Total Duration - 165 minutes

1 . The nurse determines that the nutrient intake of the 19-year-old female is inadequate according to the U.S. Department of Agriculture MyPlate food group recommendations. Which finding of the female's intake prompted this conclusion?
A. 6 ounces of whole grain bread, cereal, or pasta eaten daily.
B. 3 cups of a variety of fruits, juices, and vegetables eaten daily.
C. 5 ½ oz of protein daily with seafood eaten four of the seven days
D. 1 cup of yogurt, ½ cups skim milk, and ½ ounce cheddar cheese daily.

2. The client with a BMI of30 is attending a health promotion program at a clinic. Which outcome is best for the nurse to document in the client's plan of care? A. Client will lose 2 lb per week for the next 4 weeks.
B. Client will gain 2 lb per week for the next 4 weeks.
C. Teach client to increase intake of fruits and vegetables.
D. Inform client to call clinic weekly with weight results.

3. The nurse is planning a nutrition session during a health fair. Which food choices should the nurse include when teaching about omega-3 fatty acids? A. Fatty fish at least twice weekly
B. Leafy green vegetables daily
C. Low-fat mozzarella cheese weekly
D. Cholesterol-free margarine once daily

4. The client is told to consume high-protein foods for wound healing. Of the food choices, which should the nurse recommend?
A. 1 hard-boiled egg
B. 1 cup of cooked broccoli
C. ½ cup ½ cottage cheese
D. 1 ounce cheddar cheese

5. The nurse is ensuring that an adolescent diagnosed with type 1 DM knows about foods that are high in carbohydrates and those that contain little or no carbohydrates. Which foods should the adolescent identify as those that contain approximately 15 g of carbohydrate per serving? Select all that apply. A. Pancake
B. Green beans
C. Corn
D. Taco shells
E. Carrots
F. Cottage cheese

6. The nurse taught the client who has type 2 DM about carbohydrate counting and the fact that 15 g of

carbohydrate equals one carbohydrate choice. When consuming the following meal, the client should calculate that the meal contains how many carbohydrate choices?

1 small banana

2 slices bread with 1 slice turkey breast

1 cup milk

2 tomato slices

_____ Carbohydrate choices (Record your answer as a whole number.)

7. The nurse is caring for the client with a history of chronic alcoholism. Which observation should prompt the nurse to assess for a magnesium deficiency? A. Flickerlike movements under the skin

B. Absent reaction when kneecap is tapped

C. Falling from having flaccid muscles

D. Rumbling bowel sounds after eating

8. The nurse is caring for the client experiencing CRF. Which low-potassium foods (less than 400 mg of potassium per serving) should the nurse plan to include on a list of acceptable foods for the client?

A. Cranberry juice, grapes, flesh string beans, fortified puffed rice cereal

B. Prune juice, dried fruit, tomatoes, and all-bran cereal

C. Milk, cantaloupe, peas, and granola cereal

D. Orange juice, raisins, spinach, and dried beans

9. The client with early-stage iron-deficiency anemia is on a. high-iron diet. An increase in the level of which specific serum laboratory test should indicate to the nurse that the diet has been effective?

A. Hemoglobin

B. Folate

C. Ferritin

D. Vitamin B12

10. The nurse teaches the client with iron-deficiency anemia to eat foods high in iron and foods that contain vitamin C at the same meal to increase iron absorption. The nurse evaluates that teaching is effective when the client selects the meal that includes which foods?

A. Yogurt and oranges

B. Shrimp and potatoes

C. Lean beefsteak and broccoli

D. Chicken and leafy green vegetables

11 . The nurse educates the client about foods that are high in calcium. The nurse evaluates that teaching has been effective when the client selects which foods? A. 1 cup whole milk, 1 cup spinach, and 3 ounces

sardines

B. 1 cup low-fat yogurt, 1 cup broccoli, and 3 ounces sardines

C. ½ cup 2 ½ cottage cheese, 1 cup spinach, and 3 ounces frozen tofu

D. 1 medium baked potato with 1 tbsp fat—free sour cream, 1 cup spinach, and 3 ounces tofu

12. The nurse educates the client recovering from acute diverticulitis about the need to increase the amount of dietary fiber in the diet. The nurse evaluates that teaching has been effective when the client makes which menu selection for lunch?

A. A chicken sandwich on whole Wheat bread with raw carrots and celery sticks B. Baked chicken, mashed potatoes, and herbal tea

C. Chicken noodle soup with soda crackers and chocolate pudding

D. Cooked acorn squash, flied chicken, and pasta

13. The nurse is planning a seminar on healthy living for college students. The nurse should educate the students about consuming a minimum of how many grams of fiber per day?

A. 5 to 20 g

B. 20 to 35 g

C. 35 to 50 g

D. 50 to 75 g

14. The nurse is caring for the malnourished adolescent consuming a vegan diet. The nurse should assess for signs of which vitamin deficiency in the client? A. 1 . Vitamin A

B. 2. Vitamin C

C. 3. Vitamin K

D. 4. Vitamin B12

ANSWER: D

A. Fruits and vegetables that are eaten by vegans contain Vitamin A.

B. Fruits and vegetables that are eaten by vegans contain vitamin C.

C. Fruits and vegetables that are eaten by vegans contain vitamin K.

D. Vegans abstain from eating animal products, which provide vitamin B12.

15. The client prescribed a high—protein, high-calorie diet is not meeting protein or caloric intake goals. The client states, “I feel full quickly after eating three meals daily.” Which interventions should the nurse recommend? Select all that apply. A. Include more fresh fruits and vegetables in the diet

B. Eat six smaller meals instead of three meals daily

C. Include protein bars and whole milk yogurt as snacks

D. Drink regular instead of diet carbonated beverages

E. Add protein supplements to cooked cereals

16. The nurse evaluates that the client placed on a DASH diet can correctly identify the salt content per serving on a food label. Place an X on the food label illustrated where the client should have identified the salt

Nutrition Facts

Serving Size 1/2 cup (114g)
Servings Per Container 4

Amount Per Serving

Calories 90	Calories from Fat 30
	% Daily Value *
Total Fat 3g	5%
Saturated Fat 0g	0%
Trans Fat 0g	0%
Cholesterol 0mg	0%
Sodium 300mg	13%
Total Carbohydrate 13g	4%
Dietary Fiber 3g	12%
Sugars 3g	
Protein 3g	

Vitamin A	80%	Vitamin C	60%
Calcium	4%	Iron	4%

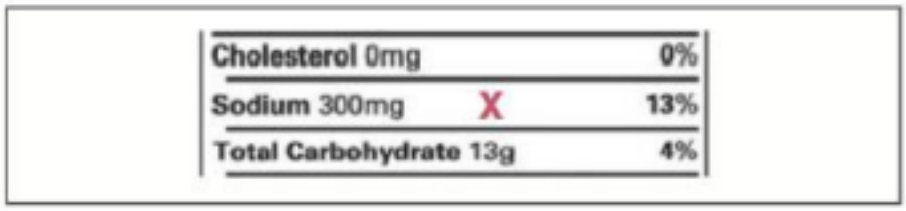
* Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:

	Calories	2,000	2,500
Total Fat	Less than	65g	80g
Sat Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodium	Less than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

Calories per gram:
Fat 9 ● Carbohydrate 4 ● Protein 4

content per serving.

ANSWER:



Cholesterol 0mg		0%
Sodium 300mg	X	13%
Total Carbohydrate 13g		4%

The salt content of one serving is sodium 300 mg.

17. The client is placed on a DASH diet. Which statement made by the client indicates that the client needs additional teaching about the DASH diet? A. “I can have 4 to 5 servings a week of almonds when on this diet.”

B. “I should be eating no more than 3 servings of meat or poultry daily.”

C. “I should be using canola, olive, or peanut oils when cooking foods.”

D. “My 4 to 5 daily fruit servings can include juice, or fresh or dried fruit.”

18. The client is recovering from an exacerbation of ulcerative colitis. The nurse evaluates that the client understands the dietary teaching for disease management when the client selects which foods?

A. Fried Cajun chicken, French fries, steamed pea pods, and a glass of fruit juice B. Cream of tomato soup, mixed green salad with oil, and a glass of whole milk C. Baked fish, steamed green beans, buttered mashed

potatoes, and herbal tea D. Chili con came, whole wheat bread with butter, and a half glass of red wine

19. The client is scheduled for a breath test for hydrogen excretion. Which statement should the nurse include when the client asks how this will evaluate for lactose intolerance?
A. Undigested lactose causes water in the colon to form oxygen and hydrogen.
B. Hydrogen is produced by lactose digestion in the small intestine.
C. Undigested lactose produces hydrogen when metabolized by colon bacteria.
D. During the digestive process, lactose is broken down into lactic acid and hydrogen.

