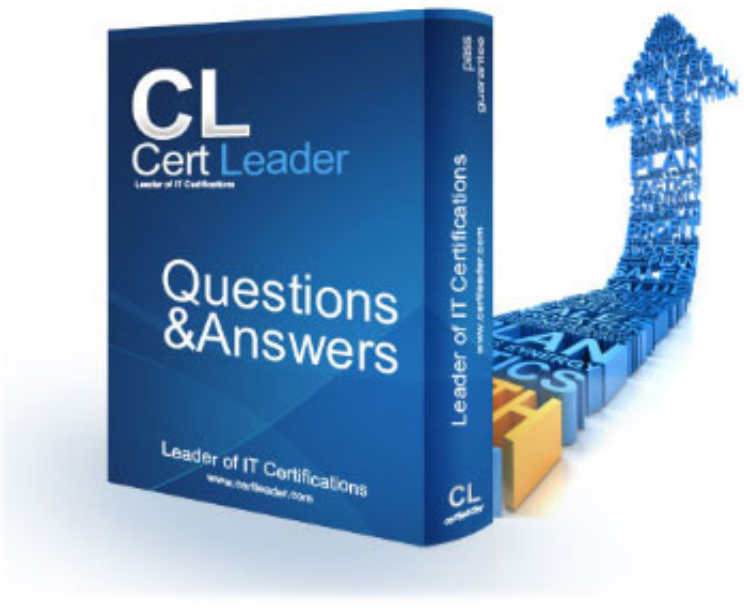
NCLEX-PN Dumps

National Council Licensure Examination(NCLEX-PN)

https://www.certleader.com/NCLEX-PN-dumps.html



NEW QUESTION 1
- (Topic 1)
While undergoing fetal heart monitoring, a pregnant Native-American woman requests that a medicine woman be present in the examination room. Which of the following is an appropriate response by the nurse?

A. ??I will assist you in arranging to have a medicine woman present.??
B. ??We do not allow medicine women in exam rooms.??
C. ??That does not make any difference in the outcome.??
D. ??It is old-fashioned to believe in that.??

Answer: A

Explanation:
This statement reflects cultural awareness and acceptance that receiving support from a medicine woman is important to the client. The other statements are culturally insensitive and unprofessional.
Reduction of Risk Potential

NEW QUESTION 2
- (Topic 1)
A woman asks, ??How much alcohol can I safely drink while pregnant??? The nurse??s best response is:

A. ??The amount of alcohol that is safe during pregnancy is unknown.??
B. ??Consuming one or two beers or glasses of wine a day is considered safe for a healthy pregnant woman.??
C. ??Drinking three or more drinks on any given occasion is the only harmful type of drinking during pregnancy.??
D. ??You can have a drink to help you relax and get to sleep at night.??

Answer: A

Explanation:
The amount of alcohol that is safe during pregnancy is unknown. Fetal alcohol syndrome is a combination of mental and physical abnormalities present in infants born to mothers who have consumed alcohol during pregnancy.Psychosocial Integrity

NEW QUESTION 3
- (Topic 1)
A health care worker is concerned about a new mother being overwhelmed by caring for her infant. The health care worker should:

A. immediately contact child protective services.
B. provide the mother with literature about child care.
C. consult a therapist to help the mother work out her fears.
D. refer the mother to parenting classes.

Answer: D

Explanation:
Prevention of child abuse is centered on teaching the parents how to care for their child and cope with the demands of infant care. Parenting classes can help build self-confidence, self-esteem, and coping skills. Parents benefit by understanding the developmental needs of their children, while learning how to manage their home environment more effectively. The classes also increase the parents?? social contacts and teach about community resources.Psychosocial Integrity

NEW QUESTION 4
- (Topic 1)
A client who is immobilized secondary to traction is complaining of constipation. Which of the following medications should the nurse expect to be ordered?

A. Advil
B. Anasaid
C. Clinocil
D. Colace

Answer: D

Explanation:
Colace is a stool softener that acts by pulling more water into the bowel lumen, making the stool soft and easier to evacuate.Basic Care and Comfort

NEW QUESTION 5
- (Topic 1)
A client is complaining of difficulty walking secondary to a mass in the foot. The nurse should document this finding as:

A. plantar fasciitis.
B. hallux valgus.
C. hammertoe.
D. Morton??s neuroma.

Answer: D

Explanation:
Morton??s neuroma is a small mass or tumor in a digital nerve of the foot. Hallux valgus is referred to in lay terms as abunion.Hammertoe is where one toe is cocked up over another toe. Plantar fasciitis is an inflammation of, or pain in, the arch of the foot.Basic Care and Comfort

NEW QUESTION 6
- (Topic 1)
Why must the nurse be careful not to cut through or disrupt any tears, holes, bloodstains, or dirt present on the clothing of a client who has experienced trauma?

A. The clothing is the property of another and must be treated with care.
B. Such care facilitates repair and salvage of the clothing.
C. The clothing of a trauma victim is potential evidence with legal implications.
D. Such care decreases trauma to the family members receiving the clothing.

Answer: C

Explanation:
Trauma in any client, living or dead, has potential legal and/or forensic implications.
Clothing, patterns of stains, and debris are sources of potential evidence and must be preserved. Nurses must be aware of state and local regulations that require mandatory reporting of cases of suspected child and elder abuse, accidental death, and suicide. Each Emergency Department has written policies and procedures to assist nurses and other health care providers in making appropriate reports. Physical evidence is real, tangible, or latent matter that can be visualized, measured, or analyzed. Emergency Department nurses can be called on to collect evidence. Health care facilities have policies governing the collection of forensic evidence. The chain of evidence custody must be followed to ensure the integrity and credibility of the evidence. The chain of evidence custody is the pathway that evidence follows from the time it is collected until is has served its purpose in the legal investigation of an incident.Physiological Adaptation

NEW QUESTION 7
- (Topic 1)
All of the following factors, when identified in the history of a family, are correlated with poverty except:

A. high infant mortality rate.
B. frequent use of Emergency Departments.
C. consultation with folk healers.
D. low incidence of dental problems.

Answer: D

Explanation:
Dental problems are prevalent because of the lack of preventive care and access to care.
High infant mortality is one of the most significant problems correlated with poverty. Pregnant women who do not have access to care might come to the Emergency Department when in labor. Those in poverty are likely to use Emergency Departments because they may not be turned away. Those in poverty might also turn to folk healers or other persons in their community for care who might be easier to access and might not demand payment.Health Promotion and Maintenance

NEW QUESTION 8
- (Topic 1)
What interpersonal relief behavior is Ashley using?

A. acting out
B. somatizing
C. withdrawal
D. problem-solving

Answer: B

Explanation:
Somatizing means one experiences an emotional conflict as a physical symptom. Ashley manifests several physical symptoms associated with severe anxiety. Acting out refers to behaviors such as anger, crying, laughter, and physical or verbal abuse. Withdrawal is a reaction in which psychic energy is withdrawn from the environment and focused on the self in response to anxiety. Problem-solving takes place when anxiety is identified and the unmet need is met.Psychosocial Integrity

NEW QUESTION 9
- (Topic 1)
Which of the following physical findings indicates that an 11–12-month-old child is at risk for developmental dysplasia of the hip?

A. refusal to walk
B. not pulling to a standing position
C. negative Trendelenburg sign
D. negative Ortolani sign

Answer: B

Explanation:
The nurse might be concerned about developmental dysplasia of the hip if an 11–12- month-old child doesn??t pull to a standing position. An infant who does not walk by 15 months of age should be evaluated. Children should start walking between 11–15 months of age. Trendelenberg sign is related to weakness of the gluteus medius muscle, not hip dysplasia. Ortolani sign is used to identify congenital subluxation or dislocation of the hip in infants.Health Promotion and Maintenance

NEW QUESTION 10

- (Topic 1)
In teaching clients with Buck??s Traction, the major areas of importance should be:

A. nutrition, ROM exercises.
B. ROM exercises, transportation.
C. nutrition, elimination, comfort, safety.
D. elimination, safety, isotonic exercises.

Answer: C

Explanation:
Nutrition, elimination, comfort, and safety are the major areas of importance. The diet should be high in protein with adequate fluids.Basic Care and Comfort

NEW QUESTION 10
- (Topic 1)
The kind of man who beats a woman is:

A. from a minority culture in a low-income group.
B. from a majority culture in a middle-income group.
C. one who was never allowed to compete as a child.
D. from any walk of life, race, income group, or profession.

Answer: D

Explanation:
Batterers cannot be predicted by demographic features related to age, ethnicity, race, religious denomination, education, socioeconomic status, or class. Ninety-five percent of domestic abuse cases
involve male perpetrators and female victims.Psychosocial Integrity

NEW QUESTION 11
- (Topic 1)
Assessment of a client with a cast should include:

A. capillary refill, warm toes, no discomfort.
B. posterior tibial pulses, warm toes.
C. moist skin essential, pain threshold.
D. discomfort of the metacarpals.

Answer: A

Explanation:
Assessment for adequate circulation is necessary. Signs of impaired circulation include slow capillary refill, cool fingers or toes, and pain.Basic Care and Comfort

NEW QUESTION 16
- (Topic 1)
Assessment of the client with an arteriovenous fistula for hemodialysis should include:

A. inspection for visible pulsation.
B. palpation of thrill.
C. percussion for dullness.
D. auscultation of blood pressure.

Answer: B

Explanation:
Thrill should be present. The client should be taught to check this daily at home. Pulsation is not typically visible. Percussion gives no information about the patency of a fistula. Blood pressure is not auscultated in a limb with an AVF. Auscultation of the AVF, for a bruit, is part of an assessment for patency.
Physiological Adaptation

NEW QUESTION 18
- (Topic 1)
A client has been taking alprazolam (Xanax) for four years to manage anxiety. The client reports taking 0.5 mg four times a day. Which statement indicates that the client understands the nurse??s teaching about discontinuing the medication?

A. ??I can drink alcohol now that I am decreasing my Xanax.??
B. ??I should not take another Xanax pil
C. Here is what is left of my last prescription.??
D. ??I should take three pills per day next week, then two pills for one week, then one pill for one week.??
E. ??I can expect to be sleepy for several days after stopping the medicine.??

Answer: C

Explanation:
Xanax, like other benzodiazepines, can cause withdrawal symptoms that include agitation, insomnia, hypertension, seizures, and abdominal pain. The drug must be slowly decreased to prevent withdrawal symptoms.

Psychosocial Integrity

NEW QUESTION 23
- (Topic 1)
For which of the following conditions might blood be drawn for uric acid level?

A. asthma
B. gout
C. diverticulitis
D. meningitis

Answer: B

Explanation:
Uric acid levels are indicated for clients with gout.Reduction of Risk Potential

NEW QUESTION 25
- (Topic 1)
Which of the following is an inappropriate item to include in planning care for a severely neutropenic client?

A. Transfuse netrophils (granulocytes) to prevent infection.
B. Exclude raw vegetables from the diet.
C. Avoid administering rectal suppositories.
D. Prohibit vases of fresh flowers and plants in the client??s room.

Answer: A

Explanation:
Granulocyte transfusion is not indicated to prevent infection. Produced in the bone marrow, granulocytes
normally comprise 70% of all WBCs. They are subdivided into three types based on staining properties:
neutrophils, eosinophils, and basophils. They can be beneficial in a selected population of infected, severely granulocytopenic clients (less than 500/mm3) who do not respond to antibiotic therapy and who are expected to experience prolonged suppression of granulocyte production.Physiological Adaptation

NEW QUESTION 30
- (Topic 1)
Which of the following statements, if made by the parents of a newborn, does not indicate a need for further teaching about cord care?

A. ??I should put alcohol on my baby??s cord 3–4 times a day.??
B. ??I should put the baby??s diaper on so that it covers the cord.??
C. ??I should call the physician if the cord becomes dark.??
D. ??I should wash my hands before and after I take care of the cord.??

Answer: D

Explanation:
Parents should be taught to wash their hands before and after providing cord care. This prevents transferring pathogens to and from the cord. Folding the diaper below the cord exposes the cord to air and allows for drying.
It also prevents wet or soiled diapers from coming into contact with the cord. Current recommendations include cleaning the area around the cord 3–4 times a day with a cotton swab but do not include putting alcohol or other antimicrobials on the cord. It is normal for the cord to turn dark as it dries.Health Promotion and Maintenance

NEW QUESTION 32
- (Topic 1)
Which is the proper hand position for performing chest percussion?

A. cup the hands
B. use the side of the hands
C. flatten the hands
D. spread the fingers of both hands

Answer: A

Explanation:
The hands are cupped for performing percussion, producing a vibration that helps loosen respiratory secretions.
The other hand positions do not accomplish this task.Reduction of Risk Potential

NEW QUESTION 36
- (Topic 1)
Which of the following foods is a complete protein?

