoral. Each has different signs and symptoms, but both occur later in the postpartum period (femoral, after 10 days postpartum; pelvic, after 14 days). Mastitis is an inflammation of the mammary glands that disrupts normal lactation and usually develops 1 to 4 weeks postpartum.

16. 3,5,6 Rationale: Supportive, nonpharmacologic measures for the client with rheumatoid arthritis include applying splints to treat inflamed joints, using Velcro fasteners on clothes to aid in dressing, and applying moist heat to joints to relax muscles and relieve pain. Never massage inflamed joints because massage can aggravate inflammation. A physical therapy program including range-of-motion exercises and carefully individualized therapeutic exercises prevent loss of joint function. Use assistive devices only when marked loss of range of motion occurs.

Part 3: Critical Thinking Delegation Questions
Question 1 - Actual answer was: Sue, RN and the Physician. Rationale: Answer B: In this case, both the RN and the physician share the accountability. Neither confirmed the identity of the baby prior to the procedure. Yes, Anna has responsibility in the matter--she got the wrong baby and prepared him for the procedure--but the agency accountability for the delegation rests with the RN.

Question 2 - Actual answer was: Accountability. Answer D: Jane was still accountable for the dressing although Joe is also responsible for his actions.

Question 3 - Actual answer was: An older adult is being treated for diabetes. Answer A: The elderly person is currently being treated. This means that an assessment was already done. Remember that assessment, teaching, admission and discharge cannot be delegated. Although this is John's 4 time to your floor, he still needs to be assessed.

Question 4 - Actual answer was: Draw up insulin BUT NOT ADMINISTER IT!. Answer A: It is important for nurses to understand appropriate activities and tasks that are acceptable to delegate. These delegated tasks typically are ones that frequently occur, are considered standard and unchanging, have predictable results, and have minimal potential for risks. Although the Aide did not administer the drug, the nurse must know for sure it is the right medication.

Question 5 - Actual answer was: State Regulations and Boards of Nursing. Answer A: The scope of authority is usually part of the job description and directs personnel in the acceptable practices within their agency. The delegator must know and understand the job descriptions of
personnel in order to assign and grant authority to those who are qualified and who have the legal and agency authority to accept the delegated activity.

**Question 6** - Actual answer was: A 55-year-old man presented to the ED complaining of abdominal pain. He stated that he thought his condition was secondary to eating too much greasy fast food too rapidly. His vital signs were blood pressure, 150/100 mm Hg; pulse, 100 bpm; respiration, 22 bpm; and temperature, 98°F. His color is pale but is skin is warm and dry. Within minutes, his blood pressure dropped to 100/60. Stated he felt fine. Answer A: Although all these cases are serious, VS are steady and there is no respiratory difficulty at any time. In scenario A, the VS changed rapidly. The abdominal pain and sudden change of blood pressure is a sign of a ruptured aortic aneurysm.

**Question 7** - Actual answer was: the amount the facility can charge for a specific item (procedure). Answer D: They can govern is how much a particular entity will pay but not the cost.

**Question 8** - Actual answer was: Urinary output. Answer C: An elderly patient with diarrhea is at risk for dehydration and urinary output is a sensitive indicator of hydration status. The other assessments would not be as useful. Note: Answer 4: Guiac comes from Latin meaning “wood”. Dark stool would indicate blood in stool. But there is nothing in the question to suggest any internal bleeding.

**Question 9** - Actual answer was: Tell the patient to call 911. Answer A: The patient should be advised to contact the local police or fire department by dialing 911. Hazardous-materials teams trained and equipped to contain such substances will respond in those situations. The physician should quickly tell the patient to make no attempt to clean up the substance, but instead to cover it with something (e.g., clothing, paper, trash can). In addition, the physician should tell the patient to leave the room immediately, close the door and wash his or her hands thoroughly with soap and water.

**Question 10** - Actual answer was: the nurse and the hospital. Answer D: The nurse is responsible for his/her actions but the hospital has a responsibility to deliver safe, effective care by hiring competent, well-trained, responsible employees

**Part 4: Critical Thinking NCLEX Questions Answers:**

**Question 1** - Actual answer was: Tetracycline. Tetracycline is a broad-spectrum antibiotic.

**Question 2** - Actual answer was: Dilute the ingested poison with milk or water. Always dilute! Some signs of poison ingestion include: burns around the mouth, unusual breath odors, abnormal breathing, dilated or constricted pupils, nausea, vomiting, diarrhea, seizure, altered LOC or shock.

**Question 3** - Actual answer was: Brush away the lyme. Washing lyme would create a corrosive liquid. Phenol does not mix with water. When possible use alcohol for initial wash after lyme has been brushed away. Then, rinse with water.

**Question 4** - Actual answer was: Food is tasty but not spicy. Food is very important in Filipino culture. Filipinos almost always ask if you have eaten. Most Filipinos are used to eating rice three times a week, but of course American eating habits have influenced Filipinos living in the US.

**Question 5** - Actual answer was: Health Management. Managing the hypertension is the PRIORITY. The other signs may be experienced but it is the assymptomatic nature of hypertension that makes it difficult to treat.
Question 6 - Actual answer was: exhaustion. Monitor closely for exhaustion as well as dehydration.

Question 7 - Actual answer was: Haitian family members place great value in caring for their elderly at home. Adults care for their elderly parents at their home. Haitian people are known as welcoming, warm, friendly and captivating. They reserve a great hospitality for strangers and visitors. They are strong believers and their belief system appears to impregnate all their ways of life.

Question 8 - Actual answer was: Right dose, right pt, right route, right time, right medication. Memorize these five rights and always check against the medex three times: THE CORRECT DOSE, THE CORRECT PATIENT, THE CORRECT TIME, THE CORRECT ROUTE and be sure to have THE CORRECT MEDICATION!

Question 9 - Actual answer was: Apical Pulse. All of the following are important 1. Vital signs, length of seizure, type of seizure, incontinence of bowel and bladder, any cyanosis and a rectal check. Straining to have a bowel movement blocks airflow to the brain. Check for impaction. LOC in post ictal state is important to note. Apical pulse is not necessary except if a heart condition is present.

Question 10 - Actual answer was: a client with a potassium level of 5.7 mmol/L. Potassium and sodium work together. If potassium is high, sodium is low and visa versa. Normal range for potassium is 3.5 mmol/L to 5.3 mmol/L.

Question 11 - Actual answer was: You may delegate a client that is being discharged because they have a clean bill of health. Remember that assessment, teaching, admission and discharge CANNOT be delegated.

