Practice Exam Questions

ANCC
AMERICAN NURSES CREDENTIALING CENTER

MEDSURG-BC

Medical-Surgical Nursing

EXAMKILLER
Help Pass Your Exam At First Try

Total Question: 600 QAs

Question No: 1
A client with acute pulmonary edema secondary to congestive heart failure has continuous monitoring of ventral venous pressure (CVP). Which of the following conditions indicates that the client's treatment regimen is effective?
A. Central venous pressure increases
B. Central venous pressure decreases
C. There is no change in the central venous pressure
D. Central venous pressure is not a useful indicator for this client
Answer: B
Explanation: Decreased central venous pressure indicates decreased fluid in the vascular space, one of the goals of treatment for this client. Choice A is incorrect because increased central venous pressure indicates increased fluid in the vascular space, which is not a desired goal. Choice C is incorrect because no change in central venous pressure indicates no change in the vascular fluid volume. Choice D is incorrect because central venous pressure is an accepted indicator of vascular fluid status.

Question No: 2
Mr. Nelson, 64 years old, is prescribed sublingual nitroglycerine for the treatment of angina pectoris. What response from the client indicates that he understands this medication?
A. "Will the physician give me a year's supply of nitroglycerine tablets?"
B. "I will carry my nitroglycerine tablets in the inside pocket of my jacket so they are always close."
C. "I usually take three of my nitroglycerine tablets at the same time. I find that they work better that way."
D. "I have a small labeled case for a few nitroglycerine tablets that I carry with me when I go out."
Answer: D
Explanation: Nitroglycerine loses potency over time when exposed to light and heat. The tablets should be kept cool, dry, and in a dark container. Clients should get a new bottle every 6 months and store in a cool place; tablets should be taken 5 minutes apart, taking more than one tablet at a time can actually decrease the effectiveness of the drug and may cause severe hypotension.

Question No: 3
Mr. Snider, a 53-year-old Gulf veteran, underwent a percutaneous transluminal coronary angioplasty (PTCA). Four hours after the procedure, the nurse reviewed his chart and noticed no vital signs and no change in the catheter was initiated since his return. The nurse obtains a 12-lead ECG and notes that the client has ST depressions. Mr. Snider denies any chest pain. Which of the following is the next action that the nurse should take?
A. Notify the physician
B. Continue to assess the client for chest pain
C. Administer nitroglycerine
D. Apply pressure to the catheter site
Answer: A
Explanation: The physician should be notified immediately because ST depressions are a sign of ischemia. This is the best first action, after which the nurse should continue to assess the client for chest pain (Choice B).

Choice C is not an appropriate nursing action. There is no sign of bleeding at the site; therefore, there is no indication to apply pressure (Choice D).

Question No: 4
The nurse is caring for Mrs. Guzman, a 47-year-old Filipina broker, on the 3rd postoperative day after coronary artery bypass (CABG) surgery. Because an important nursing diagnosis for post-CABG clients is ineffective breathing pattern, what is the best plan by the nurse?
A. Ensure that Mrs. Guzman performs deep breathing and vigorous coughing every hour
B. Ensure that Mrs. Guzman uses the incentive spirometer every hour
C. Pre-medicate Mrs. Guzman before ambulation
D. Auscultate lungs once a shift
Answer: B
Explanation: Incentive spirometry and deep breathing are the preferred techniques for lung expansion with these clients. Vigorous coughing is discouraged for post-CABG clients because it may increase intrathoracic pressure and cause instability in the sterna area (Choice A). Premedication before ambulation (Choice C) will facilitate activity intolerance, not effective breathing pattern; auscultating lungs (Choice D) will detect adventitious lung sounds resulting from the ineffective breathing pattern, but it is not an action to encourage effective breathing pattern

Question No: 5
A hospitalized client has continuous ECG monitoring and the monitor shows that the rhythm has changed to ventricular tachycardia. Which of the following is the first action that the nurse should take?
A. Administer intravenous lidocaine according to emergency protocol
B. Obtain the defibrillator and defibrillate the client
C. Quickly assess the client's level of consciousness, blood pressure, and pulse
D. Administer a precordial thump
Answer: C
Explanation: The best first action is to assess the client's level of consciousness and assess if the ventricular tachycardia is perfusing the body (BP, pulse). With pulseless ventricular tachycardia, immediate defibrillation (Choice B) is performed by an ACLS certified nurse. If the client has good BP and pulse, is awake, and is alert, the nurse may administer lidocaine as prescribed (Choice A) or in some cases, administer a precordial thump (Choice D).

Question No: 6
The physician has diagnosed a myocardial infarction on the basis of ECG changes for Mr. Montgomery, a 67-year-old retired College professor, who was rushed to the Emergency Department after collapsing in his front yard. The nurse is assessing Mr. Montgomery frequently and notes that he seems forgetful, making the nurse repeat the explanations about the ECG and non-invasive blood pressure monitors. The nurse concludes that Mr. Montgomery's response is most likely due to which of the following reasons?
A. Mr. Montgomery is showing signs of Alzheimer's disease
B. Mr. Montgomery is showing signs of fear and anxiety
C. Nurses in the Emergency Department are too busy to properly explain the purpose of the equipment
D. Memory lapses are common with clients experiencing myocardial infarction
Answer: B

Explanation: Anxiety and fear are common responses to a diagnosis of myocardial infarction because of the possibility of death. This prevents the client and family from absorbing detailed explanations about the care being provided. Memory lapses are not a common symptom of myocardial infarction (Choice D) and there is not adequate information to determine that this memory lapse is associated with Alzheimer's disease (Choice A). Nurses in the Emergency Department are able to explain procedures well to their clients (Choice C).