A. corn
B. eggs
C. peanuts Dsunflower seeds

Answer: B

Explanation:

Eggs are a complete protein. The remaining options are incomplete proteins.Health Promotion and Maintenance

NEW QUESTION 41
- (Topic 1)
Diagnostic genetic counseling, for procedures such as amniocentesis and chorionic villus sampling, allows clients to make all of the following choices except:

A. terminating the pregnancy.
B. preparing for the birth of a child with special needs.
C. accessing support services before the birth.
D. completing the grieving process before the birth.

Answer: D

Explanation:
If findings are ominous, the grieving process will not be completed before birth. If the couple elects to terminate a pregnancy based on diagnostic tests, there will be grief and concerns for future pregnancies. Couples might choose to access support services and prepare for the birth of an infant with special needs. Some fetal conditions can be treated in utero.Health Promotion and Maintenance

NEW QUESTION 45
- (Topic 1)
Which of the following medications is a serotonin antagonist that might be used to relieve nausea and vomiting?

A. metoclopramide (Reglan)
B. onedansetron (Zofran)
C. hydroxyzine (Vistaril)
D. prochlorperazine (Compazine)

Answer: B

Explanation:
Zofran is a serotonin antagonist that can be used to relieve nausea and vomiting. The other medications can be used for nausea and vomiting, but they have different mechanisms of action.
Physiological Adaptation

NEW QUESTION 50
- (Topic 1)
A client who is experiencing infertility says to the nurse, ??I feel I will be incomplete as a man/woman if I cannot have a child.?? Which of the following nursing diagnoses is likely to be appropriate for this client?

A. Risk for Self Harm
B. Body Image Disturbance
C. Ineffective Role Performance
D. Powerlessness

Answer: B

Explanation:
Of the nursing diagnoses listed, the client??s statement most represents Body Image Disturbance because it directly refers to loss of the function of having a child. Nothing in the statement indicates that the client is at risk for harming herself. Ineffective Role Performance could be correct but is not the best choice because the statement does not reflect a disruption of the parent??s role. Powerlessness could be an appropriate nursing diagnosis if the client described feeling powerless about the infertility.Health Promotion and Maintenance

NEW QUESTION 51
- (Topic 1)
James returns home from school angry and upset because his teacher gave him a low grade on an assignment. After returning home from school, he kicks the dog. This coping mechanism is known as:

A. denial.
B. suppression.
C. displacement.
D. fantasy.

Answer: C

Explanation:
Displacement is the transference of anger to another. Anger is displaced on the dog as a convenient object.
Psychosocial Integrity

NEW QUESTION 55
- (Topic 1)
A 10-month-old child is brought to the Emergency Department because he is difficult to awaken. The nurse notes bruises on both upper arms. These findings are most consistent with:

A. wearing clothing that is too small for the child.
B. the child being shaken.
C. falling while learning to walk.
D. parents trying to awaken the child.

Answer: B

Explanation:
Children who are shaken are frequently grasped by both upper arms. Symptoms of brain injury associated with shaking include decreased level of consciousness.Psychosocial Integrity

NEW QUESTION 57
- (Topic 1)
When administering intravenous electrolyte solution, the nurse should take which of the following precautions?

A. Infuse hypertonic solutions rapidly.
B. Mix no more than 80 mEq of potassium per liter of fluid.
C. Prevent infiltration of calcium, which causes tissue necrosis and sloughing.
D. As appropriate, reevaluate the client??s digitalis dosag
E. He might need an increased dosage because IV calcium diminishes digitalis??s action.

Answer: C

Explanation:
Preventing tissue infiltration is important to avoid tissue necrosis. Choice 1 is incorrect because hypertonic solutions should be infused cautiously and checked with the RN if there is a concern.
Choice 2 is incorrect because potassium, mixed in the pharmacy per physician order, is mixed at a concentration no higher than 60 mEq/L.
Physiological Adaptation

NEW QUESTION 61
- (Topic 1)
Which of the following neurological disorders is characterized by writhing, twisting movements of the face and limbs?

A. epilepsy
B. Parkinson??s
C. muscular sclerosis
D. Huntington??s chorea

Answer: D

Explanation:
Huntington??s chorea is characterized by writhing, twisting movements of the face and limbs.
The remaining options are neurological disorders that do not have such movements as part of their disease process.Reduction of Risk Potential

NEW QUESTION 64
- (Topic 1)
Which of the following is most likely to impact the body image of an infant newly diagnosed with Hemophilia?

A. immobility
B. altered growth and development
C. hemarthrosis
D. altered family processes

Answer: D

Explanation:
Altered Family Processes is a potential nursing diagnosis for the family and client with a new diagnosis of Hemophilia. Infants are aware of how their caregivers respond to their needs. Stresses can have an immediate impact on the infant??s development of trust and how others relate to them because of their diagnosis. The longterm effects of hemophilia can include problems related to immobility. Altered growth and development could not have developed in a newly diagnosed client. Hemarthrosis is acute bleeding into a joint space that is characteristic of hemophilia. It does not have an immediate effect on the body image of a newly diagnosed hemophiliac.Health Promotion and Maintenance

NEW QUESTION 66
- (Topic 1)
A client with an ileus is placed on intestinal tube suction. Which of the following electrolytes is lost with intestinal suction?

A. calcium
B. magnesium
C. potassium
D. sodium chloride

Answer: D

Explanation:
Duodenal intestinal fluid is rich in K+, NA+, and bicarbonate. Suctioning to remove excess fluids decreases the client??s K+ and NA+ levels.Basic Care and Comfort

NEW QUESTION 71
- (Topic 1)
Which of the following values should the nurse monitor closely while a client is on total parenteral nutrition?

A. calcium

B. magnesium
C. glucose
D. cholesterol

Answer: C

Explanation:
Glucose is monitored closely when a client is on total parenteral nutrition, due to high glucose concentration in the solutions. The other values are not monitored as closely.Health Promotion and Maintenance

NEW QUESTION 73
- (Topic 1)
An appropriate intervention for the client with suspected genitourinary trauma and visible blood at the urethral meatus is:

A. insertion of a Foley catheter.
B. in and out catheter specimen for urinalysis.
C. a voided urine specimen for urinalysis.
D. a urologist consult.

Answer: D

Explanation:
A urologist consult is appropriate for a client with visible blood at the urethral meatus and suspected trauma.
Choices 1 and 2 are contraindicated. A urinalysis might be ordered by the physician, but the question does not provide enough information to make Choice 3 the correct answer.Physiological Adaptation

NEW QUESTION 75
- (Topic 1)
Which of the following indicates a hazard for a client on oxygen therapy?

A. A No Smoking sign is on the door.
B. The client is wearing a synthetic gown.
C. Electrical equipment is grounded.
D. Matches are removed.

Answer: B

Explanation:
A synthetic gown might generate sparks of static electricity, which can be a fire hazard, particularly in the presence of oxygen. The client on oxygen therapy should wear a cotton gown. The remaining options are appropriate safety measures.Reduction of Risk Potential

NEW QUESTION 78
- (Topic 1)
Acyclovir is the drug of choice for:

A. HIV.
B. HSV 1 and 2 and VZV.
C. CMV.
D. influenza A viruses.

Answer: B

Explanation:
Acyclovir (Zovirax) is specific for treatment of herpes virus infections. There is no cure for herpes. Acyclovir is excreted unchanged in the urine and therefore must be used cautiously in the presence of renal impairment.
Drugs that treat herpes inhibit viral DNA replication by competing with viral substrates to form shorter, ineffective DNA chains.Physiological Adaptation

NEW QUESTION 79
- (Topic 1)
The nurse is assessing the dental status of an 18-month-old child. How many teeth should the nurse expect to examine?

A. 6
B. 8
C. 12
D. 16

Answer: C

Explanation:
In general, children begin dentition around 6 months of age. During the first 2 years of life, a quick guide to the number of teeth a child should have is as follows: Subtract the number 6 from the number of months in the age of the child. In this example, the child is 18 months old, so the formula is 18 – 6 = 12.
An 18-month-old child should have approximately 12 teeth.Health Promotion and Maintenance

NEW QUESTION 80

- (Topic 1)
Which fetal heart monitor pattern can indicate cord compression?

A. variable decelerations
B. early decelerations
C. bradycardia
D. tachycardia

Answer: A

Explanation:
Variable decelerations can be related to cord compression. The other patterns are not.
Reduction of Risk Potential

NEW QUESTION 82
- (Topic 1)
Which of the following is likely to increase the risk of sexually transmitted disease?

A. alcohol use
B. certain types of sexual practices
C. oral contraception use
D. all of the above

Answer: D

Explanation:
STDs affect certain groups in groups in greater numbers. Factors associated with risk include being younger than 25 years of age, being a member of a minority group, residing in an urban setting, being impoverished, and using crack cocaine.Physiological Adaptation

NEW QUESTION 85
- (Topic 1)
How often should the nurse change the intravenous tubing on total parenteral nutrition solutions?

A. every 24 hours
B. every 36 hours
C. every 48 hours
D. every 72 hours

Answer: A

Explanation:
The nurse should change the intravenous tubing on total parenteral nutrition solutions every 24 hours, due to the high risk of bacterial growth.Health Promotion and Maintenance

NEW QUESTION 88
- (Topic 2)
A 57-year-old woman is recently widowed. She states, ??I will never be able to learn how to manage the finances. My husband did all of that.?? Select the nurse??s response that could help raise the client??s self-esteem.

A. ??You feel inadequate because you have never learned to balance a checkbook.??
B. ??You should have insisted your husband teach you about the finances.??
C. ??You are strong and will learn how to manage your finances after awhile.??
D. ??Why don??t you take a class in basic finance from the local college???

Answer: C

Explanation:
The nurse can raise the client??s self-esteem by communicating confidence the client can participate in
actively finding solutions to the problem. The nurse also conveys the client is a worthwhile person by listening and accepting the client??s feelings and praising the client for seeking assistance.
Psychosocial Integrity

NEW QUESTION 92
- (Topic 2)
A nurse observes a client sitting alone and talking. When asked, the client reports that he is ??talking to the voices.?? The nurse??s next action should be:

A. touching the client to help him return to reality.
B. leaving the client alone until reality returns.
C. asking the client to describe what is happening.
D. telling the client there are no voices.

Answer: A

Explanation:
Nurses need to inform clients that there is a difference in perceptions and pay attention to the content of
hallucinations. The other options are not therapeutic.Psychosocial Integrity

NEW QUESTION 97
- (Topic 2)
A client recently lost a child due to poisoning. The client tells the nurse, ??I don??t want to make any new friends right now.?? This is an example of which of the following indicators of stress?

A. emotional behavioral indicator
B. spiritual indicator
C. sociocultural indicator
D. intellectual indicator

Answer: C

Explanation:
Stress can alter a person??s relationships with others.Psychosocial Integrity

NEW QUESTION 101
- (Topic 2)
A 35-year-old Latin-American client wishes to lose weight to reduce her chances of developing heart disease and diabetes. The client states, ??I do not know how to make my diet work with the kind of foods that my family eats.?? What should the nurse do first to help the client determine a suitable diet for disease prevention?

A. Provide her with copies of the approved dietary guidelines for the American Diabetic Association and the American Heart Association.
B. Ask the client to provide a list of the types of foods she eats to determine how to best meet her needs.
C. Provide a high-protein diet plan for the client.
D. Provide the client with information related to risk factors for heart disease and diabetes.

Answer: B

Explanation:
Assessment is the first step. Assessing what the client eats helps the nurse determine a plan for dietary
recommendations based on the ADA and AHA guidelines. Providing the client with a copy of the guidelines is important but is not the first priority. Based on the client??s wish to reduce her chances of heart disease and diabetes, a high-protein diet plan might not be appropriate. Providing information to the client related to risk factors for heart disease and diabetes is important but is not the first step.Health Promotion and Management

NEW QUESTION 106
- (Topic 2)
In an obstetrical emergency, which of the following actions should the nurse perform first after the baby delivers?

A. Place extra padding under the mother to absorb blood from the delivery.
B. Cut the umbilical cord using sterile scissors.
C. Suction the baby??s mouth and nose.
D. Wrap the baby in a clean blanket to preserve warmth.

Answer: C

Explanation:
After the baby delivers, the nurse should clear the mouth and nose of the infant first.
Choice 4 is the next step. Choices 1 and 2 might be performed depending on the situation.Safety and Infection Control

NEW QUESTION 109
- (Topic 2)
The nurse is teaching a client about erythema infectiosum. Which of the following factors are not correct?

A. There is no rash.
B. The disorder is uncommon in adults.
C. There is no fever.
D. There is sometimes a ??slapped face?? appearance.

