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CEN

Certified Emergency Nurse

EXAMAIDES

PASS YOUR EXAM AT FIRST TRY

Total Question: 208 QAs + 175 QAs

Question No: 1
You are administering a Snellen chart test to a patient. What results would you expect to get if your patient was legally blind?
A. 20/20 vision
B. 20/40 vision
C. 20/60 vision
D. 20/200 vision
Answer: D
Explanation: The patient would be considered legally blind if the result of the Snellen chart test is 20/200 vision. This means that the patient is able to read at 20 feet what a person with normal vision can read at 200 feet. Legal blindness is defined as 20/200 or less with corrected vision or visual acuity of less than 20 degrees of the visual field in the better eye.

Question No: 2
What is the normal intraocular pressure of the eye?
A. 2 to 7 mm Hg
B. 10 to 21 mm Hg
C. 22 to 30 mm Hg
D. 31 to 35 mm Hg
Answer: B
Explanation: The normal intraocular pressure of the eye is 10 to 21 mm Hg. The test used to measure intraocular pressure is called a tonometry. This is how glaucoma is diagnosed. A patient with glaucoma would have an intraocular pressure of 30 to 70 mm Hg.

Question No: 3
Your patient has been diagnosed with a hyphema following hitting their head on the steering wheel during a car accident. What position would you want to place this patient in?
A. Supine
B. Semi- fowlers
C. Lateral
D. Trendelenburg
Answer: B
Explanation: The patient should be placed in semi-fowlers position on bed rest. A hyphema is caused by a force, such as hitting your head on the steering wheel, strong enough to break the blood vessels in the eye. Placing the patient in semi-fowlers position lets gravity work to keep the hyphema away from the optical center of the cornea.

Question No: 4
Your patient has arrived in the emergency department with a penetrating eye injury. You are assessing the patient. What should your first action be?
A. Remove any objects from the eye.

B. Place a patch over the eye.
C. Perform a visual acuity test.
D. Use sterile saline to irrigate the eye.
Answer: C
Explanation: You would want to perform visual acuity tests on the affected eye first. This allows the nurse to assess any damage to the vision. Any foreign objects in the eye should only be removed by an ophthalmologist. Do not cover or rinse eye because it may dislodge foreign objects and cause further damage to the eye.

Question No: 5
Your patient has arrived in the emergency department with a chemical eye injury. Your first action should be to:
A. Perform a visual acuity test
B. Use sterile saline to irrigate the eye
C. Place antibiotic ointment in the eye
D. Place a patch over the eye
Answer: B
Explanation: The first reaction by the nurse should be to irrigate the eye with normal saline. This should be done for at least 10 minutes to remove any chemicals from the eye. Following irrigation of the eye the patient should have visual acuity tests to determine the extent of damage to the eye.

Question No: 6
You are caring for a patient who has come into the emergency department with a foreign body in his right ear. After further investigation you determine that the foreign object is an insect. What intervention would the physician order first for this client?
A. Sterile normal saline irrigation
B. Diluted alcohol irrigation
C. Antibiotic ear drops
D. Corticosteroids ointment
Answer: B
Explanation: The nurse would know that the physician will order diluted alcohol irrigation of the affected ear. This will suffocate the insect so it can be removed from the ear with forceps. If the foreign object were vegetable matter, irrigation would not be performed due to the enlargement of the object when it is hydrated, which would make the impaction worse.

Question No: 7
When caring for a patient what sign would indicate that he might have a basal skull fracture?
A. The auditory canal has purulent drainage.
B. The auditory canal has bloody or clear drainage.
C. Epistaxis
D. Periorbital edema
Answer: B
Explanation: A basal skull fracture would be indicated by bloody or clear drainage from the auditory canal. This indicates a cerebrospinal fluid leak from the fracture. This is a medical emergency and needs to be

addressed by the physician immediately.

Question No: 8
You are caring for a patient who complains of tinnitus. What part of the ear do you suspect is the most likely cause of the patient's complaint?
A. External ear
B. Middle ear
C. Inner ear
D. Auricle
Answer: C
Explanation: Tinnitus is the most common complaint of patients with disorders of the inner ear. Tinnitus is a ringing in the ear that can be loud intolerable ringing or mild ringing that can be unnoticed during the day.