Question No: 7
Mrs. Jenkins, 38 years old, is admitted to the Cardiac Care Unit due to complications of congestive heart failure. To evaluate the client's cardiac status, the doctor orders cardiac catheterization. The nurse reviews Mrs. Jenkins' chart following the procedure and notes the ejection fraction is 0.3 or 30% of normal. The nurse would expect the plan of care to focus on:
A. Management of pain from angina episodes
B. Inability to perform self-care caused by fatigue
C. Impaired motor and sensory function in extremities
D. Reducing risk of stroke (brain attack) from hypertension
Answer: B
Explanation: The cardiac output is significantly reduced and perfusion will be impaired, leading to almost overwhelming fatigue. Choice A is incorrect because the ejection fraction is measuring cardiac output, not coronary artery disease. Systemic perfusion will be compromised and the client will experience extreme fatigue. Choice C is incorrect because the problem is not neurological. Choice D is incorrect because the client's blood pressure will be low, not high.

Question No: 8
Michelle, a 24-year-old intern, was diagnosed with mitral stenosis. Aside from noticing a murmur during the physical examination, the nurse may also find:
A. Dyspnea upon exertion
B. Jugular vein distention
C. Syncope on exertion
D. Angina
Answer: B
Explanation: Mitral stenosis results in enlargement of the left atrium which over time, increased pulmonary pressure and jugular vein distention. Dyspnea on exertion and syncope on exertion are associated with aortic valve abnormalities (choices A and C). Angina is associated with aortic stenosis (Choice D).

Question No: 9
Which client is at greatest risk for developing hypertension?
A. Mr. Lincoln, a 52-year-old Caucasian with a family history of hypertension and heart disease
B. Mrs. Franklin, a 50-year-old African-American who is 24 pounds overweight
C. Mr. Bush, a 52-year-old African-American who smokes cigarettes
D. Mr. Carter, a 67-year-old Caucasian with diabetes
Answer: C
Explanation: African-American men are at greatest risk of developing hypertension; and this client is a smoker, which is a considered a major risk factor. While all the other clients have contributing factors to hypertension, smoking is still considered the major risk factor for hypertension.

Question No: 10
The nurse is developing a plan for Mrs. Ramos, a 38-year-old housewife, who is going home with a new diagnosis of heart failure. The nurse is teaching Mrs. Ramos to monitor fluid status. Which of the following is the best instruction?
A. Restrict fluid intake to 800ml per day
B. Increase the dose of diuretics if there is decreased urination
C. Record body weight every day before breakfast and report a weight gain of 3 or more pounds in a week
D. Keep track of daily output and call the doctor for if it is less than 1 liter on any day
Answer: C
Explanation: Daily weight is the most sensitive indicator of changes in fluid status. It is more accurate for a client at home than urine output. Fluid restriction may be recommended for a client with advanced heart failure, but it is not a method of monitoring fluid status. The client should never adjust the dose of his or her medications.

Question No: 11
Mr. Ambrose, 41 years old, has a blood pressure of 170/96 after 6 months of intensive exercise and diet modifications, which his doctor prescribed for him. The nurse advises him:
A. To continue current treatment plan, as blood pressure is being adequately controlled.
B. To discontinue current treatment plan, as it has not been effective and medications will be required.
C. To increase his exercise by two-fold and continue dietary modifications to attempt to lower blood pressure further.
D. That medication therapy will likely need to be started along with exercise and diet program.
Answer: D
Explanation: Blood pressure should be consistently below 140/90. Lifestyle modification should be used in all hypertensive clients with or without medication therapy.

Question No: 12
Which of the following findings in a client awaiting abdominal aortic aneurysm repair would you report immediately to the physician?
A. Severe back pain
B. Swelling of the arms and face
C. Increased blue areas of the feet
D. Hoarseness or difficulty swallowing
Answer: A
Explanation: The primary symptom of a dissecting aneurysm is sudden, severe pain. Abdominal dissections commonly cause back pain. The other responses don't address this emergency.

Question No: 13
A client has been receiving intravenous heparin therapy for the treatment of deep vein thrombophlebitis. In addition, the physician orders warfarin sodium (Coumadin) without discontinuing the heparin infusion. The client questions the nurse about the simultaneous use of both medications. What is the nurse's best response?
A. "I will check with the doctor about this issue. You are certainly at greater risk for bleeding with both of these medications."

B. “Because you are at risk of experiencing a pulmonary embolism, it is important for you to have additional anticoagulant.”
C. “It takes several days for the Coumadin to have an effect, so we need to keep you on heparin for a few more days.”
D. “Because you are allowed more activity now, the heparin is metabolized more quickly and needs to be supplemented with Coumadin.”
Answer: C
Explanation: The client will remain on both medications until the appropriate international normalized ratio (INR) is reached. At that point, the heparin infusion will be discontinued.

Question No: 14
Jon Stark has been diagnosed with coronary artery disease. His physician requires him to have a low-fat, low-cholesterol diet. The nurse knows that Mr. Stark understands the diet plan if which entrée is selected?
A. Fried cod
B. Grilled chicken breast
C. Pasta with cream sauce
D. Broiled T-bone steak
Answer: B
Explanation: A reduction in intake of fat and cholesterol can reduce a person’s risk of cardiovascular disease. The client should consider both the type of food consumed and the method of preparation. Grilled chicken would be the best selection for a patient on a low-fat, low-cholesterol diet.

Question No: 15
Which intervention would be appropriate for the nurse to include when discussing foot care with a client with peripheral vascular disease? Select all that apply.
A. Dry the feet thoroughly after bathing
B. Cut off all corns and calluses
C. Educate the patient to break in new footwear to prevent tissue injury
D. Sit with the legs crossed to decrease swelling
E. Use constrictive clothing on the feet and ankles
Answer: A,C
Explanation: The goal of foot care in a patient with peripheral vascular disease is to maintain and promote tissue integrity. Prevention of tissue damage acts to prevent potential complications such as ulceration, infection, and gangrene. Interventions that will facilitate maintenance of tissue integrity include washing the feet with mild soap and warm water thoroughly after bathing and breaking in new footwear.