Answer: B

Explanation:
Fifth??s disease, erythema infectiosum, is uncommon in adults. All the other statements are correct.Safety and Infection Control

NEW QUESTION 113
- (Topic 2)
Health promotion activities are designed to help clients:

A. reduce the risk of illness.
B. maintain maximal function.
C. promote healthy habits related to health care.
D. all of the above.

Answer: D

Explanation:
Health promotion activities are designed to help clients reduce the risk of illness, maintain maximum
function, and promote health habits related to health care.Health Promotion and Maintenance

NEW QUESTION 114
- (Topic 2)
The death of a beloved spouse places the surviving partner in which type of crisis?

A. maturational
B. reactive
C. nonreactive
D. situational

Answer: D

Explanation:
A situational crisis is an unexpected, unplanned event, such as the death of a spouse.
Option 1 is a normal maturational crisis; Choices 2 and 3 are not recognized crisis states.Coordinated Care

NEW QUESTION 115
- (Topic 2)
A client goes to the Emergency Department with acute respiratory distress and the following arterial blood gases (ABGs): pH 7.35, PCO2 40 mmHg, PO2 63mmHg, HCO3 23, and oxygenation saturation (SaO2) 93%. Which of the following represents the best analysis of the etiology of these ABGs?

A. tuberculosis (TB)
B. pneumonia
C. pleural effusion
D. hypoxia

Answer: D

Explanation:
A combined low PO2 and lowSaO2 indicates hypoxia. The pH, PCO2, and HCO3 are normal. ABGs are not
necessarily altered in TB or pleural effusion. Depending on the degree of the pneumonia, the PO2 and PCO2 might be low because hypoxia stimulates hyperventilation.Physiological Adaptation

NEW QUESTION 117
- (Topic 2)
In an emergency situation, the nurse determines whether a client has an airway obstruction. Which of the following does the nurse assess?

A. ability to speak
B. ability to hear
C. oxygen saturation
D. adventitious breath sounds

Answer: A

Explanation:
Ability to speak is a major way to identify an airway obstruction.Safety and Infection Control

NEW QUESTION 118
- (Topic 2)
Ethical and moral issues concerning restraints include all of the following except:

A. emotional impact on the client and family.
B. dignity of the client.
C. client??s quality of life.
D. policies and procedures.

Answer: D

Explanation:
Policies and procedures, though important, are not in the category of ethical and moral issues. The other options are ethical and moral issues.Safety and Infection Control

NEW QUESTION 123
- (Topic 2)
Which isolation procedure will be followed for secretions and blood?

A. Respiratory
B. Standard Precautions
C. Contact Isolation
D. Droplet

Answer: B

Explanation:
Standard precautions are taken in all situations for all clients and involve all body secretions except sweat and are designed to reduce the rate of transmission of microbes from one host to another or one source (environment such as the client??s bedside table) to another.Safety and Infection Control

NEW QUESTION 125

- (Topic 2)
What significant event occurs in the orientation phase of a nurse-client relationship?

A. establishment of roles
B. identification of transference phenomenon
C. placement of the client within the client??s family structure
D. client agreement that the nurse has the authority in the relationship

Answer: B

Explanation:
Transference phenomena are intensified in relationships with authority, such as physicians and nurses.
Common positive transferences include desire for affection and gratification of dependency needs. Common negative transferences include hostility and competitiveness. These transferences must be recognized and resolved before growth and positive change can be undertaken in the working stage.
Psychosocial Integrity

NEW QUESTION 129
- (Topic 2)
The family carries out its health care functions in which of the following ways?

A. Family provides very little preventive health care to its members at home.
B. Family provides sick care to its members.
C. Family pays for most health services.
D. Family decides when and where to hospitalize its members.

Answer: B

Explanation:
The family provides sick care to its members. The other options are incorrect.Prevention and Early
Detection of Disease

NEW QUESTION 133
- (Topic 2)
Which of the following solutions is routinely used to flush an IV device before and after the administration of blood to a client?

A. 0.9% sodium chloride
B. 5% dextrose in water solution
C. sterile water
D. Heparin sodium

Answer: A

Explanation:
Normal saline is 0.9% sodium chloride. This solution has the same osmolarity as blood. Its use does not
cause lysis of cells. Choices 2 and 3 are hypotonic solutions that can cause cell lysis. Choice 4 is an anticoagulant.
Pharmacological Therapies

NEW QUESTION 138
- (Topic 2)
A client begins a regimen of chemotherapy. Her platelet counts falls to 98,000. Which action is least likely to increase the risk of hemorrhage?

A. Test all excreta for occult blood.
B. Use a soft toothbrush or foam cleaner for oral hygiene.
C. Implement reverse isolation.
D. Avoid IM injections.

Answer: C

Explanation:
Reverse isolation does not affect the risk of hemorrhage.Physiological Adaptation

NEW QUESTION 140
- (Topic 2)
At what point in the nurse-client relationship should termination first be addressed?

A. in the working phase
B. in the termination phase
C. in the orientation phase
D. when the client initially brings up the topic

Answer: C

Explanation:
The client has a right to know the parameters of the nurse-client relationship. If the relationship is to be time
limited, the client should be informed of the number of sessions. If it is open-ended, the termination date is not known at the outset, and the client should know that this is an issue that is negotiated at a later date.Coordinated Care

NEW QUESTION 144
- (Topic 2)
Which of the following observations is most important when assessing a client??s breathing?

A. presence of breathing and pulse rate
B. breathing pattern and adequacy of breathing
C. presence of breathing and adequacy of breathing
D. patient position and adequacy of breathing

Answer: C

Explanation:
It is not enough to simply make sure the client is breathing. The client must be breathing adequately. Physiological Adaptation

NEW QUESTION 147
- (Topic 2)
All of the following are common reasons that nurses are reluctant to delegate except:

A. lack of self-confidence.
B. desire to maintain authority.
C. confidence in subordinates.
D. getting trapped in the ??I can do it better myself?? mindset.

Answer: C

Explanation:
If a delegator has confidence in his subordinates and feels that a task will be performed correctly, he is more likely to delegate. Reasons that delegators are reluctant to delegate include their own lack of confidence, fear of losing authority or personal satisfaction, and feeling that the task can only be performed correctly if they do it themselves.Coordinated Care

NEW QUESTION 150
- (Topic 2)
The focus of a nurse case manager is:

A. nursing care needs at discharge.
B. the comprehensive care needs of the client for continuity of care.
C. client education needs upon discharge.
D. financial resources for needed care.

Answer: B

Explanation:
By definition, case management is a process of providing for the comprehensive care needs of a client for
continuity of care throughout the health care experience.Coordinated Care

NEW QUESTION 154
- (Topic 2)
A client states, ??I eat a well-balanced diet. I do not smoke. I exercise regularly, and I have a yearly checkup with my physician. What else can I do to help prevent cancer??? The nurse
should respond with which of the following statements?

A. Sleep at least 6–8 hours a night.
B. Practice monthly self-breast examination.
C. Reduce stress.
D. All of the above.

Answer: D

Explanation:
All of the choices are methods of preventing cancer. Sleep is important in maintaining homeostasis, which
helps the body respond to disease. Monthly breast examination can indicate cancer or fibrocystic disease. The body has a physiological response to stress that can decrease the immune response and increase the risk of disease.Health Promotion and Management

NEW QUESTION 156
- (Topic 2)
Signs of impaired breathing in infants and children include all of the following except:

A. nasal flaring.
B. grunting.
C. seesaw breathing.
D. quivering lips.

Answer: D

Explanation:
Lip quivering is a distracter. Signs of impaired breathing in infants and children include all the other options.
Physiological Adaptation

NEW QUESTION 158
- (Topic 2)
Vaccines provide what type of immunity?

A. active
B. passive
C. transplacental
D. active and passive

Answer: A

Explanation:
Vaccines provide active immunity. Passive immunity comes from antibodies produced in another human or
host. Transplacental immunity comes from passive immunity transferred from mother to infant.Health Promotion and Maintenance

NEW QUESTION 161
- (Topic 2)
Medication bound to protein can have which of the following effects?

A. enhancement of drug availability
B. rapid distribution of the drug to receptor sites
C. less availability to produce desired medicinal effects
D. increased metabolism of the drug by the liver

Answer: C

Explanation:
Only an unbound drug can be distributed to active receptor sites. Therefore, the more of a drug that is bound to protein, the less it is available for the desired drug effect. Choice 1 is incorrect because less drug is available if it is bound to protein. Choice 2 is incorrect because distribution to receptor sites is irrelevant if the drug, which is bound to protein, cannot bind with a receptor site. Choice 4 is incorrect because metabolism is not increased. The liver first has to remove the drug from the protein molecule before metabolism can occur.
The protein is then free to return to circulation and be used again.Pharmacological Therapies

NEW QUESTION 162
- (Topic 2)
A syringe pump is a type of electronic infusion pump used to infuse fluids or medications directly from a syringe. This device is commonly used for:

A. solutions administered in obstetrics.
B. dilute antibiotics.
C. large volumes of IV solution.
D. the neonatal and pediatric populations.

Answer: D

Explanation:
Small volumes of medication or fluids are delivered and sometimes at slow rates to neonates and pediatric clients. The syringe pump allows precise infusion of small volumes. Choice 1 is incorrect because a syringe pump can be used in almost any setting, but is not generally for adult clients. Choices 2 and 3 are incorrect because large volumes of fluids are not administered with a syringe pump.Pharmacological Therapies

NEW QUESTION 165
- (Topic 2)
The greatest time savers when planning client care include all of the following except:

A. reacting to the crisis of the moment.
B. setting goals.
C. planning.
D. specifying priorities.

Answer: A

Explanation:
The greatest time-savers when planning client care are activities that facilitate focus and completion of priority items. Time-savers include setting goals, establishing priorities, planning tasks, delegating where appropriate, re-assessment, and ongoing evaluation of needs.Coordinated Care

NEW QUESTION 167
- (Topic 2)
Support-system enhancement includes all of the following except:

A. determining the barriers to using support systems.
B. discussing ways to help with others who are concerned.
C. exploring life problems of the support-team members.
D. involving spouse, family, and friends in the care and planning.

Answer: C

Explanation:
The exploration of life problems of support-team members is not necessary to enhance the support system.

Choices 1, 2, and 4 are all enhancements for a support system.Psychosocial Integrity

NEW QUESTION 168
- (Topic 2)
Following the change of shift report, the nurse should analyze the information and set priorities accordingly. When the plan has been formulated, at what point during the shift can or should the nurse??s plan be altered or modified?

A. halfway through the shift
B. at the end of the shift before the nurse reports off
C. when needs change
D. after the top-priority tasks have been completed

Answer: C

Explanation:
The nurse changes the plan to respond to changes in needs.Coordinated Care

NEW QUESTION 172
- (Topic 2)
Narrow therapeutic index medications:

A. are drug formulations with limited pharmacokinetic variability.
B. have limited value and require no monitoring of blood levels.
C. have less than a twofold difference in minimum toxic levels and minimum effective concentration in the blood.
D. have limited potency and side effects.

Answer: C

Explanation:
The therapeutic index is the ratio between the median lethal dose and median effective dose of a drug. It
provides a general indication of the margin of safety of a drug. Choice 1 is incorrect because pharmacokinetics is the process of adsorption, distribution, metabolism, and elimination. Choice 2 is incorrect because narrow therapeutic index drugs require close monitoring since there is often little difference between the desired drug effect and toxicity. Choice 4 is incorrect because narrow therapeutic index drugs have the potential for severe toxic effects with only slight increases in the dose or slight decreases in elimination.
Pharmacological Therapies

NEW QUESTION 174
- (Topic 2)
Which is the best way to position a client??s neck for palpation of the thyroid?

A. flexed toward the side being examined
B. hyperextended directly backward
C. flexed away from the side being examined
D. flexed directly forward

Answer: A

Explanation:
Flexed toward the side being examined.Health Promotion and Maintenance

NEW QUESTION 175
- (Topic 2)
In conducting a health screening for 12-month-old children, the nurse expects them to have been immunized against which of the following diseases?

A. measles, polio, pertussis, hepatitis B
B. diptheria, pertussis, polio, tetanus
C. rubella, polio, pertussis, hepatitis A
D. measles, mumps, rubella, polio

Answer: B

Explanation:
By 12 months of age, the child should have had DtaP and polio. MMR is not administered until a child is
12 months of age.Health Promotion and Maintenance

NEW QUESTION 176
- (Topic 3)
The nurse has completed client teaching about introducing solid foods to an infant. To evaluate teaching, the nurse asks the mother to identify an appropriate first solid food. Which of the following is an appropriate response?