Question 12 - Actual answer was: Actions. ASSESSMENT: The needs of patients must be assessed in order to determine the skill level needed by the care provider. Part two includes assessing the competency level of personnel to determine which specified team member has the skill to provide the needed care. ASSIGNMENT: Step two, the assigning phase, also requires an ability to clearly communicate the total parameters of the assignment and not just the act of assigning. AUTHORITY: The delegator must know and understand the job descriptions of personnel in order to assign and grant authority to those who are qualified and who have the legal and agency authority to accept the delegated activity. State regulations and boards of nursing rules usually dictate the approved activities that can be safely performed by personnel under the supervision of a registered nurse. ACCOUNTABILITY: The delegator must supervise the personnel to validate that the care was performed as was delegated and according to the established policies and procedures within the agency.

Question 13 - Actual answer was: Obviously mortal wounds where death appears reasonably certain. When doing nursing triage there are 3 categories: Emergent, Urgent and Non-Urgent. Remember, in an EXTERNAL disaster, help the least hurt first.

Question 14 - Actual answer was: Remember that many families have basic fears about speaking out or being perceived as speaking out. Remember that many families have basic fears about speaking out or being perceived as speaking out. In some cultures, assertiveness can result in retribution at home, in school, within the community, in the delivery of social services, or even in immigration matters. Therefore, a FULL assessment on your part is needed. They may not tell you what is wrong.

Question 15 - Actual answer was: Right work environment. Right Task:--One that is delegatable for a specific patient. Right Circumstances:--Appropriate patient setting, available resources and other relevant factors considered. Right Person:--Right person is delegating the right task to the
right person to be performed on the right person. Right Direction/Communication:--Clear, concise description of the task, including its objective, limits and expectations. Right Supervision:--Appropriate monitoring, evaluation, intervention, as needed, and feedback. Although a pleasant work environment would be nice, this is not part of the 5 rights of delegation.

**Question 16** - Actual answer was: Based on predetermined standards of care. Standards of care are established by a variety of clinically oriented healthcare professional groups, such as the American Nurses’ Association. These standards of care are based on the best information available from clinical practice and research.

**Question 17** - Actual answer was: true. TRUE: Physicians cannot give parents or guardians access to information regarding a medical treatment or procedure to which a minor patient has consented.

**Question 18** - Actual answer was: Use a family member. Cultural bias and/or personal feelings may affect family members’ translations. All the other choices are non-related individuals.

**Question 19** - Actual answer was: patient's bill of rights. The patients has a right to know all things in relation to their care.

**Question 20** - Actual answer was: Explain that this is not unusual. Pre-school aged children have been described as power houses of gross motor skills. Moving as quickly as they do, they may not always be able to judge distances and perceptions.

**Part 5: Disaster Triage Exam Answers**

1. False

2. Yes.

3. Least Traumatized

4. Most Traumatized

5. Trauma
   
   Respiratory
   Intracranial Pressure and mental status
   An Infection
   GI-Upper
   Elimination-Lower GI

6. People with trauma that can walk away, one would treat first. People lower GI injuries last.

7. False.

8. Green is for the people that can get up and walk away.
Yellow is for the people that are injured conscious but can not walk away from the scene of the disaster themselves.

Red is for the people who are unconscious but have a pulse.

Black is for the people who are unconscious no pulse and show no signs of life.

9. Respirations
   Perfusion
   Mental Status

10 Red.

Part 6: Prioritizing Care of a Cardiac Client Answers

**Question 1** - Actual answer was: Administer the morphine. The nurses PRIORITY action would be to relieve the chest pain. Thus administering the morphine would be the correct action to take FIRST. While it is true that pain is a psychosocial need and physiological needs would come first, in this case it is standard routine in an ER to get an EKG and blood work. Answers B and C do not need a doctors order.

**Question 2** - Actual answer was: Dissolve clots they may have. Throbrolytic drugs are administered within the first 6 hours of a MI to lyse clots and reduce the extent of damage.

**Question 3** - Actual answer was: Impaired Gas Exchange. Impaired Gas Exchange related to poor oxygenation and dysrhythmias is a major problem after a MI

**Question 4** - Actual answer was: Observe for chest pain. Closure of the previous obstructed coronary artery may recur. Heperin is often given in conjunction with tPA to prevent closure after the tPA is given.

**Question 5** - Actual answer was: Blood Pressure. People with Pulmonary Edema often experience hypertension.

**Question 6** - Actual answer was: Activity Intolerance related to imbalance between oxygen supply and demand. The decreased cardiac output associated with heart failure leads to reduced oxygen and fatigue.

**Question 7** - Actual answer was: Increase myocardial contractility. Dig is a cardiac glycoside with positive inotropic activity. This activity causes increased strength of myocardial contractions and increases out of blood from the left ventricle. There is then, less blood shifting from the capillaries into the alveoli. It does decrease electrical conductivity but this is not the primary reason for its use.

**Question 8** - Actual answer was: reduce peripheral vascular resistance. B-adrenergic antagonists such as metoprolol tartarate act on B1-adrenoreceptors in the cardiac muscle and thereby reduce heart rate and lower blood pressure.

**Question 9** - Actual answer was: 5 to 10 minutes. Diuresis normally begins in about 5 minutes and reaches its peak in 30 minutes. Lasts 2-4 hours.

**Question 10** - Actual answer was: excrete fluids accumulated during the night. When given in the morning, the need to void will not disturb nighttime sleeping.
Part 7: *These questions are shared from a P2P Program. The source and the compiler is unknown and to the best of Caring 4 You . Net knowledge these questions do not impose on the integrity of the nclex.

Answers to Nclex 120 Questions

1. 2. This is the best choice which describes M.S., and it is important for the nurse to be able to distinguish between these different neurological disorders in order to plan care. Choice (1) describes Parkinson’s Disease, Choice (3) refers to ALS (Amyotrophic Lateral Sclerosis), and Choice (4) refers to Myasthenia Gravis.

2. 4. Choices (1), (2) and (3) would be appropriate interventions for such a client. Bell's Palsy is a disorder involving Cranial Nerve VII, and results in facial paralysis or paresis, patients may experience a variety of symptoms including pain, drooping of the mouth on the affected side, and an inability to close the eye on the affected side. Choice (4) would NOT be appropriate, as vigorous massage could further increase pain, etc. Gentle massage, and the application of heat are preferred interventions.

3. 3. ALS is a progressive and usually fatal disease which affects the motor neurons; as they die, muscular function is affected resulting in progressive weakness, atrophy, spasticity of the muscles including the muscles of respiration. While Choices (1), (2) and (4) are all potential diagnoses, choice (3) would be the diagnosis with the highest priority. REMEMBER A PATENT AIRWAY IS ESSENTIAL TO LIFE, AND MUST BE MAINTAINED.

4. 3. Oxygen is a drug, and must be administered carefully. Clients with COPD, have adapted to breathing with lower 02 concentrations. Administering 02 at liter flow greater than 2-4L min, can result in the absence of the patient’s drive (hypoxic drive) to breathe. This will cause further CO2 retention (CO2 Narcosis), and ultimately respiratory depression. ABG's will also help to determine the liter flow. The nurse should explain this to the patient. Therefore, Choice (1) would NOT be an appropriate intervention. Choice (2) would be correct but the reason is incorrect, and Choice (4) you should let the M.D. know, but this question asks for a first nursing response.