Question No: 16
The nurse is preparing to defibrillate a pulseless adult client. Which action demonstrates safe, appropriate use of defibrillator?
A. Apply the paddles to the right anterior and right posterior chest
B. Do not take the time to remove nitroglycerine ointment
C. Ensure that the device is placed on cardiovert
D. Notify all beside personnel to stand clear immediately prior to defibrillation
Answer: D

Explanation: Defibrillation is the delivery of an electrical current to deporalize a critical mass of myocardial cells. Prior to defibrillation of a client, a verbal communication of an impending shock must be made to ensure that everyone is clear of contact with the client. Contact with client, bed, or equipment during the delivery of the shock could result in electrical injury to the person involved.

Question No: 17
The nurse is providing discharge teaching for a client's family member on the administration of enoxaparin (Lovenox). Which action by the family member would indicate an understanding of the administration procedure for the drug?
A. An 18-gauge, 1½-inch needle is selected for injection
B. The family member administers the medication subcutaneously
C. The family member aspirates for blood return after the needle is inserted in the muscle
D. The same administration site is used for every injection
Answer: B
Explanation: Lovenox is an anticoagulant medication that is administered via the subcutaneous route. The medication is injected at the anterior lateral abdominal wall (ALAW), usually once or twice a day, or as directed by the physician. The administration site is changed for every injection, between right and left ALAW, to prevent bruising and bleeding.

Question No: 18
A man came in to the Emergency Department and says that he's having a severe headache. A blood pressure of 230/150 mmHg is found when the nurse obtained his vital signs. The patient is given nitroprusside (Nipride). What is the desired action of this drug?
A. It relaxes the smooth muscles of the arterioles and veins.
B. It reduces blood volume.
C. It blocks the action of angiotensin II.
D. It blocks the action of aldosterone on the kidneys.
Answer: A
Explanation: Nitroprusside is often the first-line medication used to manage hypertensive emergencies. This drug is administered by continuous intravenous infusion and is rapid acting. By relaxing the smooth muscles of the arterioles and veins, nitroprusside promotes vasodilation and reduces blood pressure.

Question No: 19
Mr. Turner, 50-year-old journalist with acute heart failure, is receiving digoxin and furosemide. What is the best indicator that this regimen is effective in removing excess fluid?
A. Decreased weight
B. Therapeutic digoxin level
C. Decreased swelling in the ankles
D. Pulse rate decreases to 84
Answer: A
Explanation: Daily weight more rapidly reflects changes in fluid status. Choice B is incorrect because effectiveness of any therapy requires that the client be clinically assessed, in addition to reviewing lab values. Choice C is incorrect because swelling may take some time to dissipate even after the client's vascular volume is stabilized. Choice D is incorrect because decreased pulse rate may occur for several reasons, not necessarily

because the heart failure is being managed effectively.

Question No: 20
Thirty minutes after left-heart catheterization, the client's blood pressure begins to drop. Which potential complication explains this?
A. Absent distal pulses
B. Increased pain at puncture site.
C. Nausea
D. Bleeding or hematoma at the puncture site
Answer: D
Explanation: Loss of circulating volume from the puncture site or into tissues surrounding the site can result in decreased blood pressure. Choice A is incorrect because absent distal pulses indicate a blockage in the artery, but will not necessarily be accompanied by decreased blood pressure. Choice B is incorrect because increased pain is more likely to result in increased blood pressure. Choice C is incorrect because nausea is more likely to result in increased blood pressure.

Question No: 21
The nurse notes that Shelly's ECG has a rate of 78 bpm, normal P waves that precede each QRS complex, PR intervals of 0.16 seconds, and a regular pattern of shortening and lengthening of P-P and R-R intervals. The nurse should:
A. Notify the physician STAT.
B. Call for a STAT 12-lead ECG.
C. Prepare the client for cardiac catheterization.
D. Document the client as having sinus arrhythmia.
Answer: D
Explanation: The characteristics described are consistent with sinus arrhythmia, a common and non-life-threatening arrhythmia. There is no emergency in this situation (Choices A and B). The characteristics described are consistent with a sinus arrhythmia. In addition, the characteristics described do not warrant cardiac catheterization (Choice C).

Question No: 22
Mr. Eliot James, a 51-year-old truck driver, was admitted in the Cardiac Care Unit for an anterior Myocardial Infarction. On the third of hospitalization, Mr. James becomes increasingly restless. Pulse rate has increased to 126 beats per minute. The first nursing action is to:
A. Do a partial physical assessment, which includes vital signs, pulmonary auscultation, and cognitive functions.
B. Ask if the client is upset, because depression is common on the third day of hospitalization.
C. Re-administer oxygen per nasal catheter (prongs or tongs) at 6 liters, because restlessness is an early sign of cerebral hypoxia.
D. Decrease the rate of intravenous infusion to prevent fluid volume overload.
Answer: A
Explanation: An early indication of cardiac decompression is tachycardia. Therefore, the client's vital signs, mentation, and pulmonary status should be assessed to rule out this complication of myocardial infarction. Other causes of tachycardia are hypovolemia, anxiety, and pain. Assessment of pain and emotional status can be determined during cognitive assessment. Choices B, C, and D are incorrect because actions such as

encouraging verbalization of feelings, administering oxygen, and decreasing the rate of intravenous infusion will be determined by the nurse's assessment of vital signs.