20. The client tells the nurse, “My mother has celiac disease, and I might also have the disease.” The nurse agrees that this may be possible when the client states having diarrhea after eating which food?
A. 1.Eggs
B. 2. Peanut butter
C. 3. Whole wheat bread
D. 4. Dark leafy green vegetables

21 . The client is hospitalized with emphysema. When reviewing the prescribed diet, which dietary modifications should the nurse consider appropriate if the client has no other underlying medical conditions? Select all that apply.

A. Mechanical soft
B. Low calorie
C. High protein
D. Restricted potassium
E. Increased calcium

22. The clinic nurse is planning to measure the skinfold of an underweight older adult client to estimate the amount of total body fat. Prioritize the nurse’s steps when measuring the triceps skinfold on the client.
A. Mark the midpoint of the client’s arm with a pen
B. Place the calipers at the midpoint mark and read the measurement to nearest milliliter (mL)
C. Grasp the skin and subcutaneous tissue between thumb and forefinger, pulling away from the muscle
D. Measure the distance between the acromion and olecranon processes and divide by 2 E. Ask the client to bend his or her arm at the elbow and lay the arm across his or her stomach
F. Ask the client to hang his or her arm loosely at the side

23. The nurse is planning to administer an intermittent enteral feeding through an NG tube. Which intervention should the nurse implement?
A. Administer the feeding as rapidly as possible.
B. Position the client supine for 1 hour after completing the feeding

C. Confirm tube placement after the feeding has been infused.

D. Elevate the head of the client's bed to 45 degrees during the feeding.

24. A mother is concerned about achieving a nutritious intake for her 14-month old child. Which advice by the nurse would be best?

A. Feed the child before the rest of the family and then let the child play while the family cats.

B. Because the child's stomach holds only 'A cup, select food from one food group for each meal.

C. Offer 1% tablespoons of food from each food group with every meal; offer nutritious snacks.

D. Avoid retrying foods that the child pushes away because these are foods the child dislikes.

25. The nurse is caring for the 2-year-old with iron- deficiency anemia. Which should the nurse recommend? Select all that apply.

A. Limit the toddler's milk intake to 24 ounces per day.

B. Limit the toddler's juice intake to 4 to 6 ounces per day.

C. Offer iron-rich foods such as beef, lentils, broccoli, and raisins.

D. Even if vegan, avoid feeding the toddler a vegan diet.

E. Parental feeding of the toddler to ensure an adequate intake.

26. The 6-year—old with chronic constipation is prescribed a high—fiber diet and increased fluid intake. When teaching the parents, which foods should the nurse identify as having the highest amount of fiber per serving?

A. Whole wheat or rye breads

B. Raw or cooked vegetables

C. Fresh, frozen, or dried fruits

D. Baked beans or black-eyed peas

27. The hospitalized child has lactose intolerance and is placed on a lactose restricted diet. Which dietary supplement should the nurse anticipate being added to the child's diet?

A. Protein

B. Calcium

C. Vitamin B12

D. Beta-carotene

28. The home health nurse is evaluating the parents' dietary management of the child with celiac disease. Which foods, or products that contain those foods, should the parents eliminate from their child's diet? Select all that apply. A. Rice

B. Barley

C. Wheat

D. Corn

E. Oats

29. The clinic nurse is teaching the mother about childhood nutrition. Which statements is the clinic nurse likely to include? Select all that apply. A. Infants and children need all the vitamins that adults need but in different amounts.

B. Forcing a toddler to eat a distasteful food imprints a permanent avoidance behavior. C. Calculate the recommended grams of fiber for the child by taking the child's age in years.

D. Children ages I to 2 years should be drinking whole milk rather than skim milk. E. Preschoolers are able to meet their nutritional needs by eating three healthy meals a day.

F. Preschoolers tend to eat more and stay at the table longer when eating with their peers.

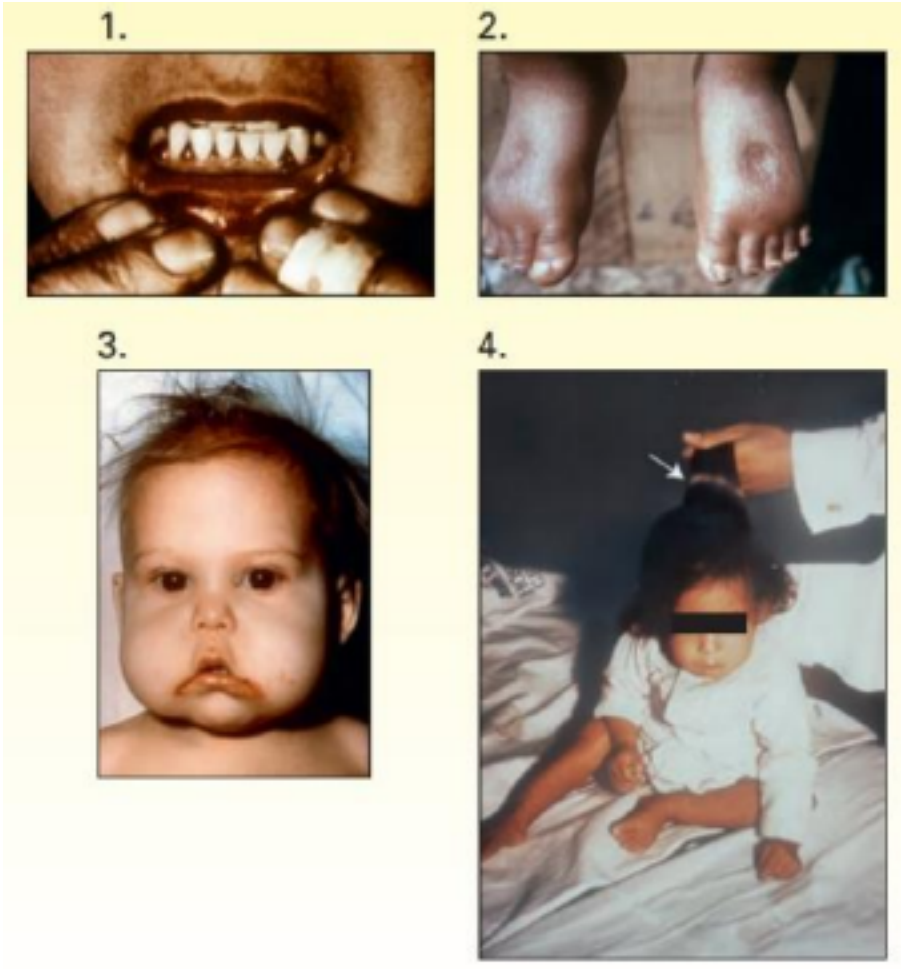
30. The child is found to be deficient in iron. To increase the child's absorption of iron, which vitamin should the nurse encourage the parents to supplement? A. Vitamin A

B. Vitamin C

C. Vitamin D

D. Vitamin E

31 . The nurse is caring for four children. Which child should the nurse further assess for a vitamin C deficiency (scurvy)?



32. The child recovering from surgery is advanced from a clear liquid to a full liquid diet. The child is requesting something to eat. Which full liquid food item should the nurse offer to the child?

A. Pudding

B. Chicken noodle soup

C. Applesauce

D. Plain gelatin

33. The older adult client is asking the nurse about nutritional information. Which response gives good nutrition advice for the older adult?

A. “Maintain an appropriate weight for your height, and include high-nutrient foods.” B. “Increase vitamin E intake, and do muscle strengthening exercises 20 minutes daily.” C. “Avoid high-fiber and gas-forming foods, and take a multivitamin supplement daily.” D. “A vegan diet and drinking at least 2 quarts of water daily are recommended as we age.”

34. The nurse is counseling the client placed on a DASH diet who has limited food refrigeration capabilities and prefers using canned vegetables. Which nutrient excess should the nurse caution the client about when eating mainly canned, rather than fresh, vegetables?

A. Potassium

B. Vitamin A

C. Vitamin C

D. Sodium

35. The clinic nurse is discussing eye health with an adult. Which nutrients should the nurse encourage the client to consume to protect against cataract development?