5. 4. Clients who have been on anti-TB drug regimes for at least 2-3 weeks and have absence of AFB in at least two successive sputum cultures, no longer need to be on Respiratory Isolation. Taking medication alone, or the absence of adventitious breath sounds such as rhonchi, rales, etc, or the absence of infiltrates on chest x-ray, usually seen with Pneumonia would not be a reason to D/C Isolation, making choices (1), (2), and (3) incorrect.

6. 2. Glycosylated Hemoglobin (Hgb) is a lab value which reflects glucose combining with Hgb and attaching to the red blood cells (RBC's) for the life of RBC. This test, therefore, is indicative of control of blood sugar, regardless of increase or decreases in serum glucose values. A value of 10% or less is considered good control. Choices (1) and (3) are incorrect, although (4) might seem likely and may be true, it is NOT correct in this instance.
7. 3. As rales are abnormal lung sounds, which are described as crackling in nature. Choice (1), rhonchi, are also adventitious, but are characterized by sonorous, dry coarse sounds which may clear if patient coughs. Sometimes called gurgles. Choice (2), wheezes, are high pitched sounds which are continuous, and can be auscultated during both inspiration and expiration, secondary to narrowed air passages. Choice (4), refers to either incomplete expansion or collapse of air passages but is not in and of itself a breath sound.

8. 4. Beta blockers act to decrease heart rate and force of contraction and reduce vasoconstriction by antagonizing Beta receptors in the myocardium and vasculature. Choices (1) and (2) refer to the action of nitrates as well as Calcium Channel Blockers such as Diltiazem. Choice (3) is not applicable.

9. 3. Loop diuretics such as Lasix result in potent diuresis. The most common side effects are electrolyte imbalances such as hypokalemia, hyponatremia making choices (1), (2) and (4) incorrect. In addition, Digoxin taken in combination with loop diuretics can result in digitalis toxicity, so the nurse should be alert to this and normal serum lab values for Digoxin (Norm: 0.5-2.0 ng/ml). The nurse should be aware that there is a very small variance between therapeutic and toxic levels of this drug.

10. 4. 3 degree A-V block is a conduction defect with A-V Junction that impairs conduction of atrial impulses to ventricular pathways. It is the highest degree of A-V Block and is characterized on EKG by choice (1), (2) and (3). Choice (4) is NOT an EKG finding, as in 3 degree A-V Block. The heart rate is slowed to 40-60 bpm, or inherent ventricular rate.

11. 1. A patient in 3 degree A-V Block has all sinus impulses blocked and abnormal ventricular conduction, as well as a heart rate of 40-60 bpm or less and will therefore need support in the form of a pacemaker and/or use of meds such as atropine or Isoproterenol (Isuprel). Choice (2) Digoxin, a cardiac glycoside would only further decrease heart rate; Choice (3) Lidocaine is used in treatment of PVC's; Choice (4) may seem a possible option, however, with proper medical management a heart rate sufficient to support perfusion can be maintained making CPR unnecessary.

12. 2. Demand Pacemakers will fire ONLY when the heart's spontaneous beat falls below the minimum rate. Electrodes for sensing and pacing are placed in the ventricles. Choice (1) refers to an Asynchronous Pacemaker which is unaffected by heart regular beat; Choice (3) refers to Synchronous and A-V Sequential type Pacemakers, however, it is the sensing electrode ONLY and both sensing and pacing electrodes are placed in the atria in the A-V mode. Choice (4), a Pacemaker may be a temporary modality, but can also be permanently implanted, making this choice incorrect.

13. 3. A client should NOT repeat a dose if first dose is vomited, as one would not know how much of the original dose was absorbed, and could possibly lead to excess Digoxin levels, which can cause arrhythmias, or slow heart rate below 60 bpm. Choices (1), (2) and (4) would be included in a teaching plan.

14. 1. Following cardiac catheterization, the nurse must make several crucial evaluations v.s. must be monitored and peripheral pulses (distal to insertion site) must be checked q 15 min x 1 hr. Then, if stable, re-assess q 1/2-1hr till stable. In addition, the site must be checked for hematoma formation and/or bleeding. The color, temperature, etc. of the extremities must also be assessed, as well as any unusual pain, nummness, or tingling in the extremity. The nurse should also be alert for any dysrhythmias, especially bradycardia (a vasovagal response to the procedure), chest pain, oliguria, etc. are ALL potential complaints or observations that require IMMEDIATE intervention by the nurse. Mild pain at the insertion site can be
expected following this procedure and analgesics are administered p.r.n. However, any unusual pain
should be assessed and reported and would require IMMEDIATE INTERVENTION.

15. 1. Although BUN is a measure of kidney function, patients who are dehydrated (without kidney disease)
can show an elevation in Blood Urea Nitrogen (BUN). Creatinine is a specific indicator of renal function
and/or failure.

16. 3. This finding is consistent with Hirschsprung's disease. Due to the aganglionic portion that is very
narrow and failure of the internal anal sphincter to relax the stool that passes is very narrow and may
appear to look like a long ribbon. Option 1 is Foul smelling stool = fat in stool, option 2 is currant jelly stool =
circulation problems, option 4 is liquid stool = malabsorption.

17. 1. Signs of Digoxin Toxicity in infants often presents with vomiting since increased drug levels stimulate
the emetic control center in the medulla. Digoxin in toxic levels significantly suppress the SA node and
cause slowing of the heart rate, therefore having the mother assess the child's pulse will help to determine
if the child is exhibiting a toxic reaction to Digoxin. Increasing fluid intake is inappropriate until it is
determined whether or not the child is toxic. Checking for wet diapers would indicate renal response to
digoxin, not toxicity. Redosing the digoxin is inappropriate until toxicity is ruled out.

18. 4. The classic finding when an appendix ruptures is a sudden cessation of pain. A ruptured appendix
requires immediate intervention to prevent serious complications. Options 1, 2 and 3 are expected findings
for a child of this age who is diagnosed with acute appendicitis.

19. 3. Blood pressure elevation is a serious and frequent complication associated with Acute
Glomerulonephritis. The nurse should expect to assess blood pressure every 4 to 6 hours with vital signs.
Options 1, 2 and 4 are appropriate orders for a child with Acute Glomerulonephritis.

20. 3. Celiac disease is caused by an intolerance to gluten, which is a protein found in wheat, oats, barley
and rye, All the foods in option 3 contain gluten. Option 1 would be eliminated if the child had a lactose
intolerance, option 4 would be eliminated if the child had a fat intolerance.

21. 4. Unless the antibiotic is safe for the infant, it is best not to feed the baby, but in order to continue
establishment of milk flow, the breasts must be stimulated.