Question No: 23
Toby Hogan, 34-year-old editor, was recently diagnosed with subacute bacterial endocarditis (SBE). The nurse determines that the client understands the discharge teaching when he does which of the following?
A. Asks for a referral to a dietician for a low-sodium diet
B. Explains to his wife why he needs antibiotics before seeing the dentist
C. Asks when he can start to take his antibiotics in pill form
D. Explains his plans to quit smoking
Answer: B
Explanation: Once a client is diagnosed with SBE, he or she is at risk for repeated episodes. Taking prophylactic antibiotics prior to dental care is an important activity to prevent further infections. There is no routine sodium restriction with SBE (Choice A). Antibiotic treatment for SBE is given by the IV route for the entire course (Choice C). Although stopping smoking will decrease his risk factor for coronary artery disease, it does not affect the SBE (Choice D).

Question No: 24
The nurse is monitoring a client who has recently undergone pericardiocentesis. The nurse suspects cardiac tamponade after observing which of the following?
A. A rapid increase in blood pressure and flushing
B. Jugular vein distention (JVD) and narrowing pulse pressure
C. Bradycardia and bilateral crackles
D. Louder and harsher heart sounds
Answer: B
Explanation: When cardiac tamponade occurs, the restriction reduces stroke volume, cardiac output, and blood pressure. The right atrium is restricted, causing JVD and increasing pressure during diastole. While the decreased stroke volume decreases the volume during systole, the client compensates for decreased stroke volume and cardiac output by increasing heart rate. Because of decreased filling pressure, cardiac output drops and blood pumped from the right heart is reduced. Lung sounds are usually clear; heart sounds become more distant and muffled because they are heard through the fluid collection in the pericardium.

Question No: 25
The nurse is caring for a client with new onset of atrial fibrillation. The nurse anticipates that which of the following is a possible treatment for this dysrhythmia when it first develops?
A. External pacemaker application
B. Insertion of automatic internal cardiac defibrillator (AICD)
C. Synchronized cardioversion
D. Defibrillation.
Answer: C
Explanation: Synchronized cardioversion is most effective with new-onset atrial fibrillation. Pacemakers are indicted for heart block. AICDs are used for ventricular dysrhythmias and defibrillation is indicated for ventricular tachycardia.

Question No: 26
The nurse is conducting an assessment on Mr. See, a 50-year-old Chinese man, who is a cashier at a local store. Mr. See acknowledged that because of his work, he often stands 6 to 8 hours at a time. The nurse should inspect Mr. See for:
A. Capillary dysfunction
B. Buerger's disease
C. Varicosities
D. Aneurysms
Answer: C
Explanation: 50 percent of people over the age of 50 develop varicose veins and a major risk factor is standing for long periods of time at work. The other responses do not address this concern.

Question No: 27
Ms. Atkins, 33 years old, arrived at the unit for her cardiac stress test. Ms. Atkins reports that no breakfast was delivered this morning and she is hungry. Which of the following is the nurse's best action?
A. Bring the client coffee and toast
B. Explain that a client should have no food the morning of a cardiac stress test
C. Call the nutrition department and get the client's regular full breakfast
D. Have the nursing assistant get the client cereal with milk and orange juice
Answer: D
Explanation: The client should have a light meal with no caffeine before a cardiac stress test. Choices A, B, and C are incorrect because they do not follow the guideline.

Question No: 28
Mrs. J. Andrews is admitted with angina pectoris and was ruled out for a myocardial infarction. The nurse reviews her laboratory results and plans to include dietary teaching after noting that Ms. Andrews's lipid profile shows which of the following sets of values?
A. Cholesterol: 180, HDL: 40, triglycerides: 220
B. Cholesterol: 190, HDL: 40, triglycerides: 160
C. Cholesterol: 120, HDL: 25, triglycerides: 220
D. Cholesterol: 220, HDL: 40, triglycerides: 190
Answer: D
Explanation: A cholesterol level > 220 indicates elevated cholesterol; the ratio of HDL to total cholesterol of less than 1:5 indicates increased cardiovascular risk; triglycerides > 190 indicates increased risk, (exception: triglycerides > 190 without elevated cholesterol do not indicate increased cardiac risk until they reach 250.)

Question No: 29
A client tells the nurse that he has leg pains that begin when he walks, but cease when he stops walking. Which of the following conditions would the nurse assess for?
A. An acute obstruction in the vessels of the legs
B. Peripheral vascular problems in both legs
C. Diabetes
D. Calcium deficiency
Answer: B

Explanation: Intermittent claudication is a condition that indicates vascular deficiencies in the peripheral vascular system. If an obstruction were present, the leg pain would persist when the client stops walking. Low calcium level may cause leg cramps, but would not necessarily be related to walking.

Question No: 30
Rodrick Simpson a.k.a. "Crook", a 35-year-old gangster, was knifed in a street fight. He was admitted through the Emergency Department and is now in the ICU. An assessment of his condition reveals the following: respirations shallow and rapid, paradoxical pulse, CVP 15 cm H2O, BP 90mmHg systolic, skin cold and pale, and urinary output 60-100mL.hr for the last 2 hours. Analyzing these findings, the nurse will base a nursing diagnosis on the conclusion that the client has which one of the following conditions?
A. Hypovolemic shock
B. Cardiac tamponade
C. Wound dehiscence
D. Atelectasis
Answer: B
Explanation: All of the client's manifestations are found in both cardiac tamponade and hypovolemic shock except the increase in urinary output. In shock, urinary output decreases to less than 30mL/hr; thus, this is a sign that would distinguish hypovolemic shock from cardiac tamponade and from the basis for a nursing diagnosis.