A. Minerals

B. Lecithins

C. Antioxidants

36. The nurse is caring for the older adult client who has experienced unintended weight loss. Which energy-dense protein foods should the nurse offer to the client when the client requests a snack?

A. Carrot sticks or apple wedges with dip

B. Peanut butter on celery or a hard-boiled egg

C. Whole wheat toast with grape jelly or a bagel

D. Yogurt or cottage cheese with blueberries

37. The nurse reads in the HCP’s history and physical note that the hospitalized child has a pica eating disorder. Which conclusions by the nurse are correct? Select all that apply.

A. The child consistently eats nonfood substances such as dirt, crayons, and paper. B. The child regurgitates, chews, and then reswallows previously ingested food. C. A primary safety concern for the child is the

possibility of accidental poisoning. D. The child's greatest risk, aspiration, should be monitored for at all times. E. Complications of the disorder can include malabsorption and fecal impaction. F. Usually children with a pica disorder are intellectually bright and precocious.

38. An experienced nurse is observing a new nurse teaching the client about TPN. Which statement indicates that the new nurse needs additional orientation regarding the administration of TPN?

A. "A gastrostomy tube will be inserted through the abdominal wall into your stomach to administer your TPN."

B. "Your blood glucose will be monitored frequently because the TPN has a high concentration of dextrose."

C. "Although an infusion pump will be used to administer the TPN solution, you can still ambulate with assistance."

D. "The TPN provides nutrients of proteins, carbohydrates, fats, electrolytes, vitamins, and trace minerals."

39. The client's infusion pump delivering TPN malfunctions, and the nurse determines that, based on the amount of solution left in the TPN bag, the client did not receive any TPN for the last 6 hours. The nurse should monitor the client for which immediate complication?

A. Air embolism

B. Rebound hypoglycemia

C. Rebound hyperglycemia

D. Low serum albumin level

40. The nurse is caring for the client with agoraphobia who has an inadequate milk intake. For which vitamin deficiency should the nurse specifically assess when caring for the client?

A. Vitamin B6

B. Vitamin A

C. Vitamin D

D. Vitamin C

41 . The nurse is caring for the client experiencing dysphagia. Which food item should the nurse remove from the client's meal tray?

A. Corn

B. Custard

C. Pureed meat

D. Moist pasta

42. The client taking lithium for treatment of a bipolar disorder is concerned that the medication is becoming less effective in controlling symptoms. It is most important for the nurse to question the client's intake of which nutrient? A. Salt

B. Protein

C. Potassium

D. Carbohydrates

43. The nurse is presenting a nutritional teaching session in a rural community. Which statement should the nurse exclude?
A. “Iron is needed for energy; fish and poultry are significant sources of iron.” B. “Fluoride is needed for bone and teeth health; well water is a good source of fluoride.” C. “Iodine deficiency can cause mental retardation; seafood is a good source of iodine.” D. “Potassium is essential to heart function; bananas are a good source of potassium.”

44. A dietary aide shows the nurse the snack options for the client on a clear liquid diet. Which selection should the nurse eliminate from the snack choices? A. Glass of skim milk
B. Small dish of plain gelatin
C. Glass of iced tea
D. Carton of apple juice

45. The nurse is caring for the newly hospitalized child whose parents practice the Hindu faith. Which dietary modification should the nurse anticipate based on their faith beliefs?
A. Abstaining from meat on Fridays
B. Eating only a vegetarian diet
C. Avoiding pork or pork products
D. Serving “hot” foods to treat a “cold” illness

46. The nurse is caring for the uninsured, homeless client with chest pain who has sought care in an ED. Which action should the nurse take? Select all that apply. A. Ask the health care provider (HCP) to see the client before admission.
B. Provide care according to the standard of care and emergency protocols.
C. Refer the client to the nearest hospital that provides charity care.
D. Treat the client respectfully and honor the client’s request to be seen.
E. Initiate a social worker consult after stabilizing and treating the client.

47. The older adult client wishes to be discharged home after a kyphoplasty. The client has a history of emphysema requiring oxygen at home. To ensure discharge to home is appropriate, which is most important for the nurse to assess?
A. Home care resources
B. Pain management plan
C. Self-care deficits
D. Medication regime

48. The client is admitted for coronary artery bypass surgery (CABG) with an anticipated admission to the coronary care unit (CCU). In preparation for the client’s hospital admission, implementation of which component will best predict the sequence and timing of care, and direct the course of the client’s hospital stay?
A. A clinical pathway

B. A client education plan

C. HCP-initiated interventions

D. Discharge planning at the time of admission

49. The 72-year—old client with a left leg DVT and a history of a brain tumor is hospitalized for 3 days. The client's care plan indicates a nursing problem of Imbalanced nutrition: less than body requirements related to poor appetite and decreased oral intake. Which assessment finding would best indicate a need to revise the care plan related to the nursing problem?

A. Oral mucous membranes are dry and cracked due to dehydration.

B. Daily intake and output shows that caloric intake is inadequate.

C. Client is not receptive to education regarding nutrition.

D. Client states not feeling hungry and not wanting to eat.

50. The pediatric client, newly diagnosed with CF, is being discharged home. The client's parents are anxious, asking many questions about the child's nutrition, medication regimen, nebulizer treatments, and chest percussion- They are expressing concerns about the high cost of care and financial hardship. Which health care disciplines should be included in a planned multidisciplinary care conference? Select all that apply.

A. Nurse

B. Dietitian

C. Social worker

D. Nursing assistant

E. Respiratory therapist

51. The client is hospitalized for GI bleeding. The client's family tells the nurse the client has a history of drinking four to eight beers every day. The client lives alone, is unemployed, and is uninsured. Which collaborative action provides the best overall client care?

A. Calling the case manager to obtain a consult for chemical dependency

B. Consulting a multidisciplinary team to review the client's problem list

C. Calling the HCP and recommending orders to treat delirium tremens (UPS)

D. Consulting the social worker to address client finances and placement

52. The nurse reviews the plan of care for the client with COPD and limited mobility. The nurse notes that the physical therapist changed the plan to progress the client's ambulation from 100 to 200 feet twice a day. Which intervention should the nurse implement to ensure that the client's needs are met?

A. Instruct the physical therapist not to ambulate the client without the nurse present B. Inform the physical therapist of the client's respiratory status prior to ambulation

C. Tell the physical therapist that changes to the plan of care should not be made at this time

D. Inform the HCP about the physical therapist's plan to progress the client's ambulation

53. The HCP notifies the nurse that the client will be discharged from the hospital tomorrow. The client is unable to ambulate to the bathroom independently, lives alone, and has a poor appetite. With which discipline is it most important for the nurse to collaborate for discharge planning?

A. Dietitian

B. Social worker

C. Pharmacist

D. Physical therapist

54. The nurse is caring for the client who has a permanent tracheostomy, is receiving oxygen therapy and oral respiratory medications, and requires chest physiotherapy. Which members of the interdisciplinary team should the nurse initially include in the plan of care? Select all that apply.

A. Respiratory therapist

B. Physical therapist

C. Speech therapist

D. Social worker

E. Occupational therapist

55. The client with CRF is placed on a restricted renal diet that includes limiting protein and dairy intake. Alter reviewing a list of allowed, limited, and restricted foods, the client tells the muse, “I don’t like any of the acceptable food choices, and some are against my faith beliefs!” Which collaborative action would best meet the client’s needs?

A. Review the list With the client and compromise on which foods are acceptable

B. Identify the primary meal preparer in the family and review the list with that person

C. Report the client’s noncompliance to the HCP so medications may be adjusted

D. Initiate a referral to the dietitian for counseling the client on acceptable foods

56 . The client is going home with a new prescription of fluticasone/salmetcrol diskus. The client has never used a diskus delivery system before. Which member of the health care team should the nurse consult to instruct the client in the proper use of the diskus?

A. Case coordinator

B. Respiratory therapist

C. Social worker

D. Pharmacist

57. TWO years ago, the older adult client was diagnosed with CRF requiring dialysis. The client is admit- ted to a hospital with pneumonia for the third time in the last 9 months. Which health care team member should the nurse consult to enable the client to cope with a chronic disease? \

A. palliative care nurse

B. Social worker

C. Dialysis nurse

D. Charge nurse

58.The new nurse reattaches the client’s pulse oximeter finger probe after it was off and the machine was alarming. When the alarm is heard again, the nurse finds a reading of 84 with the number quickly changing to 92. The client’s pulse oximeter readings continue to vary from 84 to 94, causing the machine to alarm

frequently. Which action will help the nurse to establish a safe and accurate pulse oximeter reading?
A. Replace the machine with a functioning oximeter machine.
B. Consult with a more experienced nurse about the problem.
C. Turn the alarm off, since it is not functioning properly.
D. Notify the HCP of the client's low oximeter readings.