22. 4. The medication may irritate the baby's eyes, thereby, the bonding process should be initiated before
the medication is instilled in the eyes.

23. 2. One of the toxic effects of Pitocin is uterine tetany. Contractions that last more than 60 seconds may
indicate uterine tetany.

24. 1. Choice 2 is an indication of false labor; Choices 3 and 4, are signs of approaching labor.

25. 3. The nurse should understand that these findings are signs and symptoms of mild dehydration.

26. 4. In the therapeutic milieu, the nurse is responsible for maintaining safety of all patients. Utilizing a sign
out and sign in sheet for razors keeps track of who has the razor, when it was taken and assures that it is
returned. Sharps count at the end and beginning of each shift provides documentation that the items
deemed sharps or dangerous are accounted for.
27. 2. Thorazine blocks the neurotransmitter dopamine resulting in side effects that look like Parkinson's disease. Cogentin reduces side effects such as stiffness, pill rolling tremor, mask-like face and cogwheeling rigidity associated with the Thorazine.

28. 4. Antisocial patients believe that rules do not apply to them so they frequently get into trouble. The nurse reinforces the rules of the unit and helps the patient deal with delaying his/her need for immediate gratification of personal needs.

29. 3. The primary goal of a conversion disorder is to reduce intolerable anxiety. The secondary gain involves meeting dependency needs. When dependency needs are met, the individual is comfortable and may have no motivation to change behavior.

30. 4. Over the counter cold remedies often contain stimulants or other ingredients that would cause a hypertensive crisis. The patient must consult their doctor before taking ANY drug.

31. 3. Reorganization implies the individual has begun to move on with their life. This involves making life decisions and or beginning new relationships indicating they have accepted the loss and are coping effectively to begin living again.

32. 2. The cardinal signs that a patient withdrawing from alcohol may be going into delirium tremens are elevated temperature, elevated blood pressure, elevated pulse and tremulousness.

33. 3. Korsakoff's syndrome is a form of dementia secondary to the thiamine deficiency known as Wernicke's encephalopathy. Both the short and long term memory are affected leaving the patient very confused and having amnesia of many if not most events.

34. 2. Alzheimer's disease is a progressive disease that takes years until the patient is completely incapacitated. It is best to support the individuals self esteem by helping them maintain as much control of their life through independent functioning of self care and activities of daily living.

35. 3. It is essential that the patient receive fluids, calories and rest to avoid cardiac complications related to dehydration and exhaustion.

36. 4. Patients with renal failure should have a diet that provides (high biologic value) proteins rich foods such as eggs, dairy products and meats. These are necessary to maintain a positive nitrogen balance. Foods high in calories are also necessary, and sodium intake should be limited. Foods high in Potassium should be AVOIDED due to decreased ability of the kidney(s) to filter and excrete Potassium.

37. 1. One of the possible complications of Peritoneal Dialysis is Peritonitis. The signs and symptoms may include: nausea, vomiting, abdominal pain or tenderness or rigidity, and cloudy dialysate. Blood tinged or slightly bloody drainage may be observed during the first one to two exchanges, and is not considered to be abnormal unless seen after such, making choices (2), (3), and (4) possible signs of Peritonitis, but NOT choice (1).

38. 4. Since an isotonic solution must be used 0.9 or Normal Saline MUST be used in order to irrigate a Nasogastric Tube. Use of a solution that is not isotonic could result in the undue removal of sodium and acids etc. from the stomach, and lead to potential fluid and/or electrolyte imbalances in the patient.
39. 2. The presence of dark brown "coffee ground" drainage may indicate the presence of bleeding or blood in the GI tract. Because this maybe the case the nurse should FIRST perform a Hemoccult Test to determine this. Choice (1) checking the pH will only help to determine gastric acidity; Choice (3) and (4) would not be correct nursing actions in this case.

40. 3. The HIV virus has been found and isolated in all of the above body fluids, as well as in the stool and urine. However, the highest concentration is found in the blood of infected individuals.

41. 1. Although abstinence is still the best protection against spread of the HIV virus, the use of a latex condom with a H2O soluble lubricant is the most effective means. All other choices given have no proven validity against the spread of the HIV Virus.

42. 4. Although the patient with SIADH has many needs, the one with the highest priority is that of safety. The patient with SIADH is at risk for dilutional hyponatremia which may result in seizures. Therefore, of the diagnoses given Choice (4) would have the highest priority. Choice (1) - Oxygenation - is not a problem in these patients, and Choice (2). Nutrition, although dietary changes may be needed to manage fluid and electrolyte disturbances associated with this syndrome, it does not take priority over safety.

43. 3. Signs and symptoms that may indicate an increase in Intracranial Pressure may include headaches, visual changes, seizures, vomiting, stiff neck etc. VS are also an important indicator, as indicated by Choice (3) the triad of decreased pulse and respirations, and a rising BP, also called Cushing's Triad are very important indicators of increased intracranial pressure (ICP) and MUST be monitored carefully by the nurse.

44. 4. Maintaining an ICP of less than 20mmHg, and a CPP (Cerebral Perfusion Pressure), usually at least 60mmHG, or as ordered are considered to be within normal limits. Intracranial Pressure monitoring is done through the placement of a catheter in the ventricle of the brain. Normal ventricular pressure is 10mmHg. Pressures of 11-20mmHg are considered to be mildly elevated, and pressure above 20mmg is to be high, and a definitive sign of increased ICP.

45. 2. Changes in level of consciousness, and responsiveness are among the earliest signs, with lethargy being the earliest sign or indicator of increased ICP. The other choices are also associated with increasing/increased ICP, however they are usually later manifestations of such.

46. 2. This patient is suffering from frostbite, due to prolonged exposure to sub-freezing temperatures without proper protection. Frostbite is a condition in which there is trauma to the tissues without actual freezing of tissue fluids. Exposed areas of the body such as hands, feet, earlobes, etc. are all subject to this. The affected part becomes hard, cold, and is not sensitive to touch, and mottled bluish-white in color. The aim of nursing care is to restore normal temperature and circulation to the part. All other choices would be included in the management of such a patient. Choice (2) is incorrect in that wrapping of the part could further constrict circulation. If blankets are used, it should be supported with a foot cradle and not in direct contact with the extremity. Prolonged applications of heat should also be avoided due to the patient's diminished sensitivity, and could result in a burn if not carefully monitored.

47. 3. All choices, except choice (3) are essential parts of the nursing care of a patient with a Tracheostomy. In tracheostomy tubes with both an inner and outer cannula, it is ONLY the inner cannula which is removed for cleaning. Newer plastic tubes have disposable inner cannulas that are changed as ordered.
48. 4. In suctioning a patient with a Tracheostomy, the nurse should employ all of the above choices, except choice (4). However, when the catheter is inserted it should be done gently, and to a depth of 10-12.5cms (4-5"s) or until the patient begins to cough. Suction should never be applied when inserting the catheter, not should it be rotated during this period. Suction should be applied by occluding the Y-port with the thumb of the unsterile gloved hand, while the catheter is rotated gently during withdrawal. The patient should never be suctioned for more than 10 seconds at one time to avoid the development of hypoxia.