Question No: 9
You are caring for a patient who has had a right eye cataract removal. What discharge instruction would you want to include in the plan of care?
A. Do not sleep on right side.
B. Do not sleep on left side.
C. Do not sleep with head elevated.
D. Do wear glasses until physician says it is okay.
Answer: A
Explanation: The patient should not sleep on the right side following surgery. The patient should be placed in a semi-Fowler position to minimize edema and intraocular pressure. The patient should wear glasses and a protective shield over the affected eye.

Question No: 10
You have delegated the care of an older patient with hearing loss to a nursing assistant. You tell the nursing assistant that patients with this diagnosis:
A. Are often distracted.
B. Respond better to low pitched sounds.
C. Have middle ear changes.
D. Develop moist cerumen production.
Answer: B
Explanation: Older patients with hearing loss respond better to low pitch sounds. Age-related changes of the inner ear are called presbycusis. As a result of these changes the patient often loses the ability to hear high-pitched sounds.

Question No: 11
The most appropriate action by the nurse who is preparing to communicate with an older patient who has hearing loss is:
A. Stand in front of the patient.
B. Exaggerate lip movements.
C. Obtain a sign language interpreter.
D. Pantomime and write the patient notes.

Answer: A
Explanation: The nurse should stand in front of the patient with hearing loss while trying to communicate with them. By standing in front of the patient and providing adequate lighting, the nurse insures that the patient can see the nurse clearly. If there is still difficulty communicating, then notes and pantomime can be used.

Question No: 12
Which of the following assessments would make the nurse suspect that a child has strabismus?
A. Tilts head to see
B. Turns head to see
C. Does not respond when spoken to
D. Has difficulty hearing
Answer: A
Explanation: A child with strabismus will tilt head to see. Strabismus is when the extraocular muscles have a lack of coordination so the eyes do not align. The patient may complain of frequent headaches and squint to see and may need to go to surgery to realign the weak muscles if nonsurgical interventions do not work.

Question No: 13
You are caring for a child with chlamydial conjunctivitis. What would you want to investigate if you had a patient with this diagnosis?
A. Presence of an allergy
B. Possible trauma
C. Possible sexual abuse
D. Presence of a respiratory infection
Answer: C
Explanation: The nurse would want to investigate possible sexual abuse. This diagnosis in a child who is not sexually active should trigger suspicions in the nurse. Allergy, trauma and infection can all cause conjunctivitis, but chlamydia is a sexually transmitted disease.

Question No: 14
You are caring for a child who is going to have a tonsillectomy. Which of the following laboratory results would you want to check preoperatively?
A. Prothrombin time
B. Sedimentation rate
C. Blood urea nitrogen
D. Creatinine
Answer: A
Explanation: The nurse would want to check the prothrombin time preoperatively and report any abnormal results to the surgeon. The tonsillar area is very vascular, which can increase the patient's chance of bleeding. If the prothrombin time is not adequate, the patient could bleed to death.

Question No: 15
You are caring for a child who will have a tonsillectomy. Which of the following would increase the child's risk of aspiration during surgery?
A. Difficulty swallowing

B. Loose teeth
C. Bleeding
D. Exudate in the throat
Answer: B
Explanation: If the child has loose teeth it increases the risk of aspiration. A and D are symptoms that indicate the need for surgery. C will be taken care of during surgery with suctioning and packing. Therefore it is important that the nurse check the child for loose teeth prior to surgery to prevent aspiration.

Question No: 16
You are caring for the child who has had a tonsillectomy. The physician has written postoperative orders. Which of the following orders would the nurse question?
A. Clear, cool liquids when awake
B. No milk or milk products
C. Monitor for bleeding
D. Suction every 2 hours
Answer: D
Explanation: You would not want to suction a patient who just had a tonsillectomy. Suction equipment should be available at bedside in case of airway obstruction. Otherwise, a patient would not be suctioned due to the risk of trauma to the oropharynx. All other orders listed are appropriate for this patient.

Question No: 17
You are monitoring a child who had a tonsillectomy. On assessment, which findings would indicate to you that the child might be bleeding?
A. Decreased pulse
B. Elevation in blood pressure
C. Complaints of discomfort
D. Frequent swallowing
Answer: D
Explanation: Frequent swallowing by the child might indicate that there is bleeding. Other signs or symptoms might include restlessness, vomiting blood, and a fast, thready pulse. Elevation of blood pressure and discomfort do not indicate bleeding.