A. pureed canned squash
B. pureed apples
C. yogurt
D. infant rice cereal

Answer: D

Explanation:
Single-grain infant cereals are recommended first because they are easily digestible and have added iron content. Choice 3 is incorrect because yogurt is a milk product and introduction should be delayed until the child is 12 months of age because of the risk of milk allergy. Choices 1 and 2 are incorrect because fruits and vegetables are usually given following the introduction of cereals.Basic Care and Comfort

NEW QUESTION 179
- (Topic 3)
A client with Parkinson??s disease has difficulty performing voluntary movements. This is known as:

A. akinesia.
B. dyskinesia.
C. chorea.
D. dystonia.

Answer: B

Explanation:
Dyskinesia is an impairment of the ability to execute voluntary muscles.Physiological Adaptation

NEW QUESTION 184
- (Topic 3)
A client describes her cervical mucus as clear, thin, and elastic. Upon examination, the nurse demonstrates that the cervical mucus can be stretched 8–10 cm. The nurse correctly documents the finding as:

A. ferning capacity.
B. lack of ferning.
C. spinnbarkheit.
D. inhospitable.

Answer: C

Explanation:
Spinnbarkheit is the correct terminology to identify the cervical mucus described. This type of mucus occurs at ovulation and its assessment is used to help couples determine the time they are most likely to conceive. Ferning capacity or crystallization also increases as ovulation approaches. The only way that ferning can be identified is to place the cervical mucus on a microscope slide, let it air dry, and then examine it for a fern-type appearance. Lack of ferning cannot be determined without microscopic examination. Inhospitable cervical mucus refers to mazelike patterns of mucoid strands in cervical mucus that prohibit sperm motility. Other characteristics that make the mucus inhospitable relate to hormone levels, infection, and so on.These conditions cannot be determined by the description supplied in the question.Health Promotion and Maintenance

NEW QUESTION 189
- (Topic 3)
Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board. When the nurse who was not promoted first read the memo and learned that the other nurse had received the promotion, she left the room in tears. This behavior is an example of:

A. conversion.
B. regression.
C. introjection.
D. rationalization.

Answer: B

Explanation:
Crying is a regressive behavior. The ego returned to an earlier, comforting, and less- mature way of behaving in the face of disappointment. Conversion involves the transformation of anxiety into a physical symptom. Introjection involves intense unconscious identification with another person. Rationalization involves the unconscious process of developing acceptable explanations to justify unacceptable ideas, actions, or feelings.Psychosocial Integrity

NEW QUESTION 192
- (Topic 3)
Which of the following should not be included in the teaching for clients who take oral iron preparations?

A. Mix the liquid iron preparation with antacids to reduce GI distress.
B. Take the iron with meals if GI distress occurs.
C. Liquid forms should be taken with a straw to avoid discoloration of tooth enamel.
D. Oral forms should be taken with juice, not milk.

Answer: A

Explanation:
Iron should not be mixed with antacids.Physiological Adaptation

NEW QUESTION 195
- (Topic 3)
A client, age 28, is 8 12 months pregnant. She is most likely to display which normal skin- color variation?

A. vitiligo
B. erythema
C. cyanosis

D. chloasma

Answer: D

Explanation:
Chloasma, also known as the mask of pregnancy, is described as tan-to-brown patches on the face. This hyperpigmentation results from hormonal changes.Health Promotion and Maintenance

NEW QUESTION 200
- (Topic 3)
Which of the following statements by an adult child of a client with late-stage Alzheimer??s disease indicates a need for further teaching by the nurse?

A. ??I should provide a regular schedule for toileting.??
B. ??I should talk to my father less because he can??t communicate.??
C. ??I should give my father oral care after every meal and bedtime.??
D. ??I should assist my father with eating and drinking.??

Answer: B

Explanation:
Even though an Alzheimer??s client might not be able to talk or communicate his needs, the family should still communicate through talking and touching. The other statements are correct and indicate adequate understanding.
Reduction of Risk Potential

NEW QUESTION 203
- (Topic 3)
A client newly diagnosed with Diabetes Mellitus needs education. Which of the following statements should the nurse include in this education?

A. ??You can eat anything you want, but no foods with sugar.??
B. ??You need to lose weight, so your diet must be a restricted one.??
C. ??You need a diet and exercise program.??
D. ??You must eliminate all salt, fat, and sugar from your diet.??

Answer: C

Explanation:
A client newly diagnosed with Diabetes Mellitus needs teaching about diet and exercise.
Physiological Adaptation

NEW QUESTION 208
- (Topic 3)
A client receiving drug therapy with furosemide and digitalis requires careful observation and care. In planning care for this client, the nurse should recognize that which of the following electrolyte imbalances is most likely to occur?

A. hyperkalemia
B. hypernatremia
C. hypokalemia
D. hypomagnesemia

Answer: C

Explanation:
Diuretics such as furosemide might deplete serum potassium. Additionally, the action of digitalis might be potentiated by hypokalemia. These drugs are not associated with hyperkalemia. Diuretic therapy could cause hyponatremia, not hypernatremia. Choice 4 is generally associated with poor nutrition, alcoholism, and excessive GI or renal losses.Physiological Adaptation

NEW QUESTION 209
- (Topic 3)
The nurse is caring for a postpartum woman who has relinquished her baby for adoption. The care plan for the client should include which of the following priority strategies?

A. Make a referral for grief counseling.
B. Allow the woman to see her baby initially, and then discourage further visits.
C. Provide opportunities for the woman to express her feelings.
D. Inform the woman she has the right to change her mind about relinquishment.

Answer: C

Explanation:
Most women who relinquish their infants at birth have come to that decision with a great deal of love and pain. They have made plans in advance. The nurse needs to first provide them with opportunities to express their feelings that might include grief, loneliness, and guilt. A referral for grief counseling might be appropriate if no other support system exists or the mother indicates that she wants assistance working through her grief. If the nurse assesses that the grief process is abnormal, a referral is also appropriate. The mother has probably already made a decision about whether or not she wants to see her baby. The nurse should ask her and make arrangements for that to happen if the mother requests it. Seeing the baby might aid in the grief process.
Until relinquishment occurs, this is the mother??s baby and she should be allowed to see it as often as she wants.

The mother does have the right to change her mind until final legal arrangements are made. But suggesting this option might lead her to think that the nurse believes she shouldn??t relinquish her baby.Health Promotion and Maintenance

NEW QUESTION 213
- (Topic 3)
While performing a physical assessment on a 6-month-old infant, the nurse observes head lag. Which of the following nursing actions should the nurse perform first?

A. Ask the parents to allow the infant to lay on her stomach to promote muscle development.
B. Notify the physician because a developmental or neurological evaluation is indicated.
C. Document the findings as normal in the nurse??s notes.
D. Explain to the parents that their child is likely to be mentally retarded.

Answer: B

Explanation:
Head lag should be completely resolved by 4 months of age. Continuing head lag at 6 months of age indicates the need for further developmental or neurological evaluation. Laying the infant on her stomach promotes muscle development of the neck and shoulder muscles, but because of the age of this child, a referral should be the first action. These findings are not normal for a 6-month-old infant. Significant head lag can be seen in infants with Down syndrome and hypoxia, as well as neurologic and other metabolic disorders. Some of those disorders might have mental retardation as a component. However, this child needs to have the referral to determine the cause of the head lag first.Health Promotion and Maintenance

NEW QUESTION 217
- (Topic 3)
Incidences of child abuse apperar to be higher in the African-American community and might be explained by:

A. the increased number of African Americans viewing violence on television.
B. more single-parent households in African- American communities.
C. stricter child-rearing practices in African- American households.
D. a higher occurrence of rage in African Americans.

Answer: B

Explanation:
Child abuse is higher in households with lower socioeconomic status and single parents. The increased incidence might be due to increased stress and fewer support systems. Psychosocial Integrity

NEW QUESTION 218
- (Topic 3)
A client??s postoperative pain seems to be getting worse instead of better. When the nurse asks the client, ??Why do you think it??s getting worse??? the client replies, ??My wife died last month. It??s all I can think about.?? The nurse must now consider:

A. calling the physician for an increased dosage of pain medication.
B. calling the physician for a sedative.
C. referring the client for a psychiatric consult.
D. developing interventions for grief and loss.

Answer: D

Explanation:
The client??s pain is affective as well as sensory. Grieving his wife??s death is a normal response that does not necessarily require psychiatric consult. Choices 1 and 2 address the sensory, not the affective component of his pain.Basic Care and Comfort

NEW QUESTION 222
- (Topic 3)
Melissa Smith came to the Emergency Department in the last week before her estimated date of confinement complaining of headaches, blurred vision, and vomiting. Suspecting PIH, the nurse should best respond to Melissa??s complaints with which of the following statements?

A. ??The physician will probably want to admit you for observation.??
B. ??The physician will probably order bed rest at home.??
C. ??These are really dangerous signs.??
D. ??The physician will probably prescribe some medicine for you.??

Answer: B

Explanation:
Pregnancy-induced hypertension (PIH) is a hypertensive disorder of pregnancy, developing after 20 weeks gestation. It is characterized by edema, hypertension, and proteinuria (preclampsia and eclampsia). The cause is unknown. The client with advanced PIH needs rest, and home is the best place to get it. Hospitalization is not necessary in this situation. Medication is not indicated.Physiological Adaptation

NEW QUESTION 224
- (Topic 3)
Accurate documentation of assessment findings regarding pressure ulcers is very important because:

A. the law requires the nurse to document lesions.
B. the hospital requires the nurse to document lesions.

C. the physician requires the nurse to document lesions.
D. the nursing assessment of ulcers is a standard of nursing practice.

Answer: D

Explanation:
Documentation of assessments by the nurse promotes continuity of care and helps prevent further progression of the ulcer.Basic Care and Comfort

NEW QUESTION 225
- (Topic 3)
A contraindication for topical corticosteroid use in a client with atopic dermatitis (eczema) is:

A. parasite infection.
B. viral infection.
C. fungal infection.
D. spirochete infection.

Answer: B

NEW QUESTION 230
- (Topic 3)
To ensure proper immobilization and increase client comfort when using a rigid splint:

A. place the client on a stretcher before splinting.
B. place the client on a long spine board before splinting.
C. pad the spaces between the body part and the splint.
D. ensure that the splint conforms to the body curves.

Answer: C

Explanation:
To ensure proper immobilization and increase client comfort when using a rigid splint, pad the spaces between the body part and the splint.Basic Care and Comfort

NEW QUESTION 233
- (Topic 3)
In managing nausea related to Morphine epidural analgesia, the nurse should administer:

A. Indocin
B. Codeine
C. Motrin
D. Compazine

Answer: D

Explanation:
Compazine is the drug that should be administered.Basic Care and Comfort

NEW QUESTION 238
- (Topic 3)
Which of the following instructions should a nurse give a client who is about to undergo pelvic ultrasonography?

A. ??Urinate prior to the test.??
B. ??Have someone drive you home.??
C. ??Do not drink after midnight.??
D. ??Drink plenty of water.??

Answer: D

Explanation:
A full bladder is required to serve as a landmark to define pelvic organs. No sedation is given, so the client may drive herself home after the test.Reduction of Risk Potential

NEW QUESTION 241
- (Topic 3)
When assessing a client with amytrophic lateral sclerosis (ALS), the nurse should expect which of the following findings?

A. mental confusion
B. muscular weakness
C. sensory loss
D. emotional liability

Answer: B

Explanation:
Clients with ALS have progressive muscular weakness and wasting. However, the mind remains clear and sharp, and there is no sensory loss. There might be periods of grieving, but usually not emotional liability.Reduction of Risk Potential

NEW QUESTION 245
- (Topic 3)
Which of the following statements is correct regarding rape?

A. Most rapes are reported.
B. Legally, a woman can be raped by her spouse.
C. Prosecution and conviction for rape is easy.
D. The most common location of rape is the victim??s own home.

Answer: B

Explanation:
The definition ofrapeis sexual intercourse against someone??s will. It is a degrading, brutal crime of violence and can occur between any two persons regardless of their marital status.Psychosocial Integrity

NEW QUESTION 250
- (Topic 3)
An 8-year-old Asian child is being examined during a school screening. The nurse notices small bruises on the anterior and posterior ribs. The nurse should ask the child:

A. if the family practices coining.
B. who hit him.
C. if the child has fallen.
D. how long the abuse has been occurring.

Answer: A

Explanation:
The nurse must be aware of cultural practices that resemble child abuse. These practices include coining, cupping, and fallen fontanella. Coining and cupping are thought to draw infections from the body. Coining involves rubbing a heated coin on the chest and torso and might cause bruising. Cupping uses heated glasses that can produce erythematous and ecchymotic rounded lesions or linear streaks on the body from the suction. Fallen fontanella involves turning a child upside down to correct a depressed fontanelle; it can cause vomiting, diarrhea, and dehydration in infants. Retinal hemorrhages can also occur, and sometimes Shaken-Baby Syndrome is erroneously diagnosed.Psychosocial Integrity

NEW QUESTION 251
- (Topic 3)
The best lab test to diagnose disseminated intravascular coagulation (DIC) is:

A. platelet count.
B. protime (PT).
C. partial thromboplastin time (PTT).
D. D-dimer.

Answer: D

Explanation:
In DIC, many small clots form throughout the body and are immediately broken down. D- dimer measures a
specific fibrin split (or degradation) product and is the most specific test for DIC. Choice 1 is incorrect because platelets are consumed in DIC, but this is not specific. Choices 3 and 4 are both elevated (because clotting factors have been used up) but, again, are not specific.Physiological Adaptation

NEW QUESTION 253
- (Topic 3)
Which of the following coping mechanisms protects an individual from anxiety?