49. 1. Following a Vasectomy a patient may experience localized discomfort. The patient is advised to apply ice bags intermittently for several hours after the surgery, to the scrotal area, to relieve mild pain and discomfort. Choice (4) may also initially seem to be correct, however, analgesics are usually administered on a p.r.n. basis, vs. q4h. Choices (2) and (3) are not correct interventions for pain relief in this situation.

50. 1. Abnormal discoloration of the scrotal area following Vasectomy is not unusual, and usually responds well to warm sitz baths. The nurse should reassure the patient of such. However, ecchymoses, swelling, superficial wound infection of the vas deferens or epididymitis, or sperm granulomas, are all potentially serious complications, and the M.D. should be notified of any unusual findings immediately. Therefore, choices (2), (3) and (4) are incorrect.

51. 2. The first three days will produce colostrum. The "let down reflex" usually occurs around the third post partum day and then milk will flow.

52. 3. Elevated AFP may indicate a neural tube defect.

53. 3. Pressure on the head during this type of delivery will likely create a cephalohematoma.

54. 2. SE of Cocaine include vasoconstriction, stimulation of neuro system.

55. 3. Changing the baby's position will distribute the pressure on the nipples more evenly and will make it less likely to cause soreness.

56. 2. Skin integrity is correct because the myelomeningocele is only covered by a thin membrane and damage to the membrane can cause severe spinal cord injury and infection. All of the other options are appropriate concerns for a child with this condition, but are not as life threatening. Potential problems never take priority over actual problems.

57. 3. This position in the immediate post operative period allows for constant observation of the airway and prevention of injury to the suture line. Options 1, 2 and 4 will risk injury to the suture line.

58. 2. Children with cardiac disease have lowered resistance to upper respiratory infections and should avoid any circumstances that may expose them to even mild infections. Option 1 is unrealistic and option 3 would not put the child at risk since allergies are not contagious, option 4 is wrong because children with cardiac conditions do receive routine immunizations.

59. 3. Avoiding known sources of respiratory infections decrease the risk of hypoxia, which will cause decreased oxygen tension and sickling of RBCS. Option 4 is related to CHF, Option (1), weight loss, with dehydration could contribute to a crisis. Midrange altitudes do not cause problems it is high range altitudes that cause problems.
60. 4. In a vasooocclusive crisis tissue perfusion to the vital organs is threatened. Vital organs require perfusion of blood and oxygen in order to perform their functions and maintain homeostasis. All the other options are important concerns when planning care for an adolescent with Sickle Cell Disease, but are not life threatening.

61. 3. The antisocial patient manipulates the environment to get needs met. The nursing staff must act in a unified and consistent manner to help the patient learn to follow rules and function within limits imposed on him, as it will be, when he lives in the community.

62. 1. Tricyclic antidepressants tend to cause weight gain and potentiate seizures.

63. 3. Lithium is a salt and it is stored in the body fluids. Loss of body fluids by diuretics would make Lithium levels dangerously high. In addition, loss of body fluids through vomiting and/or diarrhea would also make the Lithium level dangerously high.

64. 2. Prolixin Decanoate is good for non-compliant patients as it's a time released medication lasting 1-2 weeks.

65. 4. Hyperorality is a symptom of Dementia associated with the 3rd stage of Alzheimer's disease.

66. 3. Haldol is good with paranoid patients because it is less sedating. Very sedating medications tend to increase suspicions of the patient that the staff are out to hurt or poison them.

67. 1. A focused game of cards with the nurse would be most therapeutic. This activity limits competition with others, stimulation from others and allows for consistent limit setting in the event the patient begins to escalate.

68. 3. It is highly unusual for ECT to cause a manic episode.

69. 3. Putting feelings into words is a sign of improvement for this patient who has shown his angry feelings only through verbal abuse and threats.

70. 2. Splitting is a primitive defense mechanism in which persons see themselves or others as all good or all bad, failing to integrate the positive or negative of the self or others into a cohesive whole.

71. 3. Patients with Alzheimer's Disease often focus a great deal on the past. It is important for the nurse to allow the patient to do this in order to maintain self-esteem and self-concept. The nurse should set aside a certain amount of time in providing daily care in which the patient is allowed to reminisce about the past.

72. 2. Elderly patients, even if only minimally confused, are at a higher risk for sustaining injuries, especially in unfamiliar surroundings. While other choices are potential interventions that the nurse could implement, choice (2) would allow the patient to better visualize the surroundings, delimiting possible accidents or falls. Orienting the patient, as well as checking the patient, and keeping side rails up (judgement has to be made if such a measure is necessary) are also important. Each patient must be assessed individually to determine which measure(s) should be employed.

73. 1. One of the more common problems following Gastric surgery is Dumping Syndrome. Dietary management is the key to reduce or prevent this potential problem from developing. The diet should contain moderate amounts of fat, as well as be low in carbohydrates, especially small molecular
carbohydrates such as sucrose and glucose. These dietary modifications will result in decreased hypertonicity of the intestinal contents, and prevent osmotic pull of extracellular fluid into the intestinal area, lessening the possibility for Dumping Syndrome to develop.

74. 4. Following Total Gastrectomy the production of Intrinsic Factor is permanently destroyed. This is necessary (Intrinsic Factor) for the absorption of Vitamin B12 from the GI tract. As a result patients MUST receive Vitamin B12 by parenteral route throughout life, or a condition known as Pernicious Anemia will develop, and can prove to be fatal. Regular IM injections on a monthly basis of 100-200ug is the usual therapeutic dose.

75. 4. The nurse should be alert for the potentially serious adverse ototoxic and nephrotoxic effects this drug may cause. Signs and symptoms of such as those in Choices (1), (2) and (3), are especially important in assessing a patient on this therapy. Choice (4) - nausea and vomiting - are side effects, but are usually not considered to be adverse or toxic to the patient if they should occur.

76. 2. Amphotericin-B is an antifungal/antimycotic drug, and is the preferred drug of choice for the treatment of severe systemic mycotic infections. Side effects and adverse effects which the nurse must be alert for include fever, chills, nausea, vomiting, etc. Electrolyte disturbances especially Hypokalemia and Hypomagnesemia are frequently observed. The drug is also potentially nephrotoxic and therefore changes in BUN and Creatinine are also significant. However, the question specifically asks for ELECTROLYTE disturbances making Choice (2) correct.