Question No: 31
In preparation for discharge of a client with arterial insufficiency and Raynaud's disease, client teaching instructions should include:
A. Walking several times each day as part of an exercise routine
B. Keeping the heat up so that the environment is warm
C. Wearing TED hose during the day
D. Using hydrotherapy for increasing oxygenation
Answer: B
Explanation: The client's instructions should include keeping the environment warm to prevent vasoconstriction. Wearing gloves, warm clothes, and socks will also be useful in preventing vasoconstriction, but TED (thrombo-embolic deterrent) hose would not be therapeutic. Walking will most likely increase pain.

Question No: 32
A 45-year-old client with leg ulcers and arterial insufficiency is admitted to the hospital. The nurse understands that leg ulcers of this nature are usually caused by:
A. Decreased arterial blood flow secondary to vasoconstriction
B. Decreased arterial blood flow leading to hyperemia
C. Atherosclerotic obstruction of arteries
D. Trauma to the lower extremities
Answer: A
Explanation: Decreased arterial flow is a result of vasospasm. The etiology is unknown. It is more problematic in colder climates or when the person is under stress. Hyperemia occurs when the vasospasm is relieved.

Question No: 33

Mr. GB is diagnosed with thromboangiitis obliterans (Buerger's disease). As a nurse caring for her, it is essential for you to teach modifications to which risk factor of the disease?
A. Familial tendency
B. Cigarette smoking
C. Excessive stress
D. Diet low in vitamin C and iron
Answer: B
Explanation: Cigarette smoking. Buerger's disease may result in occlusion of the vessels and thrombus formation. It occurs predominantly in men between 20 to 55 years of age who smoke cigarettes or chew tobacco. A familial tendency is noted, but cigarette smoking is consistently a risk factor. Symptoms of the disease improve with smoking cessation.

Question No: 34
Arnold Swanson, a 54-year-old janitor of Middletown High School, suddenly felt a crushing chest pain while doing his early chores one morning. He called for his neighbor to drive him to the nearest hospital. Upon arrival in the Emergency Department, the doctor ordered for a 12-lead ECG to determine a possible myocardial infarction. The nurse would know that an early finding in the ECG of a client with an infarcted myocardium would be:
A. Disappearance of QRS complex
B. Elevated ST segments
C. Absence of P wave
D. Flattened T waves
Answer: B
Explanation: Elevated ST segments. This is a typical early finding after a myocardial infarct because of the altered contractility of the heart. The other choices are not typical of MI.

Question No: 35
Arnold Swanson, who had a myocardial infarction 2 days ago, has been complaining to the nurse about issues related to his hospital stay. The best initial nursing response would be to:
A. Allow him to release his feelings and then leave him alone to allow him to regain his composure.
B. Refocus the conversation on his fears, frustrations, and anger about his condition.
C. Explain how his being upset dangerously disturbs his need for rest.
D. Attempt to explain the purpose of different hospital routines.
Answer: B
Explanation: Refocus the conversation on his fears, frustrations, and anger about his condition. This provides the opportunity for the client to verbalize feelings underlying behavior and can be helpful in relieving anxiety. Anxiety can be a stressor that can activate the sympatho-adrenal response, causing the release of catecholamines that can increase cardiac contractility and workload that can further increase myocardial oxygen demand.

Question No: 36
Mr. Ong, a 61-year-old cook in a Chinese restaurant, is admitted to the hospital with a diagnosis of Left-sided CHF. In the assessment, the nurse should expect to find:
A. Crushing chest pain

B. Dyspnea on exertion
C. Extensive peripheral edema
D. Jugular vein distention
Answer: B
Explanation: Dyspnea on exertion. Pulmonary congestion and edema occur because of fluid extravasation from the pulmonary capillary bed, resulting in difficult breathing. Left-sided heart failure creates a backward effect on the pulmonary system that leads to pulmonary congestion.

Question No: 37
Mr. Ong, a client with CHF, has been receiving a cardiac glycoside, a diuretic, and a vasodilator drug. His apical pulse rate is 44 and he is on bed rest. The nurse concludes that his pulse rate is most likely the result of the:
A. Diuretic
B. Vasodilator
C. Bed-rest regimen
D. Cardiac glycoside
Answer: D
Explanation: Cardiac glycoside. A cardiac glycoside such as digitalis increases force of cardiac contraction, decreases the conduction speed of impulses within the myocardium, and slows the heart rate.

Question No: 38
Thrombus formation is a danger for all postoperative clients. The nurse should act independently to prevent this complication by:
A. Encouraging adequate fluids
B. Applying elastic stockings
C. Gently massaging the legs with lotion
D. Performing active-assistive leg exercises
Answer: D
Explanation: Performing active-assistive leg exercises. Inactivity causes venous stasis, hypercoagulability, and external pressure against the veins, all of which lead to thrombus formation. Early ambulation or exercise of the lower extremities reduces the occurrence of this phenomenon.

Question No: 39
Mr. Josef Braga was ordered Digoxin 0.25 mg. OD. The nurse should include in her teaching plan how this drug affects Mr. Braga's condition. Which statement is poor knowledge regarding this drug?
A. It has positive inotropic and negative chronotropic effects.
B. The positive inotropic effect will decrease urine output.
C. Toxicity can occur more easily in the presence of hypokalemia, liver, and renal problems.
D. Do not give the drug if the apical rate is less than 60 beats per minute.
Answer: B
Explanation: The positive inotropic effect will decrease urine output. Inotropic effect of drugs on the heart causes increased force of its contraction. This increases cardiac output that improves renal perfusion, resulting in an improved urine output.

Question No: 40

The nurse is teaching the client regarding his permanent artificial pacemaker. The nurse needs to enhance the client's understanding regarding the artificial pacemaker if he/she states:
A. "I will take my pulse rate once a day, in the morning upon awakening."
B. "I may be allowed to use electrical appliances."
C. "I have to observe regular follow up care."
D. "I may engage in contact sports."
Answer: D
Explanation: "I may engage in contact sports." The client should be advised by the nurse to avoid contact sports. This will prevent trauma to the area of the pacemaker generator.