A. denial and fantasy
B. rationalization and suppression
C. regression and displacement
D. reaction formation and projection

Answer: A

Explanation:
Denial, rationalization, regression, and fantasy are coping mechanisms that protect persons from anxiety.
Psychosocial Integrity

NEW QUESTION 256
- (Topic 3)
What happens if folic acid is given to treat anemia without determining its underlying cause?

A. Erythropoiesis is inhibited.
B. Excessive levels of folic acid might accumulate, causing toxicity.
C. The symptoms of pernicious anemia might be masked, delaying treatment.
D. Intrinsic factor is destroyed.

Answer: C

Explanation:

Folic acid should not be used if pernicious anemia is suspected because it does not protect the client from
CNS changes common to this type of anemia. Folic acid is usually given with Vitamin B12. Both are part of the Vitamin B complex and are essential for cell growth and division. Folic acid is sometimes used as a rescue drug for cells exposed to some toxic chemotherapeutic agents. The nature of the anemia must be confirmed to ensure that the proper drug regimen is being used.Physiological Adaptation

NEW QUESTION 259
- (Topic 3)
When teaching parents how their children learn sex role identification, the nurse should include which of the following statements?

A. Sex role identification begins in infancy.
B. Sex role identification begins in the preschool years.
C. Sex role identification begins during the school-age years.
D. Sex role identification begins during early adolescence.

Answer: A

Explanation:
Sex role identification begins during infancy. Infants can identify body parts by the end of the first year. Preschoolers frequently engage in masturbation and sex play with peers. School-age children continue to gain awareness of their sexual identity. During this time they might continue to masturbate and engage in sex play. They might add behaviors such as hugging and kissing members of the opposite sex. Adolescent sex role identification is largely influenced by sexual maturation and trying out or assuming a sex role.Health Promotion and Maintenance

NEW QUESTION 262
- (Topic 3)
Which of the following NSAIDS is most commonly used for a brief time for acute pain?

A. Advil
B. Aleve
C. Toradol
D. Bextra

Answer: C

Explanation:
Toradol is an NSAID found to be very effective for brief periods of time for acute pain. It can be given IM, IV, or PO.Basic Care and Comfort

NEW QUESTION 264
- (Topic 3)
Which of the following foods present a problem for a client diagnosed with Celiac Disease?

A. butter
B. oats or barley cereal
C. fresh vegetables
D. coffee or tea

Answer: B

Explanation:
Celiac disease, orceliac sprue,is a malabsorption disorder affecting the small intestine in which there is a problem with the ingestion of gluten, a protein normally found in grain products such as wheat, rye, oats, or barley. The other choices reflect substances that do not contain gluten and should not pose problems for a client with this disorder.Basic Care and Comfort

NEW QUESTION 269
- (Topic 3)
Appropriate nursing strategies to assist a client in maintaining a sense of self include:

A. using the client??s first name when addressing the client.
B. treating the client with dignity.
C. explaining procedures only if the client is attentive.
D. discouraging the use of personal items.

Answer: B

Explanation:
All clients must be treated with dignity. Rather than a strategy, treating clients with dignity is a basic core value universal to nursing.Psychosocial Integrity

NEW QUESTION 272
- (Topic 3)
A client had a colostomy done one day ago. Which of the following is an abnormal finding when assessing the stoma?

A. mild edema
B. minimal bleeding
C. rose color
D. dark red color

Answer:

D

Explanation:
A dark red color is an abnormal finding when assessing the stoma. It indicates inadequate blood supply. The other findings are normal one day postoperatively.Physiological Adaptation

NEW QUESTION 276
- (Topic 3)
Which of the following is the most appropriate diet for a client who is unable to swallow?

A. nothing by mouth
B. nasogastric feedings
C. clear liquids
D. total parenteral nutrition

Answer: B

Explanation:
Nasogastric feedings are most appropriate for a client who is unable to swallow. Nothing by mouth leads to nutritional deficiencies. The client might aspirate a clear liquid diet. TPN is not necessary as long as the gut is still functioning.Reduction of Risk Potential

NEW QUESTION 277
- (Topic 3)
The test used to differentiate sickle cell trait from sickle cell disease is:

A. sickle cell preparation.
B. peripheral smear.
C. sickledex.
D. hemoglobin electrophoresis.

Answer: D

Explanation:
Hemoglobin electrophoresis is used to differentiate between sickle cell trait and sickle cell disease. Physiological Adaptation

NEW QUESTION 280
- (Topic 3)
In evaluating the lab work of a client in a hepatic coma, which of the following lab tests is most important?

A. blood urea nitrogen
B. serum calcium
C. serum ammonia
D. serum creatinine

Answer: C

Explanation:
When a client is in a hepatic coma, he is in live liver failure. The liver can no longer metabolize amino acids completely, thus ammonia levels increase causing brain-tissue irritation.Basic Care and Comfort

NEW QUESTION 285
- (Topic 3)
When caring for a client with a possible diagnosis of placenta previa, which of the following admission procedures should the nurse omit?

A. perineal shave
B. enema
C. urine specimen collection
D. blood specimen collection

Answer: B

Explanation:
An enema could dislodge the placenta and increase bleeding.Physiological Adaptation

NEW QUESTION 290
- (Topic 3)
Which of the following strategies should the nurse include when planning care for children of migrant workers?

A. Delay immunization because of acute illness.
B. Provide parents with copies of medical records.
C. Schedule preventive services at acute illness visits.
D. Stress the importance of using one primary care provider.

Answer: B

Explanation:

Migrant workers should be provided with the medical records and immunization records for their children, including growth charts. The parents should also be encouraged to take those records with them to every health care visit, including Emergency Department visits. It is important to provide immunizations even when the child is there for an acute illness because preventive care is often not obtained. Preventive services should also be provided, not scheduled, when a child presents for an acute illness. Using a single primary care provider is not an option for most migrant families. The nurse should ask the parents about where they are going next and give them the name, address, and phone numbers of providers there.Health Promotion and Maintenance

NEW QUESTION 291
- (Topic 3)
Milieu therapy is best employed to perform which activity?

A. investigating the client??s view of the world
B. promoting socialization skills
C. focusing on inappropriate behavior
D. providing repetitive ordinary experiences on a daily basis

Answer: D

Explanation:
Milieu therapy provides repetitive ordinary experiences on a daily basis, controls the environment by minimizing change as much as possible, and decreases disruptive behavior by keeping tasks simple.Psychosocial Integrity

NEW QUESTION 295
- (Topic 4)
When assessing a client with early impairment of oxygen perfusion, such as pulmonary embolus, the nurse should expect to find restlessness and which of the following symptoms?

A. warm, dry skin
B. bradychardia
C. tachycardia
D. eupnea

Answer: C

Explanation:
The cardinal signs of respiratory problems and hypoxia are restlessness, diaphoresis, tachycardia, and cool skin.
Bradycardia might occur much later in the process when the condition is severe. Eupnea is normal respirations in rate and depth.Physiological Adaptation

NEW QUESTION 300
- (Topic 4)
A 50 milliliter (ml) bolus of normal saline fluid is ordered by the physician. The physician wants it to infuse in 30 minutes. The nurse should set the pump rate at:

A. 100 ml per hour for one hour.
B. 60 ml per hour for one-half hour.
C. 120 ml per hour for one hour.
D. 50 ml per hour for one hour.

Answer: A

Explanation:
One hundred ml in one hour equals 50 ml in 30 minutes, which is what the physician prescribed. Choice 2 is 10 ml more than the physician prescribed for 30 minutes. Choice 3 is the same asChoice 2; it is 10 ml more than the physician prescribed for 30 minutes. Choice 4 only provides 25 ml over 30 minutes, or half the volume prescribed. Pharmacological Therapies

NEW QUESTION 304
- (Topic 4)
A client and his family facing the end stage of a terminal illness might be best served by:

A. a rehabilitation center.
B. an extended care facility.
C. Hospice.
D. a crisis intervention center.

Answer: C

Explanation:
Hospice has the belief that more humanized alternative care for dying clients is needed than is being provided in hospitals, which focus mostly on medical cures. No matter where the care is delivered, Hospice provides a specialized interdisciplinary team of health care professionals who work together to manage client care.HealthPromotion and Maintenance

NEW QUESTION 306
- (Topic 4)
Mrs. Peterson complains of difficulty falling asleep, awakening earlier than desired, and not feeling rested. She attributes these problems to leg pain that is secondary to her arthritis. What is the most appropriate nursing diagnosis for her?

A. Sleep Pattern Disturbances (related to arthritis)
B. Fatigue (related to leg pain)
C. Knowledge Deficit (regarding sleep hygiene measures)
D. Sleep Pattern Disturbances (related to chronic leg pain)

Answer: D

Explanation:
The client??s sleep pattern is directly disturbed by the chronic leg pain, which is secondary to the arthritis. This nursing diagnosis is the appropriate one to directly deal with comfort measures and the like.Basic Care and Comfort

NEW QUESTION 307
- (Topic 4)
The nurse is preparing to administer IV Vancomycin to a client. Which of the following nursing actions should be taken first?

A. performing a physical assessment prior to administration
B. obtaining the most recent lab values regarding renal function
C. reviewing peaks and troughs for the past few days
D. ensuring the client is not allergic to the medication

Answer: D

Explanation:
Even before the physical assessment (which might or might not be indicated at the time of administration of Vancomycin), ensuring that the client is not allergic to the medication is the most critical action the nurse must take before administering any drug. Lab values regarding renal functioning and therapeutic ranges via peaks and troughs are also important with some medications such as Vancomycin because renal damage can occur if blood drug levels remain high over time.Safety and Infection Control

NEW QUESTION 312
- (Topic 4)
The intravenous route is potentially the most dangerous route of drug administration because:

A. the IV might infiltrate.
B. it is expensive and nursing intensive.
C. rapid administration of a drug can lead to toxicity.
D. the client always has more side effects.

Answer: C

Explanation:
The bioavailability of the injected medication is 100% and might lead to toxicity. An IV infiltration can cause serious problems with tissue necrosis, but this is not life threatening. Expensiveandtime consumingdo not equate withdangerous. Choice 4 is not always true. Pharmacological Therapies

NEW QUESTION 315
- (Topic 4)
An adolescent female reports being raped at a party where alcohol was served. The client admits to drinking alcohol before being raped by an acquaintance. The nurse should:

A. inform the client that because she is underage, she is at fault for attending a party where alcohol was served.
B. ask the client if anyone witnessed the event because the client was intoxicated and might not remember correctly.
C. inform the client that it was not her fault, and support the client through the physical examination.
D. question whether the woman had consensual sex and now just feels guilty.

Answer: C

Explanation:
Acquaintance rape remains a controversial topic because of lack of agreement on the definition of consent. Most acquaintance rapes take place in either the victim??s or the assailant??s home or apartment. Most victims of acquaintance rape inform someone close to them, but less than 30% report the incidence to the authorities. Survivors of acquaintance rape report similar levels of depression, anxiety, complications in subsequent relationships, and difficulty attaining prerape levels of sexual satisfaction to what survivors of stranger rape report. Coping is more difficult for victims of acquaintance rape if others fail to recognize that the emotional impact is just as serious.Psychosocial Integrity

NEW QUESTION 316
- (Topic 4)
Some drugs are excreted into bile and delivered to the intestines. Prior to elimination from the body, the drug might be absorbed. This process is known as:

A. hepatic clearance.
B. total clearance.
C. enterohepatic cycling.
D. first-pass effect.

Answer: C

Explanation:
Drugs and drug metabolites with molecular weights higher than 300 can be excreted via the bile, stored in the gallbladder, delivered to the intestines by the bile duct, and then reabsorbed into the circulation. This process reduces the elimination of drugs and prolongs their half-life and duration of action in the body. Choice 1 is the amount of drug eliminated by the liver. Choice 2 is the sum of all types of clearance including renal, hepatic, and respiratory. Choice 4 is the amount of drug absorbed from the GI tract, then metabolized by the liver (reducing the amount of drug that makes it into circulation).Pharmacological Therapies

NEW QUESTION 318
- (Topic 4)

How many temporary teeth should the nurse expect to find in a 5-year-old client??s mouth?