77. 3. The chancre, Choice (3), is seen in the Primary Stage, the stage at which the disease is most infectious. These lesions and the area in which they present are usually related to the pattern of sexual activity. The Secondary Stage, from a few weeks to several months in duration, sees the treponeme infecting agent traveling to various body systems and organs resulting in the signs and symptoms listed in Choices (1), (2) and (4), as well as others.

78. 1. Rheumatoid Arthritis is a chronic inflammatory Connective Tissue Disease in which the synovial joints of the hands, wrist, knees, feet are usually affected. RA also has systemic effects as well. Choices (2), (3) and (4), are all potential assessment findings in a patient with this diagnosis. Heberden's Nodes, however are associated with Osteoarthritis, and appear as bony nodules on distal finger joints.

79. 3. The prosthesis should be worn as described in Choice (3), to prevent swelling of the stump. The use of lotions or creams should be avoided as they can result in excessive softening of the skin. They can also set up a potential area for bacteria formation and infection. The prosthesis should NEVER be adjusted by the patient ONLY by a trained professional, making the other options (1), (2), and (4) incorrect.

80. 4. In the post-op period following an amputation of a lower extremity, nursing interventions are aimed at preventing deformities, building and maintaining muscle strength, and mobilizing patient's joints. Placing the patient in the prone position twice daily is specifically aimed at stretching the flexor muscles, and preventing flexion contractures of the hip. The other choices (1), (2) and (3), are also important parts of the nursing care, but do not answer the question.

81. 3. Side effects of NSAIDS are GI upset, rash, easy bruisability, etc. More serious side effects and adverse responses to therapy can include purpura, petechiae and more serious blood dyscrasias, among them Thrombocytopenia (decreased platelet count). The lab value of 9,000 in this situation denotes severe thrombocytopenia, (Normal values 150,00-400,000).
82. 1. A colostomy is one form of bowel diversion created through surgical intervention. Choices (2), (3) and (4) are all proper statements concerning colostomy care, and should be included by the nurse in the teaching plan. However, Choice (1) refers to an ileostomy, as the contents of such are liquid unlike the colostomy, and therefore irrigation is not required.

83. 4. Patients on TPN must be monitored closely, and the rate of the infusion maintained as ordered. If the rate is too fast, hyperosmolar diureses occurs, and the patient may complain of headache, nausea, chills and may have an elevated temperature. The rate of the infusion must NEVER be increased or decreased abruptly, nor should it be changed. In this situation, the nurse should suspect Hyperglycemia, and should immediately check the patient's glucose level through (Finger Stick), as well as urinary output, as diuresis is likely. Notification of the M.D. of the patient's symptoms, as well as your assessment findings are also part of the nursing interventions.

84. 2. Nursing care for patients with DVT include bed rest, elevation of the extremity, application of warm, moist heat, anticoagulation therapy, and elastic stockings only if edema is present once the patient resumes ambulation. For the patient on bed rest, elastic stockings (TEDS), are applied to the UNAFFECTED EXTREMITY ONLY. Note in elevating the legs NEVER use pillows under the knees and/or knee gatch the bed. Teaching the patient how to ambulate should also be included in your patient care.

85. 4. Patients with Arterial Occlusive Disease have decreased perfusion of tissues. By placing the patient in a dependent position, blood flow to the lower extremities is enhanced, and, therefore, the nursing diagnosis for this intervention would be Altered Tissue Perfusion. Choices (1), (2) and (3), do not relate to the given problem of Arterial Occlusive Disease.

86. 4. All options may help to increase a child's intake, but in order to promote optimal nutrition the nurse must provide foods that are high in calories and protein.

87. 2. When the inflammatory process begins to resolve renal function improves. Urinary output must increase before the blood pressure or edema decreases. Serum protein loss is not the problem in acute glomerulonephritis.

88. 2. At 6 months babies sit with support and by nine months they sit unassisted, therefore a child between this stage would be able to achieve sitting alone for brief period. This is a demonstration of cephalocaudal development. Option 1 is expected of a 12 month old, option 2 is expected of a 9 month old and option 4 is expected of a 3 month old.

89. 2. Croup is an upper airway obstruction and the signs and symptoms are because of difficulty getting air past the upper airway. Wheezing is found with Asthma, decreased aeration in lung fields is found with Pneumonia. Shallow respirations are unlikely, the child may exhibit retractions, but not shallow respirations.

90. 3. Spica casts are body casts and cover the trunk of the body. If the cast is too tight the child's respiratory effort would be compromised. Diapering babies in spica casts is indicated as the perineal area is exposed. There are no feeding restrictions with spica casts and applying baby powder is contraindicated as it may cake and cause skin breakdown.

91. 2. Choice 2 is the normal post partum fundus, at two hours, regardless of mode of delivery.
92. 3. Celestone prevents Respiratory Distress Syndrome in a premature neonate by stimulating surfactant production.

93. 4. Cervical dilation of 6cm, contractions lasting for 45 sec. with a frequency of 3 minutes apart is the active phase of labor. Choices 1 and 2 are the latent phase of labor; Choice 3 is the transitional phase of labor.

94. 3. Uteroplacental insufficiency reduces O2 to the fetus and causes fetal hypoxemia

95. 2. During this phase of labor, the patient may experience strong forceful contractions which will distract the patient from concentrating. The nurse can redirect the patient and reduce the stress of this time of labor.

96. 3. This is the correct positioning of Bryant’s traction. When a nurse observes an appropriate treatment the nursing action to be taken is to document the findings.

97. 3. The increased viscosity of mucous in the GI tract is frequently responsible for development of meconium ileus in the newborn period. Developmental delay in walking is not directly related to Cystic Fibrosis, tripling birth weight is a normal milestone expected of all children. History of dehydration may or may not be related to Cystic Fibrosis.

98. 1. A “tet” spell is when the child is having difficulty meeting oxygen demands. The knee chest position reduces venous blood return from the lower extremities and increases vascular resistance to divert blood flow to the pulmonary artery. Option 2 is to be initiated for cardiac arrest. Options 3 and 4 would not help to oxygenate a child with TOF.

99. 2. Elbow restraints can be removed with supervision and children wearing restraints should have them removed every 2 hours to allow for ROM exercises. Developmental stimulation with play activities must be encouraged so the child should not be removed from the playroom. Distraction might work but it is not the optimal choice. Giving a child pain medication would be inappropriate since the child is not complaining of pain.

100. 4. Although all the above suggestions may make the baby feel less pain the only safe practice is to allow the child a hard rubber toy to bite on. The toy should be larger than the child’s fist and easy to clean. An ice cube may be aspirated. Aspirin is contraindicated to be given to children and the action of aspirin is systemic not local. All alcoholic beverages are contraindicated to be given to children in any form.

101. 3. Patients with Sepsis are subject to coagulation problems and blood loss, which may also result in poor or inadequate tissue perfusion. Choices (1), (2) and (4) are all useful assessment parameters in determining if tissue perfusion is adequate. An increased heart rate above 100bpm is not an indication of adequate tissue perfusion. Trends and patterns in levels of consciousness, skin color and turgor, urinary output above 30ml/hr, BP, CVP, etc. are all important parameters to be observed for in a patient with Sepsis.