Question No: 41
A patient with angina pectoris is being discharged home with nitroglycerine tablets. Which of the following instructions does the nurse include in the teaching?
A. "When your chest pain begins, lie down and place one tablet under your tongue. If the pain continues, take another tablet in 5 minutes."
B. "Place one tablet under your tongue. If the pain is not relieved in 15 minutes, go to the hospital."
C. "Continue your activity and if the pain does not go away in 10 minutes, begin taking the nitro tablets one every 5 minutes for 15 minutes, then go lie down."
D. "Place one Nitroglycerine tablet under the tongue every five minutes for three doses. Go to the hospital if the pain is unrelieved.
Answer: D
Explanation: "Place one Nitroglycerine tablet under the tongue every five minutes for three doses. Go to the hospital if the pain is unrelieved. Angina pectoris is caused by myocardial ischemia related to decreased coronary blood supply. Giving nitroglycerine will produce coronary vasodilation that improves the coronary blood flow in 3 - 5 mins. If the chest pain is unrelieved after three tablets, there is a possibility of acute coronary occlusion that requires immediate medical attention.

Question No: 42
A client receiving heparin sodium asks the nurse how the drug works. Which of the following points would the nurse include in the explanation to the client?
A. It dissolves existing thrombi.
B. It prevents the conversion of factors that are needed in the formation of clots.
C. It inactivates thrombin that forms and dissolves existing thrombi.
D. It interferes with vitamin K absorption.
Answer: B
Explanation: It prevents the conversion of factors that are needed in the formation of clots. Heparin is an anticoagulant. It prevents the conversion of prothrombin to thrombin. It does not dissolve a clot.

Question No: 43
A patient is hemorrhaging from multiple trauma sites. The nurse expects that compensatory mechanisms associated with hypovolemia would cause all of the following symptoms except:
A. Hypertension
B. Oliguria
C. Tachycardia

D. Tachypnea
Answer: A
Explanation: Hypertension. In hypovolemia, one of the compensatory mechanisms is activation of the sympathetic nervous system that increases the RR & PR and helps restore the BP to maintain tissue perfusion, but not cause a hypertension. The SNS stimulation constricts renal arterioles that increases release of aldosterone, decreases glomerular filtration, and increases sodium and water re-absorption that leads to oliguria.

Question No: 44
Ms. Sy undergoes surgery and the abdominal aortic aneurysm is resected and replaced with a graft. When she arrives in the RR, she is still in shock. The nurse's priority should be
A. Placing her in Trendelenburg position
B. Putting several warm blankets on her
C. Monitoring her hourly urine output
D. Assessing her VS, especially her RR
Answer: D
Explanation: Assessing her VS, especially her RR should be the nurse's priority. Shock is characterized by reduced tissue and organ perfusion and eventual organ dysfunction and failure. Checking on the VS, especially the RR, which detects the need for oxygenation, is a priority to help detect its progress and provide for prompt management before the occurrence of complications.

Question No: 45
The nurse is teaching a group of call center agents about deep vein thrombosis. She includes in her teaching plan the factors that usually cause deep vein thrombosis (DVT) which includes:
A. Aerobic exercise
B. Inactivity
C. Pregnancy
D. Tight clothing
Answer: B
Explanation: A thrombus lodged in a vein can cause venous occlusion as a result of venous stasis. Inactivity can cause venous stasis, leading to DVT. Aerobic exercise helps to prevent venous stasis. Pregnancy and tight clothing can cause varicose veins, which can lead to venous stasis and eventually DVT, but these are not primary causes.

Question No: 46
Ms. JMM has been diagnosed with Hashimoto's disease, an autoimmune disorder. Which of the following signs and symptoms were most probably exhibited by the client that led to the diagnosis?
A. Increased appetite, weight loss, hyperdefecation
B. Increased urination, weight loss, increased thirst
C. Decreased appetite, weight gain, constipation
D. Increased urination, weight gain, and purplish red striae
Answer: C
Explanation: Decreased appetite, weight gain, and constipation are indications that the client is having Hashimoto's disease, which is the most common cause of hypothyroidism. Other signs and symptoms to

watch for are lethargy, brittle nails, coarse hair, muscle cramps, weakness, and apnea. Choice A includes signs of hyperthyroidism. Symptoms presented in Choice B are characteristic of uncontrolled diabetes mellitus. Symptoms presented in Choice D are characteristic of hypercortisolism.

Question No: 47
Mrs. Teasedale is to undergo a thyroidectomy. The nurse should be on the lookout for which electrolyte imbalance?
A. Hypokalemia
B. Hyperkalemia
C. Hypercalcemia
D. Hypocalcemia
Answer: D
Explanation: The nurse should monitor the client for hypocalcemia. Symptoms like numbness or tingling of toes, extremities, and lips; muscle twitches; Chvostek's; and Trousseau signs are all indicative of tetany, which develops after the thyroid gland is surgically removed.

Question No: 48
The nurse is teaching Mrs. Jones, a known diabetic, to monitor her blood glucose using a glucometer. The nurse will know that Mrs. Jones is competent in performing her finger-stick to obtain blood when she:
A. Uses the ball of a finger as the puncture site
B. Uses the side of a fingertip as the puncture site
C. Avoids using the fingers of her dominant hand as puncture sites
D. Avoids using the thumbs as puncture sites
Answer: B
Explanation: Using the side of a fingertip as the puncture site confirms that the client understands the health teaching on blood glucose monitoring using a glucometer. The sides of the fingertips have fewer nerve endings than do the balls of the finger, so less discomfort will result from selecting the sides as puncture sites. Both hands, including the thumbs, can be used as puncture sites.