Question No: 18
After a tonsillectomy, your patient begins to vomit. What intervention should be your priority?
A. Administer an antiemetic
B. Turn the patient to the side
C. Notify the physician
D. Maintain the patient's "nothing by mouth" status
Answer: B
Explanation: Your first priority should be to turn the patient on the side to prevent aspiration. Only then should you notify the physician. It is also important to continue to maintain the "nothing by mouth" feeding status of the patient and give antiemetic if prescribed.

Question No: 19

When caring for a patient with glaucoma, which of the following symptoms would you not expect to see on the patient's chart?
A. Severe eye pain
B. Frequent pink-eye infections
C. Blurred vision
D. Nausea and vomiting
Answer: B
Explanation: Frequent pink-eye infections are not symptomatic of glaucoma, but reddening of the eyes is a common sympton.

Question No: 20
Which of the following orders would the physician prescribe for the patient with retinal detachment?
A. Bathroom privileges
B. Head of bed up 45 degrees
C. Eye patch to affected eye
D. Dark glasses to read or watch television
Answer: C
Explanation: The physician would order an eye patch to the affected eye. This decreases movement of the eye and prevents further damage to the eye. The physician may limit activity until the eye can be repaired.

Question No: 21
What is the accurate procedure for performing a confrontational peripheral vision test?
A. Both examiner and patient cover the same eye and stare at each other while an object is brought into the line of sight.
B. Examiner and patient cover opposite eyes and stare at each other while an object is brought into the line of sight.
C. The patient is asked to discriminate numbers from a chart composed of colored dots.
D. The room is darkened and the patient is asked to identify colored blocks and shapes when they appear in the visual field.
Answer: B
Explanation: The examiner and the patient cover the opposite eyes and stare at each other while an object is brought into the line of sight. This test assumes that the examiner has normal vision. The patient indicates when they can see the object. This tests nasal, superior, temporal and inferior visual fields.

Question No: 22
Which of the following would the nurse do when performing an otoscopic exam on a patient?
A. Pull the pinna up and back.
B. Pull the earlobe down and back.
C. Use the smallest speculum available.
D. Tilt the patients head forward and down.
Answer: A
Explanation: The nurse would pull the pinna up and back before inserting the speculum, holding the head slightly away and holding the otoscope upside down like a large pen. The other three options are incorrect.

Question No: 23
Your patient is scheduled to go for cataract surgery. What nursing diagnosis should you include in the patients plan of care?
A. Self care deficit
B. Imbalanced nutrition
C. Disturbed sensory perception
D. Anxiety
Answer: C
Explanation: Disturbed sensory perception should be included in this patient's plan of care. The patient's vision would be disturbed related to lens extraction and replacement. The other nursing diagnoses may be appropriate for this patient, but are not relevant to cataract surgery.

Question No: 24
What clinical manifestations would you see if your patient had cataracts?
A. Eye pain
B. Floating spots
C. Blurred vision
D. Diplopia
Answer: C
Explanation: Blurred vision is a clinical manifestation of cataracts. The patient may also exhibit decreased color perception. All other signs are not signs of cataracts.

Question No: 25
What type of eye drops would be ordered for the patient who is being prepared for cataract surgery?
A. Osmotic diuretic
B. Miotic agent
C. Mydriatic medication
D. Thiazide diuretic
Answer: C
Explanation: A mydriatic medication would be ordered for the patient who is being prepared for cataract surgery. This will produce mydriasis and dilation of the pupil. It will also constrict blood vessels.

Question No: 26
Which of the following would be associated with detached retina?
A. Pain in the affected eye
B. Total loss of vision
C. Feeling like a curtain had fallen over their eyes
D. Yellow discoloration of the scleroses
Answer: C
Explanation: A patient with a detached retinapatient would complain of a sense of a curtain falling across their field of vision There is no pain associated with retinal detachment, but it is an ophthalmic emergency in that immediate steps must be taken to protect the patient's vision.

Question No: 27

What intervention would you need to take if your patient had a contusion of the eyeball following a traumatic injury?
A. Notify the physician.
B. Irrigate the eye with cool water.
C. Apply ice to the affected eye.
D. Accompany the patient to the emergency room.
Answer: C
Explanation: The priority intervention for this patient would be to apply ice to the affected eye. The patient should then be seen by a physician to rule out any other eye injury. Do not irrigate the eye with cool water until it is examined by a physician.