59. The nurse assesses that the client with delirium tremens is becoming increasingly agitated. The nurse notes that IV doses of diazepam, lorazepam, and propofol are prescribed for the client, but is unclear regarding which medication would be most effective. Which action by the nurse will best improve the client's outcome?
A. Give the same medication given by the previous nurse, knowing it will provide some relief
B. Contact the HCP for a different medication, knowing these will not reduce agitation
C. Administer the propofol, because the client's agitation may lead to client self-harm
D. Consult a pharmacist on the medication actions and ask for advice on which to give

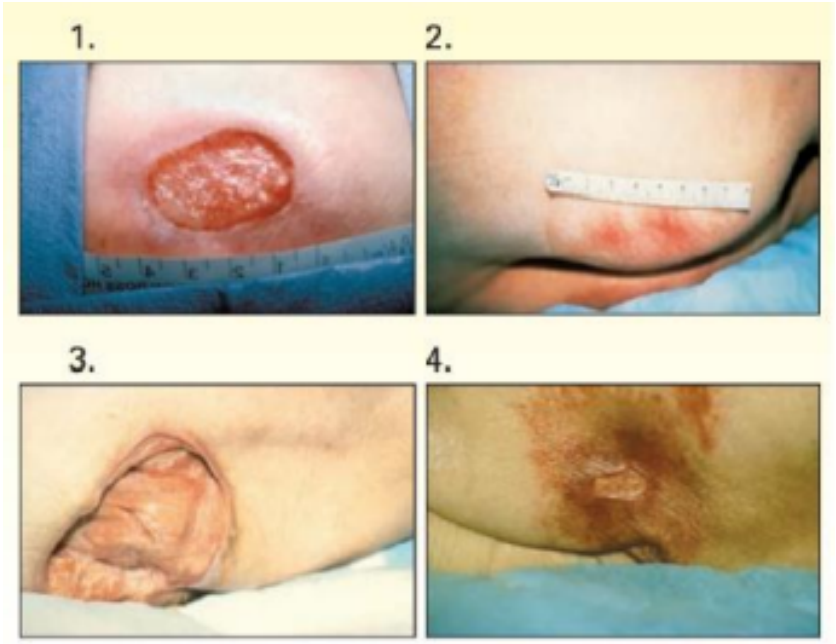
60. The nurse expects the client who returned from surgery performed 2 hours ago to be more alert. The client is difficult to awaken and has intermittent apnea. The client's BP was in the low 1003 but is now 90/54 mm Hg. Rank the nurse's actions to obtain immediate assistance in the order of importance.
A. Assist in the reassessment of the client.
B. Contact the surgeon
C. Request the acute response team (ART).
D. Prepare necessary equipment, including an oximeter and noninvasive BP monitor.
E. Communicate using a handoff method such as SBAR.
F. Contact the client's family to update them regarding the changes in the client's condition

61. The nurse finds the client in respiratory distress with a decreasing level of consciousness and calls the ART. The ICU nurse is on the ART. Which action demonstrates that the ICU nurse is a resource to the nurse on the medical unit?
A. The ICU nurse requests information in the SBAR format.
B. The ICU nurse obtains the client's vital sign measurements
C. The ICU nurse calls the client's health care provider.
D. The ICU nurse reviews assessment findings with the medical nurse.

62. The new client is admitted to a facility and requires an initial admission assessment. Which actions should the nurse include in the admission assessment? Select all that apply.
A. Ask questions to obtain subjective data
B. Take the client's vital signs
C. Develop the client's care plan
D. Obtain functional ability information
E. Document the education completed

63. After finding a pressure ulcer on a client's but- tock, the nurse documents the following description in a

variance (incident) report: Right buttock area reddened. There is a break in the skin with skin loss iI-zvolving the dermis and epidermis. It appears crater-like. There is no slough present. Which illustration best identifies the pressure ulcer about which the nurse is documenting in the variance re



64. The client is being transferred to a subacute unit at another facility. The nurse calls the facility to give a verbal report to the nurse assuming the client's care. Which statement best ensures that the continuity of care is maintained?

A. "Because I am passing responsibility for care to you, I need to document your name."
B. "I am calling to give you an overview of the client's condition, treatment plan, and needs."
C. "I sent the transfer forms with the client; these pro- vide the information you need for care."
D. "I let the client know about the plans for transfer and the care that the client will receive."

65. The client is being referred to the neurosurgeon at another facility. The nurse prepares the client for transfer. Which items should be included in the transfer? Select all that apply.

A. Medications supplied by the hospital
B. Clinic records from birth to present time
C. Emergency supplies and medications
D. A copy of the client's medical record
E. Personal belongings brought to the hospital

66. The homeless client is being discharged from the hospital. The client has no family support or resources. To which service should the nurse refer the client?

A. The Social Security office
B. Homeless shelter facility
C. Public health clinic
D. Parish nursing program

67. The nurse is giving a change-of-shift report to another nurse. What are the essential components of a change-of-shift report? Select all that apply.

A. Reporting the client's medical diagnosis

B. Sharing new orders, medications, and treatments

C. Sharing personal opinions about treatment options

D. Discussing the effectiveness of analgesics

E. Sharing routine turning schedule for the client

F. Identifying areas for priority focus on the next shift

68. The client is urgently being prepared for transfer to another facility to receive a higher level of care. Which documents are essential to provide to the receiving facility? Select all that apply.

A. EMTALA form

B. Client teaching record

C. Transfer note

D. History and physical

E. Progress notes

F. Activity flowsheet

69. The elderly client, who has been newly diagnosed with end-stage COPD, is to be discharged home. The client is unable to provide self—care and requires continuous assistance. Which service would provide the greatest assistance to the client's spouse, who would be the sole caregiver?

A. Skilled nursing care

B. Respite care

C. Hospice care

D. Physical therapy

70. The client is scheduled to have a CXR and a pulmonary function test (PFT). The client tires easily. Which action should be taken by the nurse to best coordinate the client's care?

A. Send the client for the CXR but have the PF T rescheduled for the next day

B. Have the CXR changed to a portable CXR and then send the client for the PFT

C. Escort the client to both tests so the client can be returned to the unit if too tired

D. Call the radiology department to request that the CXR be done right before the PFT

71. The nurse on a hospital's performance improvement committee evaluates potential activities that will lead to performance improvement for the department. Which are performance improvement activities? Select all that apply.

A. Improve client satisfaction scores

B. Reduce client fall rates

C. Increase client census

D. Reduce anticoagulant medication safety events

E. Increase the number of quality assurance nurse staff

F. Reduce hospital-acquired infections

72. The nurse manager is teaching nursing staff about the use of an evidence-based practice (EBP) framework for performance improvement. Which description should the nurse manager include?
A. Utilizing the Cochrane Collaboration Database to find research summaries that have compared and contrasted various research study findings and made recommendations for nursing practice.
B. Collecting information on a problem, establishing a clinically focused question, analyzing pertinent research and clinical practice evidence, and identifying implications for practice.
C. Accessing guidelines from the National Guideline Clearinghouse to evaluate whether the client's treatments for a particular diagnosis are according to the established guidelines.
D. Determining whether the nursing process steps of assessment, analysis, planning, implementation, and evaluation are being implemented when providing nursing care to clients.

73. The nurse is aware of the American Nurses Association's nursing-sensitive quality indicators regarding the management and prevention of hospital- acquired infections. Which nursing action is most likely to reduce hospital-acquired infection rates?

A. Ensuring appropriate nurse-to-client ratios
B. Improving functioning of the team
C. Monitoring medication safety events
D. Ensuring adequate supplies are available for care Delivery

74. The new nurse manager on the maternity unit is informed by staff that family members have been unhappy about the policy limiting the number of visitors for the first 24 hours postpartum. Which initial action by the nurse manager is most appropriate?
A. Compare policies for the number of allowable visitors in other maternity units in area hospitals
B. Change the policy to allow an unlimited number of visitors for a 3-month pilot program
C. Plan to explore this concern in two months when the orientation to the new position is finished
D. Mail surveys to past clients exploring their feelings about the hospital's visiting policies

75.The supervising nurse is double- checking the new nurse's heparin dose prior to administration and determines that the dose is incorrect. The nurse has withdrawn 2.5 mL of heparin from a vial labeled 5000 units/mL. The client is to receive 2500 units. How much heparin should the supervising nurse ask the new nurse to expel from the syringe? _____ mL (Record your answer as a whole number.)