A. up to 10
B. up to 15
C. up to 20
D. up to 32

Answer: C

Explanation:
A child can have up to 20 temporary (deciduous or baby) teeth. The first tooth usually erupts by age 6 months and the last by age 30 months. All temporary teeth usually are shed between 6 and 13 years of age.Preventionand Early Detection of Disease

NEW QUESTION 319
- (Topic 4)
Which of the following symptoms is most characteristic of a client with cancer of the lungs?

A. exertional dyspnea
B. persistent changing cough
C. air hunger; dyspnea
D. cough with night sweats

Answer: B

Explanation:
The most common sign of cancer of the lung is a persistent cough that changes. Other signs are dyspnea, bloody sputum, and long-term pulmonary infection. Choice 1 is common with chronic obstructive pulmonary disease (COPD). Choice 3 is common with asthma. Choice 4 is common with tuberculosis.PhysiologicalAdaptation

NEW QUESTION 321
- (Topic 4)
A neighbor telephones the nurse to tell her that her child has erythema infectiosum and asks for information. The nurse knows that another name for the disorder is:

A. Kawasaki disease.
B. rheumatic disease.
C. lupus erythematosus.
D. fifth disease.

Answer: D

Explanation:
The child has Fifth disease, a parvovirus flulike illness that is self-limiting but is contagious for two–three weeks.Safety and Infection Control

NEW QUESTION 325
- (Topic 4)
A client is assessed by the nurse as experiencing a crisis. The nurse plans to:

A. allow the client to work through independent problem-solving.
B. complete an in-depth evaluation of stressors and responses to the situation.
C. focus on immediate stress reduction.
D. recommend ongoing therapy.

Answer: C

Explanation:
A crisis is an acute, time-limited state of disequilibrium resulting from a situational, developmental, or societal source of stress. Utilizing the nursing process, the nurse should assist clients to work through a crisis to its resolution and restore their precrisis level of functioning.Psychosocial Integrity

NEW QUESTION 330
- (Topic 4)
The nurse suspects an elderly client has been the victim of abuse. The client denies abuse and declines assistance. The nurse??s next action should be to:

A. do nothing; the client has the right to refuse treatment.
B. report the incident to the police.
C. arrange an appointment with the client??s next of kin.
D. educate the client about available services.

Answer: D

Explanation:
Although clients do have the right to refuse treatment, the nurse should remain nonjudgmental and inform the client of available services. Frequently elders are not aware of existing programs.Psychosocial Integrity

NEW QUESTION 331
- (Topic 4)
The three major sequential maturational crises for females include:

A. puberty, pregnancy, and menopause.
B. death of a spouse, menopause, and childbirth.
C. rape, divorce, and menarche.
D. dating, engagement, and separation.

Answer: A

Explanation:
The three major sequential maturational crises affecting females are puberty, pregnancy, and menopause. These are life events that have been studied by many researchers and are considered the major events in a woman??s life. Puberty is the onset menarche. Pregnancy is a turning point in one??s life from which there is no return. Menopause is the cessation of menses. The nurse has the responsibility to assess, plan, implement appropriate concepts to facilitate effective functioning, and enhance growth and development. Choices 2, 3, and 4 are not sequential maturational crises.Psychosocial Integrity

NEW QUESTION 332
- (Topic 4)
Which of the following clients require airborne precautions?

A. a client with fever, chills, vomiting, and diarrhea
B. a client suspected of varicella (chickenpox)
C. a client with abdominal pain and purpura
D. a client diagnosed with AIDS

Answer: B

Explanation:
Chickenpox (varicella) is an acute, infectious, airborne illness that requires others in direct contact to wear a respirator mask.Safety and Infection Control

NEW QUESTION 334
- (Topic 4)
To improve overall health, the nurse should place highest priority on assisting a client to make lifestyle changes for which of the following habits?

A. drinking a six-pack of beer each day
B. eating an occasional chocolate bar
C. exercising twice a week
D. using relaxation exercises to deal with stress

Answer: A

Explanation:
Health promotion is motivated by the desire to increase people??s well-being and health potential. The nurse promotes health by maximizing the client??s own strengths. Identification and analysis of the client??s strengths are a component of preventing illness, restoring health, and facilitating coping with disability or death. The nurse facilitates decisions about lifestyle that enhance one??s quality of life and encourage acceptance of responsibility for one??s own health.Health Promotion and Maintenance

NEW QUESTION 336
- (Topic 4)
American families are having difficulty adequately performing their vital health care function. What are the basic reasons for this difficulty?

A. structure of the health care system and family structure
B. psychological factors for men and women seeking health care
C. conditions being labeleddisabilitiesand seen as too time consuming
D. health care organizations (HMOs) and disconnected families

Answer: A

Explanation:
Scholars suggest that the reasons families are having difficulty providing health care for their members lies with both the structure of the health care system and the family structure. Major factors explaining differences in utilization patterns of medical services include the lack of healthcare insurance coverage, lack of services for special populations (that is, teenage males), perception by families of the health care system and the health care provider, and lack of partnership between health care providers and families in mutually addressing health care issues.Health Promotion and Maintenance

NEW QUESTION 340
- (Topic 4)
The tendency of a drug to combine with its receptor is called:

A. potency.
B. efficacy.
C. kinetics.
D. affinity.

Answer: D

Explanation:
Affinity is a close relationship, mutual attraction, or similarity. The tendency of a drug to combine with its receptor is called affinity. Affinity is a measure of the strength of the drug- receptor bonding. Choices 1 and 2 describe the capability of a drug to produce the desired effect. Choice 3 is the branch of science that deals with the effects of forces on the motions of material bodies or with changes in a physical or chemical system.Pharmacological Therapies

NEW QUESTION 342
- (Topic 4)
What is the reason for a contract between nurse and client?

A. Contracts state the roles the participants take.
B. Contracts are indicative of the feeling tone established between participants.
C. Contracts are binding and prevent either party from ending the relationship prematurely.
D. Contracts spell out the participation and responsibilities of both parties.

Answer: D

Explanation:
A contract emphasizes that the nurse works with the client, rather than doing something for the client.Working withsuggests that each party is expected to participate and share responsibility for outcomes. Contracts do not,however, stipulate roles or feeling tone, nor is premature termination expressly forbidden.Psychosocial Integrity

NEW QUESTION 347
- (Topic 4)
Nursing care for a client undergoing chemotherapy includes assessment for signs of bone marrow depression. Which finding accounts for some of the symptoms related to bone marrow depression?

A. erythrocytosis
B. leukocytosis
C. polycythemia
D. thrombocytopenia

Answer: D

Explanation:
Thrombocytopenia is an abnormal decrease in the number platelets, which results in bleeding tendencies. Erythrocytosis is an abnormal increase in the number of circulating red blood cells. Leukocytosis is an increase in the number of white blood cells in the blood. Polycythemia is also an excess of red blood cells and is a synonym for erythrocytosis. With chemotherapy there is a decrease in red and white blood cells, not an increase.
Physiological Adaptation

NEW QUESTION 348
- (Topic 4)
A hospitalized adult client who routinely works from midnight until 8 a.m. has a temperature of 99.1?? F at 4 a.m. The nurse determines that this is most likely due to:

A. delta sleep
B. slow brain waves
C. pneumonia
D. circadian rhythm

Answer: D

Explanation:
Biological rhythms that follow a cycle lasting about 24 hours are termed circadian rhythm. The sleep-wake cycle is closely linked with cardiac rhythms, such as body temperature. While a person sleeps, core body temperature drops, often reaching the 24-hour low at 4 a.m. When the sleep period shifts, temperature fluctuations also shift to match the new sleep patterns.Basic Care and Comfort

NEW QUESTION 353
- (Topic 4)
A serious complication of a total hip replacement is displacement of the prosthesis. What is the primary sign of displacement?

A. pain on movement and weight bearing
B. hemorrhage
C. affected leg appearing 1–2 inches longer
D. edema in the area of the incision

Answer: A

Explanation:
Pain on movement and weight bearing indicates pressure on the nerves or muscles caused by the dislocation. Other symptoms of dislocation include an inability to bear weight and a shortening of the affected leg. Edema is not a primary sign of displacement.Physiological Adaptation

NEW QUESTION 358
- (Topic 4)
A visitor accidentally knocks over a plastic pleural drainage system connected to a client, and it cracks. What should the nurse do first?

A. Observe the client??s response.
B. Notify the physician.
C. Change the drainage system.
D. Observe for leaks.

Answer: C

Explanation:

If a crack is seen in a pleural drainage system, it should be changed immediately. The remaining choices can be performed later.Reduction of Risk Potential

NEW QUESTION 359
- (Topic 4)
A complication of total parenteral nutrition (TPN) is the development of cholestasis. What is this condition?

A. an inflammatory process of the extrahepatic bile ducts
B. an arrest of the normal flow of bile
C. an inflammation of the gallbladder
D. the formation of gallstones

Answer: B

Explanation:
Cholestasis due to TPN administration is an intrahepatic process that interrupts the normal flow of bile. Extrahepatic bile duct inflammation is cholangitis. Inflammation of the gallbladder is cholecystitis. Gallstones are formed by bile components.Pharmacological Therapies

NEW QUESTION 364
- (Topic 4)
Activities of effective supervisors can be taskrelated or people-related activities. An example of a task-related supervisory activity is:

A. coaching.
B. evaluating.
C. delegating.
D. facilitating.

Answer: C

Explanation:
Delegating is the act (or task) of assigning work to those that are capable and competent to do the work. Coaching, evaluating, and facilitating are supervisory activities that are people related.Coordinated Care

NEW QUESTION 366
- (Topic 5)
All of the following are clinical manifestations indicating male climacteric except:

A. hot flashes.
B. loss of reproductive ability.
C. headaches.
D. heart palpitations.

Answer: B

Explanation:
The likelihood of fathering children does decrease with aging and decreased testosterone production, but men do not lose their ability to reproduce during the climacteric. Many men do not experience any physical symptoms of climacteric but some men do report hot flashes, headaches, and heart palpitations, among other symptoms.Health Promotion and Maintenance

NEW QUESTION 367
- (Topic 5)
A physician orders a serum creatinine for a hospitalized client. The nurse should explain to the client and his family that this test:

A. is normal if the level is 4.0 to 5.5 mg/dl.
B. can be elevated with increased protein intake.
C. is a better indicator of renal function than the BUN.
D. reflects the fluid volume status of a person.

Answer: C

Explanation:
A serum creatinine level should be 0.7 to 1.5 mg/dl, and it does not vary with increased protein intake, so it is a better indicator of renal function than the BUN.Physiological Adaptation

NEW QUESTION 368
- (Topic 5)
When teaching a woman about possible side effects of hormone replacement therapy, the nurse should include information about all of the following except:

A. Hypoglycemia in diabetic women.
B. The possible return of monthly menses when taking combination hormones.
C. Increased risk of gallbladder disease.
D. Increased risk of breast, cervical, and ovarian cancer with long-term use.

Answer: A

Explanation:
When taking estrogen, there is an increased risk of diabetes or hyperglycemia due to lowered glucose tolerance. It is true that monthly menses might return when taking combination hormones. The progestin is responsible for this. There is also a risk of gallbladder disease. It is also true that there is an increased risk of

breast, cervical, and ovarian cancer with long-term hormone replacement therapy.Health Promotion and Maintenance

NEW QUESTION 373
- (Topic 5)
With a breech presentation, the nurse must be particularly alert for which of the following?

A. quickening
B. ophthalmia neonatorum
C. pica
D. prolapsed umbilical cord

Answer: D

Explanation:
Prolapsed umbilical cord is the descent of the umbilical cord into the vagina before the fetal presenting part and compression of the cord between the presenting part and the maternal pelvis, compromising or completely cutting off fetoplacental perfusion. This is an emergency situation; immediate delivery should be attempted to save the fetus. Physiological Adaptation

NEW QUESTION 375
- (Topic 5)
After 12 months of cessation of menses, which of the following assessment findings in a client who is taking hormone replacement therapy should the nurse report to the physician immediately?

A. breast tenderness
B. weight gain
C. fluid retention
D. uterine bleeding

Answer: D

Explanation:
Uterine bleeding on combination hormone replacement therapy, after 12 months of menses cessation, indicates an increased risk of carcinoma and should be reported to the physician immediately. Breast tenderness, weight gain, and fluid retention are all routine side effects ofhormone replacement therapy. They should be noted in the record and reported to the physician, but they are not urgent.Health Promotion and Maintenance

NEW QUESTION 379
- (Topic 5)
What is pica?

A. dependency on alcohol
B. increased iron in the diet
C. the sickle cell trait
D. eating ice

Answer: D

Explanation:
Pica represents the ingestion of nonfood substances that leads to a clinical iron deficiency and might actually be the first sign of a problem. Clients eat a wide range of nonfood items, including ice, clay, dirt, and paste.Physiological Adaptation

NEW QUESTION 382
- (Topic 5)
What are the implications for a client with renal insufficiency who wants to start a low- carbohydrate (CHO) diet?