Question No: 28
What nursing action would the nurse take when caring for a patient with enucleation with bright red drainage?
A. Notify the physician.
B. Continue to monitor the drainage.
C. Document the finding.
D. Mark the drainage on the dressing.
Answer: A
Explanation: The nurse's first priority would be to notify the physician. The presence of bright red drainage on the dressing is an indication of hemorrhage. The other options are inappropriate for this patient.

Question No: 29
You are completing a hearing screening on a patient. You note that the sound lateralizes to the patient's left ear during a Weber test. What does this finding indicate?
A. A normal finding
B. Conductive hearing loss in the right ear
C. Sensorineural or conductive loss
D. Presence of nystagmus
Answer: C
Explanation: This test indicates sensorineural or conductive loss in the right ear. The Weber test is done by placing a vibrating tuning fork at the middle of the forehead. The patient should hear sound by bone conduction equally in both ears; if not, then the patient has hearing loss in the ear that did not hear the sound.

Question No: 30
When caring for a hearing impaired patient what approach will facilitate communication?
A. Speak frequently.
B. Speak loudly.
C. Speak directly into the impaired ear.
D. Speak in a normal tone.
Answer: D
Explanation: The nurse should speak in a normal tone of voice when addressing the patient. The nurse should talk directly to the patient while facing them. If the patient still does not understand then the nurse should move closer to the better ear to facilitate communication.

Question No: 31
You have delegated care of a patient in restraints to a nursing assistant. How often should the nursing assistant assess skin integrity for this patient?
A. Every 30 minutes
B. Every 2 hours
C. Every 3 hours
D. Every 4 hours
Answer: A
Explanation: The nursing assistant should assess the patient's skin integrity every 30 minutes for as long as the patient is in restraints. In order to delegate this task to the nursing assistant the nurse must insure that the nursing assistant is clear on what care the patient requires.

Question No: 32
You are working in the emergency department and find out that a tornado has hit the local area. Numerous casualties are being sent to the emergency department. What action should you take at this time?
A. Prepare the triage room.
B. Obtain additional supplies.
C. Activate the agency disaster plan.
D. Call in additional staff.
Answer: C
Explanation: The nurse should activate the agency disaster plan. All the other options may be part of the disaster plan, but the first priority of the nurse should be to activate the disaster plan. This will cover all the necessary steps that the will need to take.

Question No: 33
You receive an order for 1000 mL of normal saline over 12 hours. The drop factor is 15 drops per 1 mL. You prepare to set the flow rate at how many drops per minute?
A. 15 drops a minute
B. 17 drops a minute
C. 21 drops a minute
D. 23 drops a minute
Answer: C
Explanation: The drop rate is 21 drops a minute.
(Total volume ÷ Time in minutes) × Drop factor = Drops per minute
(1000 mL ÷ 720 minutes) × 15 gtts = 1.4 mL/min × 15 gtts = 21 drops a minute

Question No: 34
You are preparing to give an intravenous dose of 400,000 units of penicillin G benzathine (Bicillin). The 10 mL ampule label reads penicillin G benzathine 300,000 units per mL. You prepare to administer how much of the medication?
A. 1.3 mL
B. 1.5 mL
C. 10 mL
D. 13 mL

Answer: A
Explanation: The nurse would administer 1.3 mL of penicillin G benzathine.
Desired dose: 400,000 units
Available concentration: 300,000 units (Units) per 1 mL (Volume)
(Desired dose ÷ Available concentration (units)) × Available dose concentration (volume) = Milliliters per desired dose (400,000 units ÷ 300,000 units) × 1 mL = 1.3 × 1 mL = 1.3 mL

Question No: 35
You are preparing to give potassium chloride 30 mEq in 1000 ml of normal saline over 10 hours. The medication label reads 40 mEq per 20 mL. How many milliliters of potassium chloride do you need to administer the correct dose?
A. 10 mL
B. 15 mL
C. 20 mL
D. 50 mL
Answer: B
Explanation: The nurse would prepare 15 ml of potassium chloride.
Desired dose: 30 mEq
Available concentration: 40 mEq (Units) per 20 mL (Volume)
(Desired dose ÷ Available concentration (units)) × Available concentration (volume) = Milliliters per desired dose (30 mEq ÷ 40 mEq) × 20 mL = 0.75 × 20 mL = 15 mL

Question No: 36
You enter a patient's room and find the patient not breathing, no pulse, and unresponsive. You have called for help. What is the next step?
A. Bag mask ventilations
B. Chest compressions
C. Oxygen
D. Open airway
Answer: B
Explanation: New standards in CPR emphasize chest compressions over airway, so the next step after calling for help is to check the pulse and begin chest compressions. Chest compressions should be given immediately (30 for an adult patient), and then followed by opening the airway and beginning respirations. Ventilation is only initiated when the airway is open or patent, as oxygen is not needed until the patient is breathing.