76 . The table illustrated is presented at a unit's performance improvement committee meeting. Which measure indicates the greatest need for improvement compared to other hospitals?

Surgical Infection Prevention Measures	Current Rate	Benchmark
Cardiac surgery clients with controlled 6 a.m. postoperative serum glucose	90.22%	85%
Colorectal surgery clients with immediate postoperative normothermia	78.58%	85%
Surgery clients with recommended DVT prophylaxis ordered	88.72%	95%
Surgery clients who received appropriate DVT prophylaxis within 24 hours prior to surgery to 24 hours after surgery	84.75%	95%
Prophylactic antibiotic received within 1 hour prior to surgical incision	90.74%	100%
Prophylactic antibiotics discontinued within 24 hours after surgery end time	80.57%	100%

A. Cardiac surgery clients with controlled 6 am. postoperative serum glucose
B. Colorectal surgery clients with immediate postoperative normothermia
C. Surgery clients who received appropriate DVT prophylaxis within 24 hours prior to surgery to 24 hours alter surgery
D. Prophylactic antibiotics discontinued within 24 hours after surgery end time

77. The client with hyperglycemia is receiving a continuous IV insulin drip. The nurse checking the client's blood glucose hourly obtains a reading of 32 mg/dL. The client who was alert is now lethargic and does not respond to questions. The nurse administers 25 mL of Dsow per protocol. The client begins to respond. Which additional risk management action should be taken by the nurse?
A. Continue the insulin drip at the same rate
B. Report the event to the nurse manager
C. Recheck the blood glucose level in 1 hour
D. Administer a second dose of 25 mL of DSOW

78. Prior to medication administration, a hospital policy requires a double-check of two unique client identifiers against the MAR. The nurse manager forms a performance improvement team with the goal of improving nursing compliance with this important safety check. Which activity, related to checking two unique identifiers, should be the responsibility of the performance-improvement team?
A. Hold staff accountable for the practice of checking two unique identifiers
B. Discipline staff members who fail to comply with checking two unique identifiers
C. Observe and report the practice of medication administration
D. Change the practice of two unique identifiers to a more compliant practice

79. A hospital recently formed an ART with the goal of reducing unexpected cardiopulmonary arrests. Which

measures should be used to evaluate the performance of the ART? Select all that apply.

A. The number of cardiopulmonary arrests

B. The types of supplies used during the ART call

C. Evaluation of the acute response team's actions

D. The outcome of the client following the ART call

E. The types of medications given during the ART call

80. The family complains to the oncoming shift nurse about the poor care provided by the previous nurse. They state that discharge instructions including how to perform dressing changes and the client's activity level were confusing and incorrect. After meeting the client and family needs, which action should the oncoming nurse take to prevent this situation from happening again?

A. Ask other nurses if they encountered similar situations while working with that nurse

B. Review documentation to see if the previous nurse provided the discharge education

C. Describe the client and family complaint in a report to the risk manager

D. Report the incident of the nurse's alleged incompetence to the nurse manager

81. The nurse observes the following situations. Which situations would require the nurse to complete a variance (or incident) report? Select all that apply.

A. An antibiotic given 2 hours later than scheduled

B. The HCP who is angry with a delayed laboratory report

C. An incomplete laboratory draw ordered for the Morning

D. The client falling out of bed and suffering an ankle fracture

E. The new nurse arriving late to work for the third time

82. In reviewing an HCP's orders for the client, the oncoming shift nurse finds that an antibiotic was prescribed but is not listed on the client's MAR. Three doses were missed. Which action should minimize the nurse's malpractice risk?

A. Contact the previous nurse to discuss the omission

B. Complete the agency's incident or variance report

C. Contact the HCP and request a new antibiotic order

D. Document the reason for the error in the medical record

83. Two days after the client's admission, the nurse notices an omitted order to implement a venous thromboembolic protocol. Which statement best describes appropriate initial follow-up?

A. "I am glad I didn't make that mistake; that other nurse is going to be in trouble."

B. "I am too busy to complete a variance report. I'll do it tomorrow when I work."

C. "I need to contact the health care provider and complete a variance report."

D. "I will need to contact the supervisor immediately about this error."

84. The client falls from a bed, and the nurse documents the incident. Based on the following documentation of the client's fall, place an X at the time the nurse would make a risk-management error related to the client's medical record.
2100 Noise heard from the client's room. Client found lying on the floor. States she hit her head. Alert and oriented X3. PEARLA. No visible injuries, but moaning and holding head. Returned back to bed (see physical findings flowsheet). Will continue to monitor. Client instructed on use of call light for help with getting out of bed. _____ KAO

2115 Charge nurse A. Smith, RN, and Dr. Brown notified of client fall. Dr. Brown states he will come in to assess the client. _____ KAO

2130 Dr. Brown here. Client sent for CT of the head with RN monitoring. See physical findings flowsheet. No change in client status. _____KAO

2145 Variance form completed and filed in the client's medical record. _____ KAO

2200 Return from head CT. Voided 300 Ml while on bedside commode. Returned to bed with bed exit alarm on. Reminder given on use of call light for help with getting out of bed. Neuro reassessment completed. No change in neuro status. _____KAO

85. The nurse reviews the admission findings after treating the client who had fallen and determines that a fall assessment was not completed on admission. Which is the best action by the nurse?
A. Complete a variance report and place the client on high risk for a fall alert.
B. Complete a variance report and notify the nurse manager regarding the missing assessment.
C. Implement the agency's fall prevention policy.
D. Place wrist restraints on the client to prevent future falls.

86 . The nurse has a conflict with another staff member regarding a perceived lack of teamwork and negative attitude. Which are common effective conflict-resolution strategies? Select all that apply.

A. Avoiding
B. Postponing
C. Opposing
D. Confronting
E. Smoothing

87. The nurse manager is planning an orientation program for new graduates. Which strategies should the nurse manager consider to promote retention of these nurses?

A. Implement a self-scheduling system and establish a holiday work schedule based on annual rotation
B. Plan a party to welcome the new hires and assign a mentor with a ratio of one mentor to four new hires
C. Involve unit staff in interviewing new hires and initiate a preceptor program using motivated staff nurses
D. Develop a standardized six-week orientation for all new hires and celebrate their one year anniversary

88. The nurse manager is developing next year's equipment budget. Which factors should be considered

when deciding how many oxygen flow meters should be purchased next year? Select all that apply.

A. Staff request for more flow meters

B. Cost of nasal cannulas

C. Cost of flow meters

D. Current number of flow meters

E. Predicted client use days for next year

89. The nurse manager is evaluating the new nurse's time-management skills. Which statement made by the new nurse may indicate potential concerns with time management?

A. "I am late in giving the eye drops because I needed to assist with a dressing change."

B. "I completed the physical assessment before checking the morning medications to be given."

C. "I admitted the client who came 15 minutes before my shift ended so I didn't get out on time."

D. "I should be leaving, but I am still documenting all of the treatments I performed today."

90. At a staff meeting, the nurse manager shares that the unit is over budget by 2% and needs to reduce costs. A staff nurse suggests that reports could be shortened so that nurses could finish their shifts on time. How should the nurse manager measure the success of this idea once implemented?

A. Observe the change-of-shift report to determine how many nurses are leaving on time

B. Delegate monitoring the change-of-shift report to the charge nurses

C. Review the capital budget expenditures on a monthly basis

D. Monitor for a reduction in nursing hours per client day

91. The nurse notices a posting on a bulletin board for a continuing education (CE) offering on the prevention of pressure ulcers. Which is the most compelling reason for the nurse to attend?

A. The unit has experienced an increase in the number of clients with pressure ulcers.

B. The nurse wants continuing education in order to keep up with current clinical knowledge.

C. The nurse needs one more continuing education unit for state license renewal.

D. The nurse is able to attend by coming in 1 hour earlier than the next scheduled shift.

92. The nurse educator is responsible for teaching staff members about a change in a central line dressing change procedure. Which method of education would best enhance the staff's retention of this information?

A. In-service education

B. Specialty certification

C. Informal education

D. Providing a contact hour

93. The day charge nurse is preparing to report to the oncoming shift nurse. Which action should be taken first by the charge nurse when learning that the unit will be short staffed because two nurses called in ill and the hospital does not have any extra nurses?