102. 1. When removing a chest tube the physician will ask the patient to exhale and hold their breath, or exhale and bear down. This will serve to increase intrathoracic pressure, as well as prevent air from entering the pleural space.
103. 2. Water sealed chest drainage is designed to remove air and/or fluid from the pleural cavity, and to restore negative pressure in the pleural cavity, which promotes the re-expansion of the lung. In observing the water-seal drainage system, the nurse can expect to see all of the above with the exception of Choice (2), as continuous bubbling can indicate a possible air leak in the system.

104. 3. While choice (1) and (2) are important parts of nursing care for the patient in this type of traction, Choice (3) would be the priority in order to detect complications, if any, early on. Use of a special mattress to prevent skin breakdown and checking the ropes, pulleys, etc. q shift, and traction tapes for tenderness or pressure, are also important nursing responsibilities. Traction should NEVER be released, nor change in tension or weight.

105. 1. Following Total Hip Replacement, the patient should be kept flat when in the recumbent position with the affected extremity placed in abduction. The nurse can accomplish this by placing a wedge or pillow between the patient's legs. Dislocation could result if the affected leg were to be placed in adduction. If positioning the patient on the unoperated side, it should only be to a maximum of 45 degrees, while maintaining the operated side in abduction.

106. 4. Choices (1), (2) and (3) are possible signs of a hip joint dislocation which can be the result of poor positioning (extreme adduction or flexion of affected joint), or infection. Choice (4) would NOT be associated with joint dislocation. A Babinski Reflex is movement of the big toe upward (dorsiflexed) vs. downward flexion, and fanning of the other toes. It is usually seen with upper motor neuron damage, as in patient's with stroke, etc.

107. 4. For Diabetics, certain conditions will cause a rise in the patient's blood sugar (hyperglycemia), among them is infection. As this patient has an elevated temperature, and elevated WBC of 15,000 (Normal is 5,000-10,000/mm3) indicative of an infectious process, the nurse can expect that the patient is likely to be hyperglycemic and the Insulin dose would need therefore, to be increased. Dosage will be determined by patient's usual dose and blood glucose value(s).

108. 2. In addition to infection, this patient is also demonstrating Kussmaul's Respirations, which are deep, rapid, blowing like respiration, associated with ketoacidosis in the diabetic. The deep, rapid respirations are the body's attempt to compensate for this acidic state by blowing off Carbon Dioxide. The nurse should recognize these signs and symptoms as well as be aware that the patient will also have an increase in the number of circulating ketone bodies (a breakdown product from the metabolism of fat), contributing to the acidotic state. Therefore, blood should be obtained immediately for acetone and glucose, so that the body's homeostatic state can be restored. Choices (1) and (3) may also be part of subsequent nursing interventions and choice (4) is unlikely.

109. 3. The nurse would term this type of drainage serosanguinous, composed of fluid (clear and watery) serous drainage, and cells that escape from blood vessels (red/red tinged). Choice (1) - Serous drainage is watery and clear in its appearance. Choice (2) - Sanguinous drainage is blood like and bright red in appearance if fresh, and darker if the blood is old. Choice (4) - purulent drainage refers to drainage which is made up of cellular debris, white blood cells and bacteria.

110. 4. Medications to suppress the vestibular system and other drugs such as those in choice (2) serve to improve tinnitus. Restricting dietary intake of sodium and adequate hydration have proved useful in some patients to diminish vertigo. Choice (4) has no proven place in the treatment of Meniere's.
111. 1. Choice (2) Beta Agonists, are usually the initial drugs used and serve to dilate bronchial smooth muscle. Methylxanthines are among the most commonly used bronchodilators and include Aminophylline and Theophylline. Corticosteroids, which may be administered IV, or through inhalation help to reduce inflammation and reduce bronchospasm. Calcium Channel Blockers are not used in the treatment of Asthma.

112. 3. Among the most commonly lab values disturbances encountered with patients on long term Corticosteroid therapy are hypokalemia, hypocalcemia and hyperglycemia. The nurse should also be aware of the physical signs and symptoms associated with the above laboratory changes such as nausea, vomiting and muscle weakness, associated with hypokalemia, serum value of less than 3.5mg/dl, elevated BP, sodium and water retention, osteoporosis, especially in the elderly, and excessive thirst, hunger and/or urination associated with hyperglycemia.

113. 2. The major complication of thromboembolytic therapy is hemorrhage, and the antidote for this is Amicar, which aids in the stoppage of bleeding by inhibiting plasminogen, which inhibits thrombolysis. This drug should be available for any patient on this type of thromboembolytic therapy. Choices (1) and (3) are the antidotes for Heparin and Coumadin, respectively. Choice (4), Heparin, is not correct, as it is an anticoagulant.

114. 3. Incentive Spirometry is used post-operatively especially after thoracic and abdominal surgery to prevent collapse of the air passages or atelectasis. In assisting the patient, the nurse should employ choices (1), (2) and (4) and although it is more effective with the head of the bed elevated, it can be performed from any position. It should be started immediately as atelectasis can start as soon as one hour post-operatively.

115. 1. Surgical incisions, and small sutured incisions usually heal by what is called Primary Intention. In surgical incisions and the like where the edges of the wound can be approximated, healing takes place in this way. In larger wounds, when the edges cannot be approximated Secondary Intention is the usual manner of healing, the Tertiary intention occurs when there is an extended period of time between the wound and when it is sutured.

116. 1. Hep B is now a required immunization. The first dose is given at birth.

117. 2. Increasing IV fluids will address a possible hypovolemia and therefore increase fetal perfusion.

118. 3. Evaluating fetal well being is of highest priority and will direct subsequent interventions.

119. 2. Seminal fluid contains prostaglandins which causes cervical dilation. Intercourse may stimulate cervical dilation.

120. 3. This is protocol 076 and has been found to decrease transmission of HIV from 30% to 7%.

**Part 8: Infection Control**

1: What did HAI's USED to be known as?
A. Healthcare Associated Infections or Nosocomial Infections
2: For an infection to be defined as "healthcare acquired" what criteria needs to be met?

C. There must have been no evidence an infection present or incubating at the time of admission. This includes hospitals and nursing homes.

3: According to the Center for Disease Control, what constitutes the single most important procedure in the prevention of infections?

D. Handwashing using a mild soap and water or an alcohol-based solution if no water is available.

4: Respiratory and cough etiquette includes:

B. Covering the mouth and nose when sneezing and coughing. If tolerated, the patient should wear a mask for persistent coughing and sneezing.

5: VRE, or Vancomycin Resistant Enterococcus:

A. May be spread by direct contact or by indirect contact with surfaces or contaminated equipment. Contact precautions should be used and all surfaces should be cleaned as much as possible.