Question No: 49
Mr. Daniels, a 55-year-old mechanic, was diagnosed with adult-onset diabetes. The nurse will know that Mr. Daniels understand the symptoms of a hyperglycemic reaction if he verbalizes:
A. "I will experience thirst, always going to the bathroom to pee, and will also have decreased appetite."
B. "I may feel flushed cheeks, will have acetone breath, and increased thirst."
C. "I may experience nausea, even vomiting, and some episodes of diarrhea."
D. "I will experience weight gain, a normal breath, and constant thirst."
Answer: B
Explanation: "I may feel flushed cheeks, will have acetone breath, and increased thirst" is the statement that shows that the client understands the manifestations of a hyperglycemic reaction. All the other choices have one wrong answer or symptom: (A) hunger, not decreased appetite; (C) pain in abdomen, not diarrhea; (D) breath odor of acetone, not normal. Answers such as this are tricky, because you have to pick out the wrong answers from among several right answers.

Question No: 50

The nurse in a day clinic is reviewing the laboratory results of clients who were examined for a possible diagnosis of diabetes mellitus. Which of the following individuals would the nurse believe to be diagnosed with diabetes mellitus?
A. Jack, 30 years old, with a fasting plasma glucose of 126 mg/dL
B. Penelope, 42 years old, with a random plasma glucose above 200 mg/dL and symptoms of diabetes
C. Cynthia, 25 years old, with a random plasma glucose less than 140 mg/dL
D. David, 51 years old, with a fasting plasma glucose between 110 mg/dL and 125 mg/dL
Answer: B
Explanation: Penelope, 42 years old, with a random plasma glucose above 200 mg/dL and symptoms of diabetes, meets the criteria for a diagnosis of diabetes. Other criteria for the diagnosis of diabetes are a fasting plasma glucose of 126 mg/dL or above on two occasions or a plasma glucose value equal to or above 200mg/dL in the 2-hour sample on a glucose tolerance test. A random plasma glucose of 140mg/dL or less is normoglycemic. A fasting plasma glucose of 110mg/dL to 125 mg/dL is considered impaired fasting plasma glucose (IPFG) and represents an increased risk for diabetes and a need for lifestyle changes to prevent the onset of diabetes.

Question No: 51
A client was diagnosed with hyperparathyroidism. The nurse explains that because of his condition, he is at risk for having:
A. Hypothyroidism
B. Hypertension
C. Fractures
D. Gingivitis
Answer: C
Explanation: Fractures can result from hyperparathyroidism because the condition causes the release of calcium from bone into blood, resulting in demineralization of the bones.

Question No: 52
Jena, age 32, visited a day clinic to report a sudden weight gain. She also reported to the nurse on duty that her abdomen is now bigger than before and her face looks “swollen” and rounded. Which additional assessment finding would lead the nurse to suspect that Jena has Cushing’s syndrome rather than obesity?
A. Large thighs and upper arms
B. Pendulous abdomen and large hips
C. Abdominal striae and ankle enlargement
D. Posterior neck fat pad and thin extremities
Answer: D
Explanation: Posterior neck fat pad and thin extremities are also noted in a client with Cushing’s syndrome. “Buffalo hump” is the accumulation of fat pads over the upper back and neck. Fat may also accumulate on the face, which suggests a “swollen” and rounded face. There is truncal obesity, but the extremities are thin.

Question No: 53
Ricky, age 18, is admitted with a decreased level of consciousness secondary to a closed head injury resulting from a fall while roller-skating. His urine output is 500cc from 6 AM to 11 AM, 1,000cc from 11 AM to 2 PM, and 350cc from 2 PM to 3 PM. Which of the following actions by the nurse is appropriate?

A. Realize that this is normal urine output and continue to monitor Ricky
B. Encourage Ricky to drink 8 to 10 glasses of fluid daily
C. Check the urine specific gravity and report any abnormality as well as the urine output
D. Decrease the IV rate from 100cc/hr to 25cc/hr, suspecting fluid excess
Answer: C
Explanation: Check the urine specific gravity and report any abnormality, as well as the urine output. Since the urine output of the client is excessive (i.e., 350cc/hr or more), this marks a classic sign of Diabetes insipidus (DI). Diabetes insipidus can develop with head injury, tumors, and other conditions that cause increased intracranial pressure. The specific gravity provides valuable information about renal function and response to antidiuretic hormone (ADH).

Question No: 54
Lisa, the nurse on duty, is preparing to discharge a client newly diagnosed with diabetes mellitus. The client states, "I should eat a candy bar or cup of ice cream every time I feel shaky, hungry, or nauseated." Which of the following is Lisa's best response?
A. "Yes. A candy bar or cup of ice cream is needed to treat the hypoglycemia."
B. "Yes. You should eat the snack and then have a meal as soon as possible."
C. "No. You should quickly eat a meal; the candy will cause hyperglycemia."
D. "No. These have too much sugar and fat, 5 Lifesavers candies or skim milk is better."
Answer: D
Explanation: The candy bar and ice cream may have too much glucose and fat, potentially leading to hyperglycemia. In addition, the fat may delay glucose absorption. Immediate absorption of glucose is needed in hypoglycemia.

Question No: 55
The doctor orders for a glycosylated hemoglobin test for a client with diabetes. The client asked you what the purpose of this test is. You explained that glycosylated hemoglobin is used:
A. To check for anemia
B. To determine the average blood glucose level for up to 4 prior months
C. To compare hemoglobin to glucose levels
D. To calculate the amount of glucose in hemoglobin for the past 6 months
Answer: B
Explanation: Glycosylated hemoglobin reflects the average blood glucose over the life of the red blood cells, usually 4 months. This test is not a ration of hemoglobin to glucose content, nor is it helpful in diagnosing anemia. The time frame of 6 months is too long.