A. Ask two off-going nurses to stay and work overtime

B. Notify the nurse manager of the situation

C. Ask the ward secretary to call nurses who are off to come in to work

D. Reallocate responsibilities to better utilize the nursing assistants (NAs)

94. Several nurses are discussing their unhappiness with some residents of an extended care facility placing increased demands on staff. Which statement, if made by one of the nurses, suggests a unit culture characteristic of transformational leadership?
A. “I discussed this problem with the nurse manager, and the nurse manager will take this concern to the Medical Director.”
B. “Because these demands are occurring more at night, the night charge nurse should talk to the residents causing the problems for us.”
C. “The nurse manager suggested that I place this concern on the agenda for a weekly staff meeting so we can get staff input.”
D. “We made a list of the actual incidents that are concerning to us and now can send these specifics to the nurse manager and Medical Director.”

95. The nurse manager is mediating a grievance brought by the NA about the nurse after the NA was unsuccessful in resolving the conflict. At the mediation session the NA repeatedly states that THE nurse’s delegation is unfair and overloading while the nurse continues to repeat the REASONS for the *delegated* activities. Which is the nurse manager’s best course of action at this time?
A. Inform the nursing assistant that the nurse is delegating appropriately
B. Tell the two individuals that they need to reach their own resolution
C. Ask each party to explore if there are other issues surrounding the conflict
D. Continue to attentively listen as the parties repeat their thoughts and feelings

96. The nurse is counseling the client who is trying to become pregnant. To promote fetal health when the client is unaware of a pregnancy, the nurse should stress the inclusion of which nutrient in daily food intake?
A. Potassium
B. Calcium
C. Folic acid
D. Sodium

97. The nurse is reviewing the medication history of the client during preconception counseling. The client reports taking isotretinoin for acne. Which is the nurse’s best response?
A. “Stop taking isotretinoin now! It can cause serious birth defects if you become pregnant.”
B. “You need to be on some type of birth control right now. Getting pregnant is not an option.”
C. “Talk with your HCP about changing isotretinoin before you consider becoming pregnant.”
D. “Once you are off of isotretinoin for treating acne, you can then safely become pregnant.”

98. The nurse is counseling the client who has SLE. The client tells the nurse that she plans to become pregnant in the next year. Which response by the nurse is correct?
A. “It is best to plan for your pregnancy when you have been in remission for 6 months.”
B. “Having systemic lupus erythematosus will not impact your pregnancy in any way.”
C. “Your chances of having an infant with congenital malformations are increased with SLE.”
D. “You will need to be scheduled for a cesarean delivery to prevent disease transmission.”

99. The 22-year-old client tells the clinic nurse that her last menstrual period was 3 months ago, which began on November 21. She has a positive urine pregnancy test. Using Naegele’s rule, which date should the nurse

calculate to be the client's estimated date of confinement (EDC)?

A. August 28

B. January 28

C. August 15

D. January 15

100. The client, who is Chinese American and pregnant, is receiving nutritional counseling about the need for increased amounts of calcium in her diet. Which response by the nurse is most helpful when the client states she does not consume any dairy products?

A. "Tell me how you perceive dairy products in your culture."

B. "Try having a glass of soy milk at each meal and at bedtime."

C. "Tell me about your intake of fortified tom and leafy green vegetables."

D. "Rice milk fortified with calcium and nettle tea are good calcium choices."

101 . The client tells the nurse, "Most days, I am so happy I am pregnant, but other days, I am not sure that I am ready to have a baby." Which is the most accurate response from the nurse?

A. "This is such a happy time in your life. You need to be optimistic to feel happy."

B. "How does your spouse feel about the pregnancy? I hope he is happy about the baby."

C. "Feeling differently from day to day is normal. How do you feel today?"

D. "Why do you feel this way? Is there something I can do to make it better for you?"

102. The nurse is teaching the pregnant client during her first trimester. The nurse identifies that which decision is most important for her to make first?

A. Bottle versus breastfeeding

B. Labor and delivery location

C. Pain management during labor

D. Method for delivery of the baby

103. The pregnant client is experiencing low back pain. After determining that the client is not in labor, the nurse instructs the client to perform which exercises to increase comfort and decrease the incidence of the low back pain? Select all that apply.

A. Kegel exercises

B. Pelvic tilt exercises

C. Leg raises

D. Back stretch

E. Stepping

104. The nurse's assessment findings of the pregnant Client include darkening of areola and nipple, presence of Goodell's sign, leukorrhea, HR 124 bpm, dysuria, and heartburn. Of these findings, how many require further evaluation? _ findings (Record your answer as a whole number.)

105. The pregnant client and her significant other are attending childbirth classes. The client asks for guidance on preparing her school-aged child for the new baby's birth. Which strategies might the nurse suggest that the client use with her child? Select all that apply. A. Read books about bringing home a new baby.

B. Think of unique names for the new baby.

C. Help pack a bag for bringing the new baby home.

D. Explain how pregnancy occurred, if asked.

E. Help the child buy presents for the new baby.

106. The nurse is counseling the client who is pregnant. The nurse should teach that which assessment finding requires follow-up with the HCP?

A. Dependent edema

B. Edema in the hands

C. Generalized edema

D. Edema occurring every evening

107. The client expresses concerns related to nausea in the first trimester of pregnancy. Which recommendation should the nurse make?

A. Eat crackers while still in bed in the morning.

B. Lie down and rest whenever nausea occurs.

C. Eat more frequently throughout the day.

D. Avoid food items containing ginger.

108. The nurse is providing nutrition counseling to the client during her first prenatal clinical visit. Which statement, if made by the client, indicates that the client has an understanding of some of the nutritional requirements during pregnancy? A. "I can eat cheese as an alternative to milk, as I don't care for milk."

B. "I should be eating more at each meal because I'm eating for two."

C. "I will need to limit my calories because I am already overweight."

D. "I should limit myself to eating only three healthy meals per day."

109. The nurse is providing nutrition counseling to a primigravida who is 10 weeks pregnant. Which meal choice stated by the client indicates she needs additional information?

A. Black beans, wild rice, collard greens

B. Dry cereal, milk, dried cranberries

C. Tuna, broccoli, baked potato

D. Beef strips, lentils, red peppers

110. The nurse evaluates the pregnant client with sickle cell disease during her second trimester. The nurse should identify which manifestation as being related to sickle cell disease and not the pregnancy?

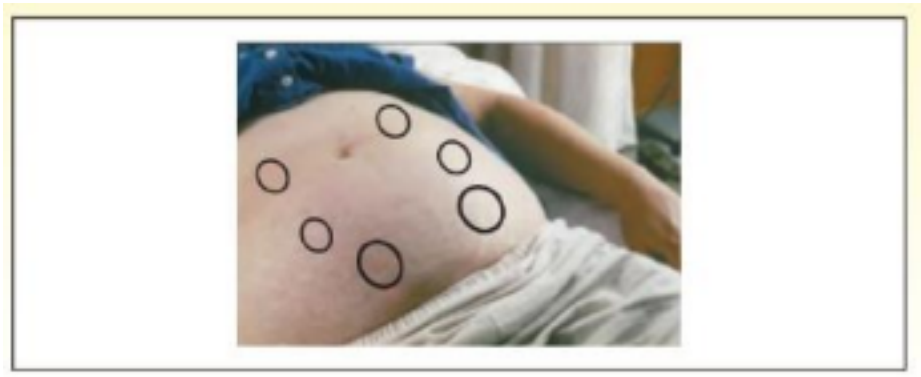
A. Hand and lower extremities edema

B. 2- Elevated serum blood glucose level

C. Decreased oxygen saturation level

D. Elevated blood pressure

111 . The nurse is assessing the client who is 34 weeks' gestation. Place an X where the nurse should place the Doppler first to assess the FHR when the fetus is thought to be left occiput anterior ('LOA).



Answer:

[Explanation: FHT are best heard in the lower left quadrant of the client's abdomen when the fetus is LOA.]

112. The client who is 32 weeks pregnant asks how the nurse will monitor the baby's growth and determine if the baby is "really okay." Which assessments should the nurse identify for evaluating the fetus for adequate growth and viability? Select all that apply. A. Auscultate maternal heart tones.

B. Measure the height of the fundus.

C. Measure the client's abdominal girth.

D. Complete a third-trimester ultrasound.

E. Auscultate the fetal heart tones (F HT).

113. The client tells the nurse that she is using cocoa butter on her abdomen to prevent stretch marks. Which is the most accurate response from the nurse?