6: What has contributed to the increase in the incidence of clostridium difficile?

A. Overuse, misuse and imprudent use of antibiotics. This is a big problem in the United States where antibiotics are often given for the common cold which is a virus!

7: Which is not considered a potentially infectious material?

D. Sweat. The body had its own sweat glands. Sweat glands are not infectious.

8: If hands are not visibly soiled, which hand cleaner is strongly encouraged by the CDC and JCAHO standards?

A. Alcohol-based hand cleaners. The alcohol is known to kill bacteria.

9: If a physician is not available to give an order, a patient can't be placed in isolation.

B. The nurse can place the patient in isolation and notify the physician as soon as possible. Being safe never hurts anything and this can prevent nosocomial infections.

10: The most frequent HAI is:

C. UTI’s This is mostly due to the insertion and reinsertion of foley catheters. Remember, this is a sterile procedure that many people forget to follow.

True or False Questions:
11. Standard precautions require that masks be worn at all times.  
False
The use of gloves when touching any body fluids, mucous membranes, and non-intact skin.  
Gowns and face protection, such as masks and goggles, or face shields, should be worn whenever there is a danger of splashing liquids or creating aerosols during a specific procedure or process.

12. Early isolation theory concentrated on those patients who were diagnosed with or strongly suspected of having an infectious process.  
True
Early isolation standards required that patients be placed under isolation protocols when an infectious process was diagnosed or strongly suspected. Patients were assigned isolation protocols based on a system that categorized them according to the type of disease and its primary method of transmission. These seven basic categories—wound and skin, respiratory, enteric, drainage, blood precautions, strict and protective isolation—were used to provide a means to identify and categorize isolation types. As infection control knowledge increased, emphasis was placed on a different protection strategy that looked upon all blood and body fluids from all patients as potentially infectious, regardless of the patient's diagnosis.

13. Transmission-based precautions are designed to be used in conjunction with standard precautions.  
True
Transmission-based precautions are not designed as stand-alone isolation systems but are designed to supplement standard precautions protocols. For that reason, transmission-based protocols must always be used in conjunction with standard precautions isolation techniques. Transmission-based precautions are divided into three basic categories: contact, airborne, and droplet.

14. Standard precautions need only be implemented when blood is visible.  
False
Standard precautions also require that the same protocols be followed when blood may not be visible. This includes, for example, body secretions, excretions, body fluids (with the exception of sweat), broken skin, and mucous membranes.

15. Contact precautions guidelines include the use of gloves when coming into contact with a patient's unbroken skin.  
True
Contact Precautions. These precautions are designed to stop the spread of bacteria via direct contact, for example, skin to skin contact and indirect contact, which is usually the result of a person making contact with a contaminated inanimate object.
Contact precautions include wearing gloves when making contact with the patient's skin or with inanimate objects that have been in direct contact with the patient. They may also include the use of gowns when there is a likelihood that the healthcare worker's clothing will come in contact with the patient or items in the patient's room.
16. Employees with no formal education in microbiology should receive training in methods of bacterial transmission.
True
When preparing employees to work within the established infection control system, every effort should be made to ensure that employees not only know what to do but also why it is important. Failure to establish a risk/benefit factor during the education process may lead to the relaxing of protocols later on.

17. Standard precautions should be followed with all patients.
True.
This protects the patient as well as yourself.

18. Airborne bacteria may stay suspended in the air for an extended period of time.
True
Guidelines include the use of respiratory protection and the use of special air handling systems to control the airborne bacteria.

19. Droplet precautions require the use of a respirator.
False
Droplet precautions protect healthcare workers, visitors, and other patients from droplets, which may be expelled during coughing, sneezing, or talking. Guidelines include using a mask when working in close proximity to the patient. Specific guidelines for the transport and placement of patients, and the environmental management of equipment, etc. should be implemented according to each category's requirements.

20. Since airborne bacteria can be dispersed by air currents, patients in airborne precautions should be placed in rooms that have specialized air handling systems.
True
Guidelines for patient placement—from the use of a private room to using a room with special air handling capabilities—should be implemented as well.

Part 9: *These questions are shared from a P2P Program. The source and the compiler is unknown and to the best of Caring 4 You . Net knowledge these questions do not impose on the integrity of the nclex.*

Answers to Nclex 37 Questions
1. (A) and (B) are both contraindicated with pregnancy.
2. (F) All of the others have can cause photosensitivity reactions.
3. (D) All of the others can cause urine discoloration.
4. (A) Corgard could be removed from the refrigerator.
5. (D) IgG is the only immunoglobulin that can cross the placental barrier.
6. (B) AZT treatment is the most critical intervention.
7. (C) Autonomic neuropathy can cause inability to urinate.
8. (B) All of the clinical signs and systems point to a condition of anorexia nervosa.
9. (B) Hypercalcaemia can cause polyuria, severe abdominal pain, and confusion.
10. (C) Rho gam prevents the production of anti-RH antibodies in the mother that has a Rh positive fetus.

11. (D) Choice A is linked to Plague, Choice B is linked to peptic ulcers, Choice C is linked to Cholera.
12. (A) Choice B is linked to Rheumatic fever, Choice C is linked to Anthrax, Choice D is linked to Endocarditis.
13. (D) A CT scan would be performed for further investigation of the hemiparesis.
14. (C) Weight gain and poor temperature tolerance indicate something may be wrong with the thyroid function.
15. (C) Blood cultures would be performed to investigate the fever and rash symptoms.
16. (A) With a history of diabetes, the first response should be to check blood sugar levels.
17. (C) Age is not the greatest factor in potty training. The overall mental and physical abilities of the child is the most important factor.
18. (C) The poison control center will have an exact plan of action for this child.
19. (C) Vastus lateralis is the most appropriate location.
20. (D) In this case you are able to determine the name of the child by the father’s statement. You should not withhold the medication from the child following identification.
21. (B) Discharge education begins upon admission.
22. (B) Initiative vs. guilt- 3-6 years old
23. (A) Trust vs. Mistrust- 12-18 months old
24. (D) Intimacy vs. isolation- 18-35 years old
25. (B) HR and Respirations are slightly increased. BP is down.
26. (A) Elavil is a tricyclic antidepressant.
27. (D) Erythromycin is used to treat conditions A-C.
28. (D) Answer choices A-C were symptoms of acute hyperkalemia.
29. (C) Weight loss would be expected.
30. (A) Loss of appetite would be expected.
31. (D) The effects of PKU stay with the infant throughout their life.
32. (D) Aspirin overdose can lead to metabolic acidosis and cause pulmonary edema development.
33. (D) This patient’s safety is your primary concern.
34. (C) The bronchodilator will allow a more productive cough.
35. (B) Weight gain is associated with CHF and congenital heart deficits.