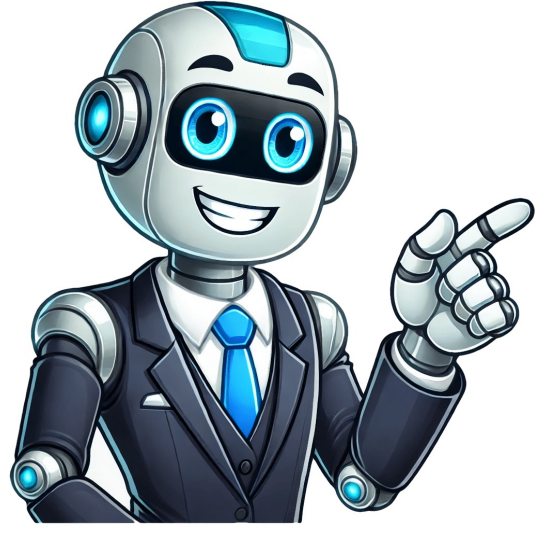


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Administration of IV benzodiazepines (e.g., lorazepam) to stop prolonged seizure activity. A nurse is caring for a client with deep vein thrombosis (DVT). Which action should be avoided? A) Elevating the affected limb B) Applying compression stockings C) Encouraging ambulation D) Administering anticoagulants Answer: C) Encouraging ambulation Explanation: Ambulation may dislodge the clot, increasing the risk of pulmonary embolism. The client should rest with the leg elevated. A nurse is assisting a client experiencing a myasthenic crisis. What is the priority intervention? A) Administer corticosteroids B) Ensure airway patency C) Offer high-calorie snacks D) Encourage deep breathing exercises Answer: B) Ensure airway patency Explanation: Myasthenic crisis can lead to respiratory failure. Ensuring a patent airway is the highest priority. A client reports severe headache. Which lab value is most concerning? A) Elevated amylase and lipase B) White blood cell count C) High hemoglobin levels D) Decreased bilirubin Answer: A) Elevated amylase and lipase Explanation: Hemorrhagic pancreatitis often presents with a sudden, intense headache due to bleeding in the brain. A nurse is caring for a client with pancreatitis. Which lab value is most concerning? A) Elevated amylase and lipase B) White blood cell count C) High hemoglobin levels D) Decreased bilirubin Answer: A) Elevated amylase and lipase Explanation: Hemorrhagic pancreatitis often presents with a sudden, intense headache due to bleeding in the brain. A nurse is caring for a client with pancreatitis. Which lab value is most concerning? A) Elevated amylase and lipase B) White blood cell count C) High hemoglobin levels D) Decreased bilirubin Answer: A) Elevated amylase and lipase Explanation: Hemorrhagic pancreatitis often presents with a sudden, intense headache due to bleeding in the brain.