Question No: 37
The correct hand placement for chest compressions is the:
A. Lower third of sternum
B. Upper half of the sternum
C. Upper third of the sternum
D. Lower half of the sternum
Answer: D
Explanation: The correct hand placement for chest compressions is the lower half of the sternum. To determine the proper placement the nurse would want to locate the notch where the rib margin meets the sternum.

Place the middle finger on the notch and index finger next to it. Next place the heel of the opposite hand on the lower half of the sternum close to the index finger. Place the first hand on top of the hand on the sternum and begin chest compressions.

Question No: 38
What is the proper technique for opening the airway on a trauma patient?
A. Head tilt-chin lift
B. Flexed position
C. Modified head tilt-chin lift
D. Jaw thrust maneuver
Answer: D
Explanation: To open the airway of any patient that might have a neck injury the nurse would perform a jaw thrust maneuver. All of the other options do not protect the neck from further injury.

Question No: 39
The most appropriate place to check the pulse on a 1-month-old infant is:
A. Brachial
B. Carotid
C. Popliteal
D. Radial
Answer: A
Explanation: Brachial pulse is the appropriate pulse for a 1 month old infant. It is difficult to check the carotid pulse on an infant due to the short, fat neck. Popliteal and radial pulses are also difficult to palpate.

Question No: 40
You are encouraging your postoperative patient to cough and take deep breaths. The patient questions why it is so important to do this. Your response would include the understanding that retaining pulmonary secretions can lead to:
A. Fluid imbalance
B. Carbon dioxide retention
C. Pulmonary edema
D. Pneumonia
Answer: D
Explanation: Coughing and deep breath exercises help prevent pneumonia in the postoperative patient. Pneumonia is inflammation of lung tissue that causes productive cough, dyspnea and crackles. Postoperative complications related to pneumonia can be prevented if the patient is encouraged to cough and breathe deeply.

Question No: 41
Which of the following would you want to include in an education session to the staff on HIV and AIDS?
A. Newborn infants of HIV positive mothers usually test positive.
B. The hematological system is usually attacked by HIV.
C. With AIDS, T4 cells cannot form protective antibodies due to depleted B cells.
D. T lymphocytes are destroyed because the virus attacks the immune system.

Answer: D
Explanation: T lymphocytes are destroyed because the virus attacks the immune system. Infants born to mothers positive for HIV usually test positive for HIV antibodies not HIV virus. HIV attacks the immune system, not the hematological system. T4 cells are depleted in numbers and can not signal B cells.

Question No: 42
You are conducting a teaching session for mothers at a local school on rubeola (measles). Which of the following would you not want to include in this education?
A. Profuse runny nose, coughing and fever occur before the rash develops.
B. The child may develop small, blue-white spots with a red base in the mouth
C. Ears usually develop a rash first, which then spreads toward the feet.
D. The communicable period usually ranges from 10 to 15 days after the rash appears.
Answer: D
Explanation: The communicable period for Rubeola (measles) is 4 to 5 days after the rash appears. The incubation period is 10-15 days. The blue-white spots found in the mouth during Rubeola are called Koplik's spots.

Question No: 43
You are providing a teaching session to a group of patients regarding skin cancer. Which of the following statements would you not want to include in this education?
A. Wear sunscreen when engaged in outdoor activities.
B. The body should be examined monthly for any lesions that appear suspicious.
C. A hat, opaque clothing, and sunglasses should be worn when in the sun.
D. Avoid sun exposure after 3pm.
Answer: D
Explanation: It would be incorrect to instruct the patients to avoid the sun after 3pm. The patients would want to avoid the sun between 11am and 3pm. All other statements are correct and should be taught to the patients.