A. As long as the client eats a minimum of 30g of CHO/day, there should be no problem.
B. The client??s clinical condition is a contraindication to starting a low CHO diet.
C. Calcium supplements should be utilized to prevent the development of osteoporosis while on a low CHO diet.
D. As long as the client eats foods that are high biologic protein sources, a low CHO diet can be followed.

Answer: B

Explanation:
A client with renal insufficiency should not start a low CHO diet because it could result in an increased renal solute load. Clients who have renal disease (renal failure, endstage renal disease [ESRD], dialysis, and transplant) or liver disease (liver failure, hepatic encephalopathy, cirrhosis, transplant, and hepatitis) require some form of protein control in dietary patterns to preventcomplications from an inability to handle protein solute load. Proteins used in the diet must be of high biologic value, and protein intake is usually weight based, starting at 0.8 g/kg of dry weight, depending on the client??s underlying clinical condition. Protein levels may be increased as necessary to account for metabolic response to dialysis and regeneration of liver tissue (1.5–2.0 g/kg/day). A minimum level of CHOs are needed in the diet (50–100 g/day) to spare protein. Vitamin and mineral supplements might be indicated with clients who have liver failure. The dietician is instrumental in calculating specific nutrient requirements for these clients and reviewing fluid intake and output, medication profile, and daily weight to monitor client outcomes in conjunction with dialysis technicians and nurses.Physiological Adaptation

NEW QUESTION 385
- (Topic 5)
In administering NSAID adjunctive therapy to an elderly client with cancer, the nurse must monitor:

A. BUN and creatinine.
B. creatinine and calcium.
C. Hgb and Hct.

D. BUN and CFT.

Answer: A

Explanation:
Elder adults might be more at risk for gastric and renal toxicity, increasing among elder adults.Basic Care and Comfort

NEW QUESTION 389
- (Topic 5)
The hydraulic lift (Hoyer lift) is:

A. used for all clients who??ve had orthopedic surgery.
B. used for all clients who are not able to stand and for extremity obese clients.
C. used for all clients, both old and young, in a hospital setting.
D. not an assistive device for special needs.

Answer: B

Explanation:
The hydraulic lift is used for safe transfer when a client is not able to stand or is too heavy for the health care workers to lift safely.Basic Care and Comfort

NEW QUESTION 393
- (Topic 5)
When a middle-age woman says to the nurse, ??I??m really worried about menopause. When my mom went through it, she got really depressed.?? The nurse??s best response is:

A. ??It is a myth that women get depressed because of menopause.??
B. ??Menopause is a normal developmental process.??
C. ??It sounds like you are worried that you might become depressed during menopause.??
D. ??When women experience depression during menopause it is usually because of social stresses.??

Answer: C

Explanation:
Choice 3 not only acknowledges the client??s fear but invites more disclosure and discussion. Reflective listening is very therapeutic and in this case acknowledges the woman??s unspoken fear that she might become depressed like her mother. When her fears have been acknowledged and she feels that the nurse understands, she will be more open to the teaching or interventions to follow. It is a myth that menopause causes depression, but to say that to this client does not acknowledge the fear she shared with the nurse and gives the impression the nurse doesn??t care about her concern. It closes down communication. It is also true that menopause is a normal developmental process. This can certainly be used in teaching but not to address her immediate concern; the client might feel the nurse doesn??t think her concern is appropriate because menopause is normal. If women experience depression during menopause, it is usually due to social stresses such as loss of loved ones, loss of roles, caregiver demands, and physical problems. Choice 4 is true but is a nontherapeutic response in this situation.Health Promotion and Maintenance

NEW QUESTION 395
- (Topic 5)
Increased cortisol levels might be found in a client with which condition?

A. Cushing??s syndrome
B. Addison??s disease
C. renal failure
D. congestive heart failure

Answer: A

Explanation:
Cushing??s syndrome produces elevated cortisol levels. Addison??s disease produces decreased cortisol levels. The other conditions are not associated with cortisol levels. Reduction of Risk Potential

NEW QUESTION 400
- (Topic 5)
Which of the following statements indicates adequate dietary understanding in a client with constipation?

A. ??I should decrease my intake of fluids.??
B. ??I should decrease my level of activity.??
C. ??I should increase my intake of apples.??
D. ??I should increase my intake of milk.??

Answer: C

Explanation:
Apples are a source of high fiber, which decreases constipation. A constipated client needs to increase fluids and activity level. Milk is not a high-fiber food.Reduction of Risk Potential

NEW QUESTION 401
- (Topic 5)
Physical examination of a client regarding mobility status should:

A. begin with gait.
B. be oriented to time, place, and person.
C. begin with the Romberg test.
D. begin with the Tandem Walk test.

Answer: A

Explanation:
Gait is usually assessed as the client walks into the room. Normal gait is smooth, flowing, and rhythmic without assistive devices.Basic Care and Comfort

NEW QUESTION 404
- (Topic 5)
For a client requiring total oral care, it is important for the nurse to:

A. assemble all equipment, assist the client tosemi-Fowler??s position, and place a towel on his chest.
B. place client in Fowler??s position, prepare the equipment, and tell the client what to do.
C. assemble all equipment, place the client in a side-lying position, and place a towel under his chin.
D. use gloves and clean the client??s mouth, including the tongue.

Answer: C

Explanation:
Assemble all equipment first; place the client in a side-lying position so that fluid can easily flow out or pool in the side of the mouth for suctioning (to prevent aspiration); and then place a towel under the client??s chin and a curved basin against the chin. Gloves should be worn.Basic Care and Comfort

NEW QUESTION 408
- (Topic 5)
The nurse can promote relief of muscle pain, spasms, and tension by:

A. having the client continue his activities as usual.
B. immobilizing the client.
C. applying heat, cold, pressure, or vibration to the painful area.
D. giving as much pain medication as needed to ease the muscle.

Answer: C

Explanation:
Superficial heat and cold, massage, pressure, or vibration can be applied to alleviate pain associated with muscle tension, pain, or spasms.Nonpharmacological Therapies

NEW QUESTION 411
- (Topic 5)
Which of the following is an indication for electroencephalography?

A. paralysis
B. neuropathy
C. seizure disorder
D. myocardial infarction

Answer: C

Explanation:
Electroencephalography is indicated for assessing clients with a seizure disorder.
Reduction of Risk Potential

NEW QUESTION 412
- (Topic 5)
What does client and family communication and education concerning restraints do?

A. confuses both groups more
B. helps with coping and stress levels
C. encourages cooperation with the client and family
D. puts the responsibility on the client and family, not the nurse

Answer: C

Explanation:
Cooperation is more likely if the client and family understand the purpose of and expected gains from restraints.
Well-meaning family members might release restraints if their purpose is not clear.Safety and Infection Control

NEW QUESTION 415
- (Topic 5)
In alcoholics with anemia:

A. pernicious anemia is more common than folic acid deficiency.
B. iron deficiency and folic acid deficiency can coexist.
C. the alcohol interferes with iron absorption.

D. oral vitamin replacement is contraindicated.

Answer: B

Explanation:
The ingestion of nonfood substances (alcohol) can lead to a clinical iron deficiency and might actually be the first sign of a problem. The client might substitute alcohol for a nutrition program that fosters a positive health habit.Physiological Adaptation

NEW QUESTION 420
- (Topic 5)
Neural tube defects in the fetus have been primarily associated with which deficiency in the mother?

A. iron
B. folic acid
C. vitamin B12
D. vitamin E

Answer: B

Explanation:
Folic acid is essential for the development of the neural tube and might prevent the defect or failure of the tube to close (congenital anomalies).Physiological Adaptation

NEW QUESTION 421
- (Topic 5)
A nurse is caring for a client with an elevated cortisol level. The nurse can expect the client to exhibit symptoms of:

A. urinary excess.
B. hyperpituitarism.
C. urinary deficit.
D. hyperthyroidism.

Answer: C

Explanation:
High levels of cortisol can produce sodium and fluid retention and potassium deficit, thus creating urinary deficit.Physiological Adaptation

NEW QUESTION 422
- (Topic 5)
When a client who is 25 years of age asks the nurse when she should seek fertility counseling, the best response by the nurse is:

A. ??Fertility counseling should be sought when you have been unable to conceive after 1 year of unprotected intercourse.??
B. ??Fertility couseling should be sought when you have not been able to conceive after 6–9 months of unprotected intercourse.??
C. ??The average time it takes someone your age to conceive is 512 months, so if you haven??t conceived by then, we can refer you.??
D. ??We can give you some guidance now on how to increase your chances of conceiving and then refer you if it doesn??t happen within a year.??

Answer: D

Explanation:
The guidelines for a fertility workup are to refer after the couple has not conceived after one year of unprotected intercourse. So, Choice 1 is technically correct, but it doesn??t consider the immediate need for the couple to have some counseling. Choice 4 is the best answer because it gives the couple guidance now and the referral at the appropriate time. If the woman is over the age of 35, an earlier referral, at six to nine months of unprotected intercourse, is appropriate. It is true that the average time it takes a 25-year-old woman to conceive is 5.3 months, but that does not address the concern the client is expressing. Choice 4 is still the most caring and correctanswer. Couples conceive within the first month of unprotected intercourse 20% of the time.Health Promotion and Maintenance

NEW QUESTION 427
- (Topic 5)
Which of the following should be included in a diet rich in iron?

A. peaches, eggs, beef
B. cereals, kale, cheese
C. red beans, enriched breads, squash
D. legumes, green beans, eggs

Answer: A

Explanation:
Home sources of iron that can be absorbed in the body include meat, poultry, and fish. In addition, these sources contain a factor that helps to enhance iron absorption of nonheme sources. Eating Vitamin C at the same time as iron sources also helps to promote iron absorption.High calcium intake in the diet promotes the absorption of iron because it helps to bind to phytates and thereby limits their effect.Physiological Adaptation

NEW QUESTION 430
- (Topic 5)
The NSAID that is comparable to morphine in efficacy is:

A. Feldene.
B. Stodal.

C. Toradol.
D. Elavil.

Answer: C

Explanation:
Toradol is the first injectable NSAID equal to morphine in efficacy.Basic Care and Comfort

NEW QUESTION 433
- (Topic 5)
When a couple experiencing infertility presents for a fertility workup, which of the following procedures should the nurse prepare the couple to have first?

A. hysterosalpingography
B. semen analysis
C. endometrial biopsy
D. transvaginal ultrasound

Answer: B

Explanation:
Because semen analysis is the least invasive of the tests listed and because in 35% of the cases the infertility is related to a male factor, semen analysis should be one of the first diagnostic tests performed. Hysterosalpingography fills the uterus and fallopian tubes with a radiopaque substance that can be seen with an X ray. It demonstrates tubal patency or any distortion of the uterine cavity. Endometrial biopsy provides information about the effects of progesterone after ovulation and the endometrial receptivity. Transvaginal ultrasound is mostly used in the treatment of infertility. For diagnosis it allows the endocrinologist to evaluate the developing follicle, assess oocyte maturity, and diagnose luteal phase defects. All the tests listed in Choices 1, 3, and 4 are more invasive, require greater expertise to evaluate and treat, and are more costly. If the semen analysis is normal, the couple can expect to progress through these tests as well.Health Promotion and Maintenance

NEW QUESTION 434
- (Topic 5)
When a woman is receiving postpartum epidural morphine, the nurse should plan to observe for which of the following side effects to occur within the first 3 hours?

A. nausea and vomiting
B. itching
C. urinary retention
D. somnolence

Answer: B

Explanation:
A side effect of postpartum epidural morphine is the onset of itching within 3 hours of injection and lasting up to 10 hours. Nausea and vomiting might occur 4–7 hours after injection. Urinary retention is a side effect of postpartum epidural morphine but is not assessed as such within the first 3 hours. Somnolence is a rare side effect.Health Promotion and Maintenance

NEW QUESTION 435
- (Topic 5)
In a disaster, triage situation, the nurse should be least concerned with which of the following regarding a client in crisis?

A. ability to breathe
B. pallor or cyanosis of the skin
C. number of accompanying family members
D. motor function

Answer: C

Explanation:
The least important factor (of those listed) during an emergency situation is the number of accompanying family members.Safety and Infection Control

NEW QUESTION 437
- (Topic 5)
A spinal change occurring with pregnancy that alters mobility is:

A. scoliosis.
B. kyphosis.
C. lordosis.
D. ankylosing spondylitis.

Answer: C

Explanation:
The spinal change occurring with pregnancy is lordosis. This occurs due to the weight of the enlarging uterus and the affect of gravity.Basic Care and Comfort

NEW QUESTION 440
- (Topic 5)
As part of the teaching plan for a client with type I diabetes mellitus, the nurse should include that carbohydrate needs might increase when:

A. an infection is present.

B. there is an emotional upset.
C. a large meal is eaten.
D. active exercise is performed.

Answer: D

Explanation:
Active exercise increases insulin sensitivity, thus lowering blood glucose levels. Additional carbohydrates might be needed to balance the usual insulin dose. All of the other choices increase blood glucose levels.BasicCare and Comfort

NEW QUESTION 445
- (Topic 5)
Which of the following medications should be held 24–48 hours prior to an electroencephalogram (EEG)?