A client with schizophrenia is experiencing auditory hallucinations. What is the best nursing response? A) "I don't hear the voices. Are they telling you to hurt yourself?" B) "You need to ignore those voices because they are not real." C) "Why do you think you are hearing voices?" D) "I will turn on the TV so you won't hear them anymore." Answer: A) "I don't hear the voices. Are they telling you to hurt yourself?" Explanation: Validating the client's experience while assessing for risk of harm is an appropriate nursing intervention for hallucinations. A nurse is reinforcing teaching with a client prescribed warfarin. Which statement indicates a need for further teaching? A) "I will avoid green leafy vegetables." B) "I will hear my INR checked regularly." C) "I will take aspirin if I have a headache." D) "I should report any unusual bruising or bleeding." Answer: C) "I will take aspirin if I have a headache." Explanation: Aspirin increases the risk of bleeding when taken with warfarin. Clients should avoid NSAIDs and use acetaminophen instead. A nurse is caring for a client experiencing an anaphylactic reaction. What is the priority nursing action? A) Administer diphenhydramine B) Give epinephrine intramuscularly C) Provide a bronchodilator D) Place the client in the Trendelenburg position Answer: B) Give epinephrine intramuscularly Explanation: Epinephrine is the first-line treatment for anaphylaxis, as it counteracts severe bronchoconstriction and hypotension. A client with cirrhosis is receiving lactulose. What is the expected outcome? A) Decreased ammonia levels B) Increased stool frequency C) Improved mental status D) Reduced ascites Answer: B) Increased stool frequency Explanation: Lactulose softens stools by drawing water into the intestines. A client is receiving insulin. Which assessment finding requires immediate intervention? A) Blood glucose level of 6.2 mEq/L B) Diluted urine output C) Mixed with normal saline and given rapidly D) Administered undiluted through a central line Answer: B) Diluted urine output Explanation: Potassium should always be diluted and infused at a controlled rate to prevent cardiac arrhythmias. It should never be given IV push. Which client is at the highest risk for developing a pressure ulcer? A) Client with urinary incontinence and limited mobility B) Client with diabetes and controlled blood glucose C) Client who ambulates with assistance twice daily D) Client who is receiving IV fluids and eating well Answer: A) Client with urinary incontinence and limited mobility Explanation: Incontinence increases skin breakdown, and immobility prevents repositioning, leading to a higher risk of pressure ulcers. A nurse is reinforcing teaching about digoxin. Which symptom should the client report immediately? A) Increased appetite B) Blurred vision and nausea C) Weight gain of 1 lb in a week D) A blood pressure reading of 120/80 mmHg Answer: B) Blurred vision and nausea Explanation: These are signs of digoxin toxicity. Other symptoms include confusion, bradycardia, and yellow halos around lights. A nurse is caring for a client post-surgery who suddenly develops shortness of breath and chest pain. What is the priority action? A) Administer a bronchodilator B) Encourage deep breathing and coughing C) Notify the healthcare provider immediately D) Elevate the head of the bed and provide oxygen Answer: C) Notify the healthcare provider immediately Explanation: These symptoms suggest a pulmonary embolism. Raising the head of the bed and providing oxygen helps improve oxygenation while notifying the provider. Which intervention is appropriate for a client receiving continuous enteral tube feeding? A) Position the client flat while feeding B) Check residual volume every 8 hours C) Flush the tube with water regularly D) Hold feedings if the client reports hunger Answer: B) Check residual volume every 8 hours Explanation: Checking residuals helps prevent aspiration. Flushing the tube with water regularly keeps it patent. A client is receiving insulin. Which assessment finding requires immediate intervention? A) Blood glucose level of 6.2 mEq/L B) Diluted urine output C) Mixed with normal saline and given rapidly D) Administered undiluted through a central line Answer: B) Diluted urine output Explanation: Potassium should always be diluted and infused at a controlled rate to prevent cardiac arrhythmias. It should never be given IV push. Which client is at the highest risk for developing a pressure ulcer? 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A client is receiving insulin. Which assessment finding requires immediate intervention? A