A. "That is wonderful. If you continue to use cocoa butter daily, you should have no stretch marks after delivery."

B. "The cocoa butter will not prevent stretch marks completely, but it will help to reduce their number."

C. “The cocoa butter will not prevent stretch marks but Will decrease the appearance of the linea nigra.”
D. “Cocoa butter does not prevent stretch marks, but it soothes itching that occurs as your abdomen enlarges.”

114. The nurse is caring for the 24-year-old client whose pregnancy history is as follows: elective termination age 18 years, spontaneous abortion age 21 years, term vaginal delivery at 22 years old, and currently pregnant again. Which documentation by the nurse of the client’s gravidity and parity is correct?
A. G4P1
B. G4P2
C. G3Pl
D. G2P1

115. The nurse is caring for the pregnant client at 20 weeks’ gestation. At what level should the clinic nurse expect to palpate the client’s uterine height?
A. Two finger-breadths above the symphysis pubis
B. Halfway between the symphysis pubis and the umbilicus
C. At the level of the umbilicus
D. Two finger-breadths above the umbilicus

116. The nurse assesses the fundal height for multiple pregnant clients. For which client should the nurse conclude that a fundal height measurement is most accurate? A. The pregnant client with uterine fibroids
B. The pregnant client who is obese
C. The pregnant client with polyhydramnios
D. The pregnant client experiencing fetal movement

117. The nurse is conducting a physical assessment of the pregnant client. Which physiological cervical changes associated with pregnancy should the nurse expect to find? Select all that apply.
A. Formation of mucus plug
B. Chadwick’s sign
C. Presence of colostrum
D. Goodell’s sign
E. Cullen’s sign

118. The nurse is assessing pregnant clients. During which time frames should the nurse expect clients to report frequent urination throughout the night? Select all that apply. A. Before the first missed menstrual period
B. During the first trimester
C. During the second trimester
D. During the third trimester
E. One week following delivery

119. The pregnant client asks the nurse, who is teaching a prepared childbirth class, when she should expect to feel fetal movement. The nurse responds that fetal movement usually can first be felt during which time frame?

A. 8 to 12 weeks of pregnancy

B. 12 to 16 weeks of pregnancy

C. 18 to 20 weeks of pregnancy

D. 22 to 26 weeks of pregnancy

120. The nurse is caring for the pregnant client at the initial prenatal visit. Which universal screenings should the nurse complete? Select all that apply.

A. Taking the client's blood pressure

B. Doing a urine dipstick test for protein

C. Doing a urine dipstick test for glucose

D. Asking questions about domestic Violence

E. Asking questions about use of tobacco

121 . While assessing the prenatal client, the nurse found a number of concerning problems. Place the concerning problems in the sequence that they should be addressed by the nurse.

A. Currently bleeding and cramping

B. Previous varicella infection

C. Currently using tobacco

D. Has intense pelvic pain

122. The nurse is reviewing the laboratory report from the first prenatal visit of the pregnant client. Which laboratory result should the nurse most definitely discuss with the HCP?

A. Hemoglobin 11 gdL; hematocrit 33%

B. White blood cell (WBC) count: 7000/mm3

C. Pap smear: human papilloma virus changes

D. Urine pH: 7 .4; specific gravity 1.015

123. The nurse is taking the health history of the 40-year-old pregnant client. Which identified medical conditions increase the client's risk for complications during her pregnancy? Select all that apply.

A. Diabetes mellitus type 2

B. Previous full-term pregnancy

C. Controlled chronic hypertension

D. New onset of iron-deficiency anemia

E. Hemorrhage with a previous pregnancy

124. Multiple women are being seen in a clinic for various conditions. From which clients should the nurse prepare to obtain a group beta streptococcus (GBS) culture? Select all that apply.

A. The client who is having symptoms of preterm labor

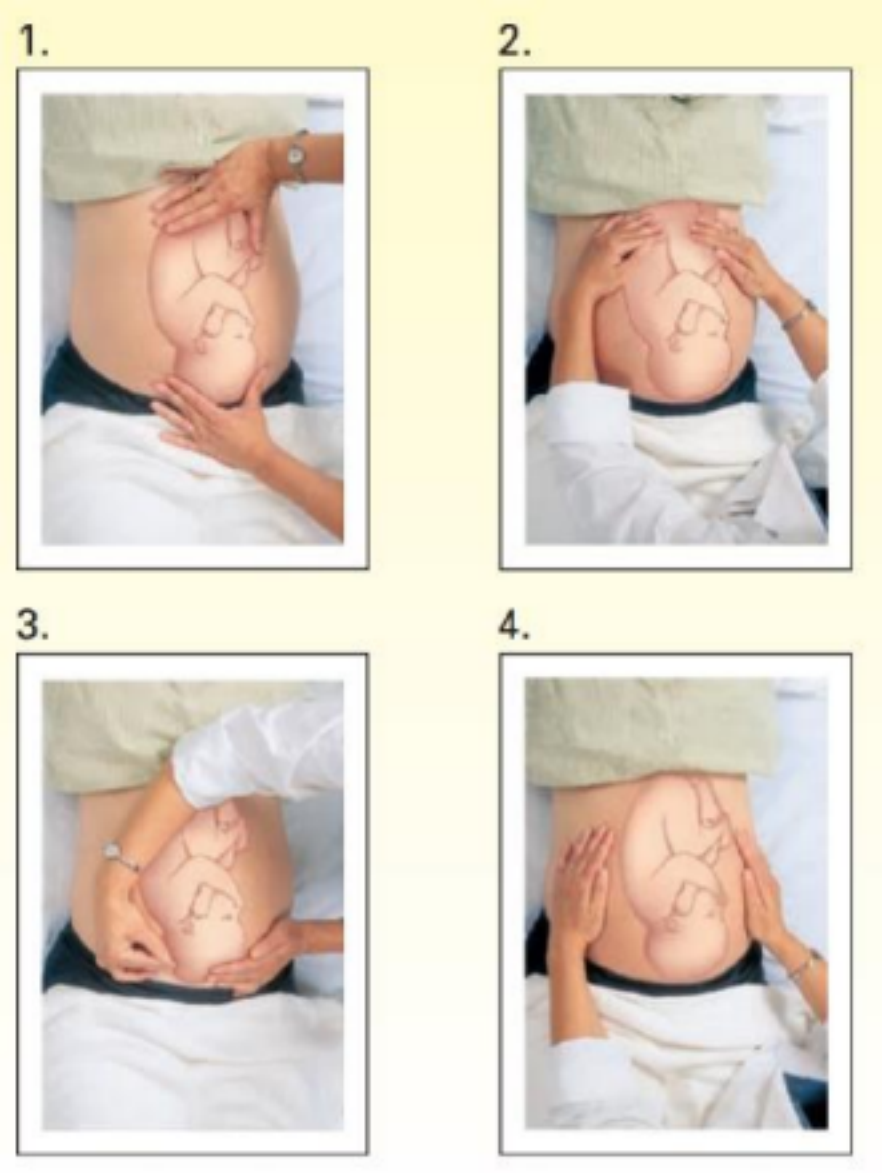
B. The women who had a neonatal death 1 year ago

C. All pregnant women coming to the clinic for care

D. The women who had a spontaneous abortion 1 week ago

E. The women who had an abortion for an unwanted Pregnancy

125. The experienced nurse is observing the new nurse determine the fetal position of the pregnant client using Leopold maneuver. The experienced nurse determines that the new nurse correctly identifies the first Leopold maneuver when placing the hands in which position illustrated first?



126. The pregnant client has an abnormal l-hour glucose screen and completes a 3-hour, 1OO-g oral glucose tolerance test (OGTT). Which test results should the nurse interpret as being abnormal?

A. Fasting blood glucose = 104 mg/dL

B. 1-hour = 179 mg/dL

C. 2-hour = 146 mg/dL

D. 3-hour = 129 mg/dL

127. The nurse is reviewing the laboratory test results of the pregnant client. Which laboratory test findings would require further follow-up from the nurse?

Laboratory Test	Result
Hgb	10.6 g/dL
Indirect Coombs' test	Negative
50-g 1-hour glucose test	137
Glucosuria	Negative
Proteinuria	Trace
Group beta streptococcus (GBS)	Negative

A. Hemoglobin

B. 50-g, l-hour glucose test

C. Glucosuria

D. Proteinuria

128. The nurse assesses the 34-week pregnant client (G2PI). Place the assessment findings in the sequence that they should be addressed by the nurse from the most significant to the least significant.