Question No: 44
You are teaching a group of mothers how to apply permethrin (Elimite, Nix) for pediculosis capitus. Which of the following would be the correct application technique?
A. Apply at bedtime and wash out in the morning.
B. Apply before washing hair.
C. Apply to hair avoiding scalp.
D. Apply to hair for 10 minutes and then rinse.
Answer: D
Explanation: In order for permethrin (Elimite, Nix) to be effective it is important to following the instructions on the bottle. The hair must be washed, rinsed and towel dried. The hair and scalp should be completely saturated and allowed to sit for 10 minutes prior to rinsing.

Question No: 45
You are preparing a teaching session on tuberculosis. What is one of the first symptoms that the group might notice in someone who has tuberculosis?
A. Bloody, productive cough

B. Cough with mucoid sputum
C. Chest pain
D. Dyspnea
Answer: B
Explanation: One of the first symptoms that would be notices would be cough with mucoid sputum. Late signs of tuberculosis would be bloody, productive cough, chest pain and dyspnea.

Question No: 46
The older patient that you have been assigned to is having difficulty distinguishing between hot and cold temperatures. Alteration of what gland activity would lead to this problem?
A. Parotid
B. Thymus
C. Pineal
D. Sweat
Answer: D
Explanation: Alterations in the sweat gland would lead to the patient having trouble distinguishing between hot and cold temperatures. The skin is important in protection, sensory reception homeostasis and temperature regulation. The parotid glands are important in the drainage of saliva. Melatonin biosynthesis occurs in the pineal gland, and immunological roles throughout the body are affected by the thymus gland.

Question No: 47
Which of the following would not encourage effective communication between a dying patient and his family?
A. Discussing feelings openly
B. Making decisions for the family and patient
C. Assisting family and patient in performing spiritual practices
D. Acceptance when family and patient express anger
Answer: B
Explanation: Making decisions for the family and patient would not encourage them to have effective communication. It is important to encourage the patient and the family to express their feeling and anger if they need to. Spiritual practices are also a very important part of a patient and family's dying process.

Question No: 48
You are working in a community that has just experienced a hurricane. You are trying to find housing and counseling for those who need it. Which type of level of preventions are you representing?
A. Primary level
B. Secondary level
C. Tertiary level
D. Forth level
Answer: C
Explanation: The tertiary level of prevention is what the nurse is displaying. This is a reduction in the amount and degree of disability, injury and damage following a crisis. The other options are incorrect.

Question No: 49
You are preparing to administer a rubella vaccination to a 2 day postpartum patient. Which of the following

potential risks would you identify for this patient?
A. Sunlight
B. Scratching of the site
C. Pregnancy within 2 to 3 months of vaccination
D. Sexual intercourse with 2 to 3 months of vaccination
Answer: C
Explanation: The nurse would want to instruct the patient to avoid getting pregnant for the next 2 to 3 months. The rubella vaccination is a live virus that creates antibodies for immunity for 15 years. Sunlight is not issue for this vaccination. The patient may have some localized reaction to the vaccine, but it is mild and short lived.

Question No: 50
You are helping out at a local health fair when a patient admits to you that he does not eat a well-balanced diet. Which of the following would be a correct statement about the Food Guide Pyramid?
A. 6 to 11 servings of bread, cereal, pasta, or rice a day
B. 2 to 3 servings of vegetables a day
C. 4 to 5 servings of milk, yogurt or cheese a day
D. 4 to 6 servings of meat, poultry, fish, dry beans or nuts a day
Answer: A
Explanation: The correct diet to recommend based on the Food Guide Pyramid would include 6 to 11 servings of bread, cereal, pasta or rice a day. Vegetables is 3 to 5 servings, diary products is 2 to 3, and meat and beans is 2 to 3 per day.

Question No: 51
You are caring for a patient in the emergency department. The patient has been drinking alcohol and is asking for medication. When you instruct the patient that they have to wait to be seen by the doctor, the patient becomes verbally abusive. You then obtain a set of restraints and instruct the patient if they do not calm down you will restrain them. What can you be charged with?
A. Assault
B. Battery
C. Negligence
D. Invasion of privacy
Answer: A
Explanation: You as the nurse can be charged with assault for threatening to restrain the patient. You as the nurse have put the patient in fear of harmful or offensive contact. In order for this to be a chargeable offense, the patient must be aware of the threat.

Question No: 52
You as the nurse are working on the unit. You enter the medication room and find another nurse taking intravenous medication and administering it to him- or herself. What should your next action be?
A. Call the police.
B. Call security.
C. Lock the nurse in the medication room.
D. Call the nursing supervisor.
Answer: D