Explanation: Digoxin can cause bradycardia; hold the dose if the heart rate is below 60 bpm. A nurse is reinforcing discharge teaching for a client with heart failure. Which statement indicates understanding?A) "I should weigh myself daily." B) "I can drink unlimited fluids." C) "I should avoid potassium-rich foods." D) "I will stop taking my diuretic if I feel better." Answer: A) "I should weigh myself daily." Explanation: Daily weights help detect fluid retention early. A nurse is reviewing dietary choices with a client on a low-sodium diet. Which food should the client avoid?A) Fresh fruit salad B) Grilled chicken breast C) Canned soup D) Steamed vegetablesAnswer: C) Canned soup Explanation: Canned soups are high in sodium and should be avoided. A nurse is reinforcing teaching about metformin for a client with type 2 diabetes. Which instruction is correct?A) "Take the medication on an empty stomach." B) "This medication may cause low blood sugar." C) "Stop taking the medication before a contrast dye procedure." D) "Monitor for weight gain while taking this medication." Answer: C) "Stop taking the medication before a contrast dye procedure." Explanation: Metformin should be held before contrast dye procedures to prevent lactic acidosis. A nurse is monitoring a client with increased intracranial pressure (ICP). Which finding requires immediate intervention?A) Blood pressure of 140/90 mmHg B) Heart rate of 48 beats per minute C) Respiratory rate of 18 breaths per minute D) Temperature of 99°F (37.2°C)Answer: B) Heart rate of 48 beats per minute Explanation: Bradycardia with hypertension and irregular respirations (Cushing's triad) indicates increased ICP. A nurse is reinforcing teaching for a client taking prednisone. Which statement indicates a need for further teaching?A) "I should not stop taking this medication suddenly." B) "I should take the medication with food." C) "I will avoid crowded places." D) "I can stop taking the medication when I feel better." Answer: D) "I can stop taking the medication when I feel better." Explanation: Steroids must be tapered gradually to prevent adrenal insufficiency. A nurse is reinforcing dietary teaching for a client with iron-deficiency anemia. Which food is the best source of iron?A) Chicken breast B) Oranges C) Spinach D) White riceAnswer: C) Spinach Explanation: Dark leafy greens like spinach are high in iron. A nurse is assisting with a lumbar puncture. Which position should the client be placed in?A) Supine with the head of the bed at 30 degrees B) High Fowler's position C) Side-lying with the knees drawn to the chest D) Prone with the arms extendedAnswer: C) Side-lying with the knees drawn to the chest Explanation: This position increases the space between vertebrae, allowing easier needle insertion. A nurse is reinforcing teaching about nitroglycerin. Which side effect should the client expect?A) Dry mouth B) Headache C) Bradycardia D) ConstipationAnswer: B) Headache Explanation: Nitroglycerin causes vasodilation, which can lead to headaches. A nurse is monitoring a client on heparin therapy. Which laboratory value should be monitored?A) INR B) Platelets C) aPTT D) HemoglobinAnswer: C) aPTT Explanation: Heparin effectiveness is monitored using aPTT. A nurse is assisting in the care of a client with a chest tube. Which action is appropriate?A) Clamp the chest tube routinely B) Strip the chest tube frequently C) Keep the drainage system below chest level D) Empty the drainage chamber every shiftAnswer: C) Keep the drainage system below chest level Explanation: Keeping it below chest level prevents fluid from re-entering the pleural space. A nurse is caring for a client with Addison's disease. Which dietary choice is appropriate?A) Low-sodium, low-potassium diet B) High-sodium, low-potassium diet C) High-sodium, high-potassium diet D) Low-sodium, high-protein dietAnswer: B) High-sodium, low-potassium diet Explanation: Addison's disease causes sodium loss and potassium retention. A nurse is reinforcing teaching for a client prescribed warfarin. Which food should the client limit?A) Bananas B) Green leafy vegetables C) Yogurt D) ApplesAnswer: B) Green leafy vegetables Explanation: These are high in vitamin K, which counteracts warfarin. A nurse is caring for a client in the manic phase of bipolar disorder. Which intervention is most appropriate?A) Encourage group therapy B) Provide frequent snacks and hydration C) Allow unlimited activity D) Discourage movementAnswer: B) Provide frequent snacks and hydration Explanation: Clients in mania may neglect nutrition and hydration. A nurse is reinforcing teaching about a clear liquid diet. Which food is allowed?A) Milk B) Chicken broth C) Orange juice with pulp D) Scrambled eggsAnswer: B) Chicken broth Explanation: Clear liquids include broth, gelatin, and clear juices. A nurse is reinforcing discharge teaching for a client with a newly placed colostomy. Which statement indicates understanding?A) "I will avoid drinking fluids to reduce stool output." B) "I will empty the pouch when it is half full." C) "I can take laxatives daily to keep my stool soft." D) "I will limit my diet to soft foods permanently." Answer: B) "I will empty the pouch when it is half full." Explanation: A full pouch may cause leakage.

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