A. Pedal edema at +3

B. BP 144/94 mm Hg

C. Positive group beta streptococcus vaginal culture

D. Fundal height increase of 4.5 cm in 1 week

129. The pregnant client tells the nurse that she thinks she is carrying twins. In reviewing the client's history and medical records, the nurse should determine that which factors are associated with a multiple gestation? Select all that apply.

A. Elevated serum alpha-fetoprotein

B. Use of reproductive technology

C. Maternal age greater than 40

D. History of twins in the family

E. Elevated hemoglobin levels

130. The 22—year-old client, who is experiencing vaginal bleeding in the first trimester of pregnancy, fears that she has lost her baby at 8 weeks. Which definitive test result should indicate to the nurse that the client's fetus has been lost?

A. Falling beta human chorionic gonadotropin (BHCG) measurement

B. Low progesterone measurement

C. Ultrasound showing a lack of fetal cardiac activity

D. Ultrasound determining crown—rump length

131 . The pregnant client (GIPO) in the first trimester tells the nurse that she is anxious about losing her baby, prenatal care, and her labor and birth. Which teaching need should the nurse identify as priority?

A. Sexual relations with her spouse

B. Fetal growth and development

C. Options for labor and delivery

D. Preparing needed items for the baby

132. The nurse is teaching the client who is wishing to travel by airplane during the first 36 weeks of her pregnancy. Which is the primary risk of air travel for this client that the nurse should address?

A. Risk of preterm labor

B. Deep vein thrombosis

C. Spontaneous abortion

D. Nausea and vomiting

133. The first trimester pregnant client asks the nurse if the activities in which she participates are safe in the first trimester. Which activity should the nurse verify as a safe activity during the client's first trimester?

A. Hair coloring

B. Hot tub use

C. Pesticide use

D. Sexual activity

134. The nurse is counseling the pregnant client who has painful hemorrhoids. Which initial recommendation should be made by the nurse?

A. Apply steroid-based creams.

B. Modify the diet to include more fiber.

C. Treat these surgically before delivery.

D. Increase intake of foods with flavonoids.

135. The client presents with vaginal bleeding at 7 weeks. Which action should be taken by the nurse first?

A. Take the client's vital signs

B. Prepare examination equipment

C. Give 2 liters oxygen per nasal cannula

D. Assess the client's response to the situation

136. The client who is actively bleeding due to a spontaneous abortion asks the nurse why this is happening. The nurse advises the client that the majority of first-trimester losses are related to which problem?

A. Cervical incompetence

B. Chronic maternal disease

C. Poor implantation

D. Chromosomal abnormalities

137. The pregnant client presents with vaginal bleeding and increasing cramping. Her exam reveals that the cervical os is open. Which term should the nurse expect to see in the client's chart notation to most accurately describe the client' condition?

A. Ectopic pregnancy

B. Complete abortion

C. Imminent abortion

D. Incomplete abortion

138. Interventions have been prescribed by the HCP for the client with decreased fetal movement at 35 weeks' gestation. Place the prescribed interventions in the sequence that they should be performed by the nurse.

A. Prepare for a nonstress test

B. Prepare for a biophysical profile

C. Palpate for fetal movement

D. Apply and explain the external fetal monitor

139. The nurse is screening prenatal clients who may be caniers for potential genetic abnormalities. Which ethnic group should the nurse identify as having the lowest risk for hemoglobinopathies, such as sickle cell disease and thalassemia?

A. African descent

B. Southeast Asian descent

C. Scandinavian descent

D. Mediterranean descent

140. The pregnant client tells the nurse that she smokes two packs per day (PPD) of cigarettes, has smoked in other pregnancies, and has never had any problems. What is the nurse's best response?

A. "I'm glad that your other pregnancies went well. Smoking can cause both maternal and fetal problems, and it is best if you could quit smoking."

B. "You need to stop smoking for the baby's sake. You could have a spontaneous abortion with this pregnancy if you continue to smoke."

C. "Smoking can lead to having a large baby, which can make delivery difficult. You may even need a cesarean section."

D. "Smoking less would eliminate the risk for your baby, and you would feel healthier during your pregnancy."

141 . The 28-year-old pregnant client (G3P2) has just been diagnosed with gestational diabetes at 30 weeks. The client asks what types of complications may occur with this diagnosis. Which complications should the nurse identify as being associated with gestational diabetes? Select all that apply.

A. Seizures

B. Large-for—gestational-age infant

C. Low—birth-weight infant

D. Congenital anomalies

E. Preterm labor

142. The client is diagnosed with pregnancy—related diabetes at 28 weeks' gestation. In teaching the client, the nurse includes which information for man- aging her blood glucose levels? Select all that apply.

A. Drawing glycosylated hemoglobin A1c levels

B. Performing home blood glucose monitoring

C. Developing a weight management plan

D. Engaging in appropriate daily exercise

E. Taking oral diabetic agents in the am.

143. The nurse informs the pregnant client that her laboratory test indicates she has iron deficiency anemia. Based on this diagnosis, the nurse should monitor this client for which problems? Select all that apply.

A. Susceptibility to infection

B. Easily fatigued

C. Increased risk for preeclampsia

D. Increased risk of diabetes

E. Congenital defects

144. The pregnant client presents to a clinic with ongoing nausea, vomiting, and anorexia at 29 weeks' gestation. Her Hgb level is 5 g/dL, and a blood smear reveals that newly formed RBCs are macrocytic. Which condition should the nurse further explore? A. Sickle cell anemia

B. Folic acid deficiency anemia

C. Beta-thalassemia. minor

D. Beta-thalassemia major

145. The nurse is caring for the client admitted to the antepartum unit at 32 weeks' gestation with possible preterm labor. The nurse is performing a fetal fibronectin (fFN) test. Which event, if it occurred, would require the nurse to recollect the specimen?

A. The specimen is collected before a vaginal examination.

B. A lubricant was used to facilitate insertion of the swab.

C. The client reports that she has not had intercourse for 3 days.

D. The specimen is collected before other specimens are collected.

146. The client admitted in preterm labor is told that an amniocentesis needs to be performed. The client asks the nurse why this is necessary when the HCP has been performing ultrasounds throughout the pregnancy. Which is an appropriate response by the nurse?

A. "Your baby is older now, and an amniocentesis provides us with more information on how your baby is doing."

B. "An amniocentesis could not be performed before 32 weeks, so you will be having this test from now until delivery."

C. "Your doctor wants to make sure that there are no problems with the baby that an ultrasound might not be

able to identify."
D. "With your preterm labor your doctor needs to know your baby's lung maturity; this is best identified by amniocentesis."

147. The 42-year-old client who had a partial hydatidiform molar pregnancy 3 months ago asks the nurse whether she and her husband can try conceiving again. Which response by the nurse is incorrect and warrants follow-up action by the observing nurse manager?
A. "You will need serial levels of beta human chorionic gonadotropin (BHCG) drawn."
B. "You cannot conceive ever again because of your risk of choriocarcinoma."
C. "You should not become pregnant for 6 to 12 months."
D. "Your risk of another hydatidiform molar pregnancy is low."

148. The pregnant client presents to the ED with a large amount of painless, bright red bleeding. She looks to be about 30 to 34 weeks pregnant based on her uterine size. She speaks limited English and is unable to communicate with the staff. Which actions should be taken by the nurse? Select all that apply.
A. Call for an interpreter for this client.
B. Establish an intravenous access.
C. Auscultate for fetal heart tones.
D. Place the client into a lithotomy position.
E. Perform a digital pelvic examination.

149. The nurse assesses the client in her third trimester with suspected placenta previa. Which finding should the nurse associate with placenta previa?
A. Cervix is 100% effaced
B. Painless vaginal bleeding
C. 3- The fetal lie is transverse
D. Absence of fetal movement

150. The client at 32 weeks' gestation presents to a hospital with a severe headache. Her admission BP is 184/104 mm Hg. Based on the assessment and findings of the serum laboratory report, which most severe complication warrants the nurse's further assessment?

Serum Laboratory Test	Client Results
Serum bilirubin	2.1 mg/dL
LDH	782 units/L
AST (SGOT)	84 units/L
ALT (SGPT)	51 units/L
Plt	99,000/mm^3
Hgb	12.1 g/dL
Hct	36.3%

A. Renal failure

B. Liver failure

C. Preeclampsia

D. HELLP syndrome