A. Lasix (furosemide)
B. Cardizem (diltiazem)
C. Lanoxin (digoxin)
D. Dilantin (phenytoin)

Answer: D

Explanation:
Anticonvulsants (such as Dilantin), tranquilizers, barbiturates, and other sedatives should be held 24–48 hours prior to an EEG. The other medications do not fall into these classifications.Reduction of Risk Potential

NEW QUESTION 450
- (Topic 5)
The nurse should consider which of the following as a possible cause for the symptoms experienced by the client in Question 28?

A. iron deficiency
B. folate deficiency
C. peptic ulcer
D. iron overload

Answer: A

Explanation:
Due to her symptoms of fatigue, shortness of breath, lightheadedness, her gender, and her fad dieting, the cause is most likely iron deficiency.Physiological Adaptation

NEW QUESTION 454
- (Topic 5)
A nurse is caring for a client with an elevated urine osmolarity. The nurse should assess the client for:

A. fluid volume excess.
B. hyperkalemia.
C. hypercalcemia.
D. fluid volume deficit.

Answer: D

Explanation:
For a client with an elevated urine osmolarity, the nurse should assess the client for fluid volume deficit.Physiological Adaptation

NEW QUESTION 458
- (Topic 5)
For which condition might a client??s antidiuretic hormone (ADH) level be increased?

A. diabetes mellitus
B. diabetes insipidus
C. hypothyroidism
D. hyperthyroidism

Answer: B

Explanation:
ADH level is increased in the client with nephrogenic diabetes insipidus.Reduction of Risk Potential

NEW QUESTION 461
- (Topic 5)
Safety measures for using crutches must be taught to clients. Safety measures for the use of crutches include:

A. properly fitting crutches with rubber tips at the end that provide a four-point gait.
B. properly fitting crutches, education in the appropriate gait, and strength in the arms.
C. crutches that fit the way the client chooses and a gait chosen by client.
D. both legs touching the floor for all gaits.

Answer: B

Explanation:
In addition to the rubber tips on the ends of the crutches, the client needs to know the appropriate gait. Arm strength exercises are important, and it is critical that the client be fitted properly for the crutches.BasicCare and Comfort

NEW QUESTION 466
- (Topic 5)
The parents of a 2-year-old child ask the nurse how they can teach their child to quit taking toys away from other children. Which of the following statements by the nurse offers the parents the best explanation of their child??s behavior?

A. ??Your child is egocentri
B. Egocentricity is normal for 2-year-old childre
C. He believes other children want him to have their toys.??
D. ??Your child is showing negativit
E. He doesn??t want other children to have the toys he wants.??
F. ??Your child is demonstrating magical thinkin
G. He believes he can make the other children want him to play with their toys.??
H. ??Your child is engaging in domestic imitatio
I. He is doing what he has seen other children do.??

Answer: A

Explanation:
Two-year-old children are very egocentric. They believe everything and everyone is concerned about them. They believe other children want them to have their toys. This is different than believing they can make other children want them to have all the toys, as in magical thinking, which normally occurs in preschool-age children. Toddlers are very negative, but this is expressed by refusal of requests made to them. Domestic imitation does occur in preschool-age children, but it refers to the imitation of household chores and roles performed by adults, not the imitation of other children.Health Promotion and Maintenance

NEW QUESTION 469
- (Topic 5)
Which of the following represents a normal serum potassium level?

A. 1.5 mEq/L
B. 3.0 mEq/L
C. 4.0 mEq/L
D. 6.0 mEq/L

Answer: C

Explanation:
Normal serum potassium levels fall in a range of 3.5–5.5mEq/L. The other choices listed fall below or above this range.Reduction of Risk Potential

NEW QUESTION 474
- (Topic 6)
The nurse sustains a needle puncture that requires HIV prophylaxis. Which of the following medication regimens should be used?

A. an antibiotic such as Metronidazole and a protease inhibitor (Saquinivir)
B. two non-nucleoside reverse transcriptase inhibitors
C. one protease inhibitor such as Nelfinavir
D. two protease inhibitors

Answer: B

Explanation:
Unless there is drug resistance, the initial prophylaxis based on CDC recommendations is 2 NNRTIs.Safety and Infection Control

NEW QUESTION 475
- (Topic 6)
Two staff nurses were considered for promotion to head nurse. The promotion is announced via a memo on the unit bulletin board. The nurse who was not promoted tells a friend, ??Oh, well, I really didn??t want the job anyway.?? This is an example of:

A. rationalization.
B. denial.
C. projection.
D. compensation.

Answer: A

Explanation:
This is called the sour grapes form of rationalization. Rationalization is an unconscious form of self-deception in which excuses are made. Denial is an unconscious process that ignores the existence of the situation. Projection operates unconsciously and results in blaming behavior. Compensation is an attempt to make up for a perceived weakness by emphasizing a strong point.Psychosocial Integrity

NEW QUESTION 479
- (Topic 6)
The Token Economy is a type of therapy that focuses on:

A. play therapy.
B. behavior modification.
C. milieu therapy.
D. associative.

Answer: B

Explanation:
Behavior modification gives positive feedback and rewards for appropriate behavior. Behavior modification requires negative behavior if it??s not destructive or life threatening. Psychosocial Integrity

NEW QUESTION 484
- (Topic 6)
A mother that has never breast-feed a child before is having trouble getting the baby to latch on to the breast. The baby has lost 3% of its?? birth weight within the first 2 days of life. The best statement is:

A. The baby will eventually take to the breast.
B. I can fix up a bottle if you want to try that.
C. A small amount of weight loss in the first few days is normal.
D. I can get the charge nurse to come and talk to you about breast-feeding.

Answer: C

Explanation:
5-10% of birth weight loss following birth is normal for the first few days of life.

NEW QUESTION 488
- (Topic 6)
The nurse seeks to assess the renal function of an elderly client who is about to receive a nephrotoxic medication. Which of the following labs provides the best indicator for renal function?

A. urinalysis
B. creatinine and blood urea nitrogen
C. chemistry of electrolytes
D. creatinine clearance

Answer: D

Explanation:
Due to decreases in lean body mass, blood creatinine is not as good an indicator of the elderly client??s renal function as creatinine clearance. Urinalysis and blood urea nitrogen reflect hydration status and other clues to health but are not specific for renal function. The electrolytes might be deranged in renal failure but are not a direct correlation to the kidneys?? capability to eliminate waste. Therefore, the best lab for renal function in the elderly is thought to be creatinine clearance, which is a widely used test for glomerular filtration rate.Safety andInfection Control

NEW QUESTION 490
- (Topic 6)
A mother of a newborn notices a nurse placing liquid in her baby??s eyes. Which of the following is an inaccurate statement about the need for eyedrops following birth?

A. Eyedrops following birth help reduce the risk of eye infection.
B. Eyedrops are required by the law.
C. Eyedrops will keep the eye moist.
D. Eyedrops are required by law every 6 hours following birth.

Answer: D

Explanation:
Laws do require placement of eyedrops; however, physicians indicate a timeframe.

NEW QUESTION 495
- (Topic 6)
A woman seeks assistance because she recently remembered childhood sexual abuse. The nurse should include which of the following goals for this client?

A. prosecuting the perpetrator
B. managing symptoms of anxiety and fear
C. determining if the memories are real
D. collaborating the client??s story

Answer: B

Explanation:
At least 10% of victims of childhood sexual abuse have periods of complete amnesia about the abuse, followed by delayed recall. Controversial evidence suggests that people who have recovered memories have had part of those memories reconstructed by therapists. The nurse??s role is not to determine if the memories are real, but to help the client deal with the stress caused by the remembered abuse.Psychosocial Integrity

NEW QUESTION 500
- (Topic 6)

The difference between spirituality and religion is that spirituality is:

A. a belief about a higher power.
B. an individual??s relationship with a higher power.
C. organized worship.
D. a belief in an invisible energy or ideal.

Answer: B

Explanation:
Religion can be considered a system of beliefs, practices, and ethical values about a divine or superhuman power or powers worshipped as the creator(s) and ruler(s) of the universe. Spirituality is a belief in or relationship with some higher power, creative force, driving being, or infinite source of energy.Psychosocial Integrity

NEW QUESTION 502
- (Topic 6)
The nurse assesses a client for physiological risk factors for falls. The nurse should conclude that the client is not at risk if which of the following is discovered?

A. history of dizziness
B. need for wheelchair due to reduced mobility
C. weakness and fatigue noted when climbing stairs
D. intact recent and remote memory

Answer: D

Explanation:
Intact recent and remote memory indicates that a client is not at risk for falls. Risk for falls can occur in elder clients, and the nurse should assess each client for the possibility of falls and take appropriate actions.Safety andInfection Control

NEW QUESTION 505
- (Topic 6)
An nurse is instructing a patient on the order of sensations with the application of an ice water bath for a swollen right ankle. Which of the following is the correct order of sensations experienced with an ice water bath?

A. cold, burning, aching, and numbness
B. burning, aching, cold, and numbness
C. aching, cold, burning and numbness
D. cold, aching, burning and numbness

Answer: A

Explanation:
CBAN, cold, burn, ache, numbness

NEW QUESTION 506
- (Topic 6)
Which of the following microorganisms are considered normal body flora?

A. staphylococcus on the skin
B. streptococcus in the nares
C. candida albicans in the vagina
D. pseudomonas in the blood

Answer: A

Explanation:
Of the choices given, only staphylococcus is considered a normal resident of the body.
Safety and Infection Control

NEW QUESTION 511
- (Topic 6)
A young female teenager describes a brutal assault and rape to the nurse on duty. Which of the following actions should the nurse take first?

A. Check with case manager on duty about possible police intervention.
B. Provide an environment of concern and emotional stabilization.
C. Clean the patient??s wounds with normal saline and gauze.
D. Recommend a good attorney to the patient.

Answer: B

Explanation:
Emotional support is what that patient needs most at this point in time.

NEW QUESTION 516
- (Topic 6)
A nurse is assessing a 18 year-old female who has recently suffered a TBI. The nurse notes a slower pulse and impaired respiration. The nurse should report these findings immediately to the physician, due to the possibility the patient is experiencing which of the following conditions?

A. Increased intracranial pressure
B. Increased function of cranial nerve X
C. Sympathetic response to activity
D. Meningitis

Answer: A

Explanation:
The patient is at high risk of developing increased intracranial pressure (ICP).

NEW QUESTION 519
- (Topic 6)
A client was involved in a motor vehicle accident in which the seat belt was not worn. The client is exhibiting crepitus, decreased breath sounds on the left, complains of shortness of breath, and has a respiratory rate of 34/min. Which of the following assessment findings should concern the nurse the most?

A. temperature of 102?? F and a productive cough
B. arterial blood gases (ABGs) with a PaO2 of 92 and PaCO2 of 40 mmHg
C. trachea deviating to the right
D. barrel-chested appearance

Answer: C

Explanation:
A mediastinal shift is indicative of a tension pneumothorax along with theother symptoms in the question.Because the individual was involved in an MVA, assessment is targeted at acute traumatic injuries to the lungs, heart, or chest wall rather than other conditions indicated in the other choices. Choice 1 is common with pneumonia. Values in Choice 2 are not alarming. Choice 4 is typical of someone with chronic obstructive pulmonary disease (COPD). A tensionpneumothorax is a dangerous complication and a medical emergency where entering air cannot escape by the same route and pressure within the pleural cavity increases, resulting in complete collapse of the lung. A mediastinal shift to the unaffected side and a downward displacement of the diaphragm can be observed. Physiological Adaptation

NEW QUESTION 522
- (Topic 6)
Medical records indicate a patient has developed a condition of respiratory alkalosis. Which of the following clinical signs would not apply to a condition of respiratory alkalosis?

A. Muscle tetany
B. Syncope
C. Numbness
D. Anxiety

Answer: D

Explanation:
Anxiety is a clinical sign associated with respiratory acidosis.

NEW QUESTION 527
.....

Thank You for Trying Our Product

* 100% Pass or Money Back

All our products come with a 90-day Money Back Guarantee.

* One year free update

You can enjoy free update one year. 24x7 online support.

* Trusted by Millions

We currently serve more than 30,000,000 customers.

* Shop Securely

All transactions are protected by VeriSign!

100% Pass Your NCLEX-PN Exam with Our Prep Materials Via below:

https://www.certleader.com/NCLEX-PN-dumps.html