Question No: 56
The non-insulin-dependent diabetic who is obese is best controlled by weight loss because obesity:
A. Reduces the number of insulin receptors
B. Causes pancreatic islet cell exhaustion
C. Reduces insulin binding at receptor sites
D. Reduces pancreatic insulin production
Answer: C
Explanation: Obesity causes a reduce insulin binding at receptor sites and this leads to pancreatic

hypersecretion of insulin and eventual pancreatic cell exhaustion.

Question No: 57
The most accurate description a nurse could give a colleague about a thyroid scan is that it:
A. Assists in differentiating between primary and secondary hypothyroidism
B. Demonstrates increased uptake of radioactive iodine in areas of possible malignancy
C. Demonstrates decreased uptake of radioactive iodine in areas of possible malignancy
D. Measures the effect of TSH on thyroid function
Answer: C
Explanation: A thyroid scan utilizes the uptake of radioactive iodine by the thyroid gland to determine the size, shape, and function of the gland. Also identified are areas of increased uptake (hot areas), indicating increased metabolic function, as in hyperthyroidism, not malignancy (choice B) and areas of decreased or no uptake (cold areas), which are associated with malignancy. Choices A and D both describe the TSH stimulation test.

Question No: 58
Following a thyroid scan with radioactive iodine for a thyroid nodule, the nurse should plan for:
A. No special radiation precautions
B. Full radiation precautions to be instituted, including segregating the client in a private room
C. Radiation precautions that are limited to urine and feces
D. Full radiation precautions to be instituted for 8 hours (the half-life of radioactive iodine)
Answer: A
Explanation: No radiation precautions are necessary after injection of radioactive iodine that will be used for thyroid scan. Choice B pertains to radium implants. Choice C may be employed to when radioactive iodine therapy is utilized to control and reduce hypersecretion by the thyroid (hyperthyroidism). Choice D is not an example of normal radiation therapy policy.

Question No: 59
The nurse knows that acetonuria develops in diabetes due to:
A. Excessive oxidation of fatty acids for energy, which increases ketones in glomerular filtrate
B. Osmotic dieresis and accompanying elevation in serum glucose levels, which decreases exchange of electrolytes in renal tubules
C. Failure of sodium-hydrogen ion exchange mechanism in the renal tubules to secrete excess hydrogen ions
D. Increased volatile H+ ions and decreased nonvolatile H+ ions in the glomerular filtrate
Answer: A
Explanation: When excessive quantities of fatty acids are oxidized, blood buffer systems may become exhausted. Ketoacidosis develops and acetone bodies are excreted in the urine. In an emergency room situation, diabetic acidosis can be recognized not only by increased rate and depth of respirations (Kussmaul's respirations) but also by the odor of acetone on the breath. Neither osmotic diuresis (Choice B) nor failure in the sodium-hydrogen ion exchange (Choice C) causes acetonuria. In the latter case, failure to excrete excess hydrogen ions would decrease urinary acids. Volatile hydrogen ions (CO_2) are excreted by the lungs; a decrease in nonvolatile hydrogen ions in the glomerular filtrate (Choice D) would move the pH of the urine toward the alkaline side.

Question No: 60
Matilda, 33 years old, was diagnosed with primary hypothyroidism. The doctor prescribed levothyroxine (Synthroid). Which statement should be included in the client education?
A. “You will need to take this medication until your symptoms are gone. Then your dose will be tapered off and discontinued.”
B. “Symptoms such as tremors, nervousness, and insomnia may indicate that your dose is too high.”
C. “You should begin to see your symptoms improve immediately after starting your medication.”
D. “The reason for taking the drug is because the thyroid gland produces too much thyroxine.”
Answer: B
Explanation: Levothyroxine is a synthetic preparation of the thyroid hormone thyroxine (T4). Tremors, nervousness, and insomnia may indicate an overdose of the medication. The client should be instructed to contact the prescriber if she experiences these symptoms.

Question No: 61
Mr. Chandler has trouble remembering to rotate his sites for insulin injections. In the past week he has self-injected into the right abdomen, left abdomen, right upper arm, left thigh, and right thigh. Into which site should he self-inject his insulin next?
A. Left ankle
B. Right abdomen
C. Left midback
D. Left upper arm
Answer: D
Explanation: He is due for an injection in the left upper arm owing to the site rotation.

Question No: 62
You are a nurse who is discussing treatment involving insulin with Mrs. Christopher, who is newly diagnosed with type 1 diabetes mellitus. Mrs. Christopher asks, “Why can’t I just take the pill like my friend who has diabetes?” After you give your explanation, which of the following responses by the patient would indicate that she understood your explanation?
A. “After I am on insulin for some time, then I can wean myself off insulin and take pills.”
B. “With exercise twice a day and a 1,200-calorie diet, I should be able to avoid having to take insulin.”
C. “Because my body does not produce insulin, I will need to take insulin by injection for the rest of my life.”
D. “When my body starts to make insulin again, then I can stop the insulin injections and try pills.”
Answer: C
Explanation: “Because my body does not produce insulin, I will need to take insulin by injection for the rest of my life.” In diabetes, the beta cells do not produce insulin, so the patient needs lifelong insulin therapy.

Question No: 63
Mr. Jeckyll, a 46-year-old hotelier, has been diagnosed with type 2 diabetes and needs to begin daily medications and blood glucose monitoring. Mr. Jeckyll’s response was, “This is not possible. How can I have diabetes when I’m not sick?” What is the most appropriate response by the nurse?
A. “Type 2 diabetes has a latent period when blood glucose levels are very high, but the body has not experienced enough deterioration to make you very ill.”
B. “You are in denial, which is preventing you from experiencing many of the symptoms.”