1. The graduate nurse working on a pediatric surgery unit presents the preceptor with the assignment for the unlicensed assistive personnel (UAP) and the licensed practical nurse (LPN). Which of the following tasks would the preceptor question?

   a. UAP assigned to walk with a child admitted with diagnosis of croup
   b. LPN assigned to teach a class to adolescence on proper nutrition
   c. UAP assigned to feed a 10 month old child
   d. LPN assigned to administer a prescribed PO antibiotic

Correct: B

Rationale: It is within an unlicensed assistive personnel job description to assist clients with walking and feeding themselves. A licensed practical nurse can administer medications; however teaching is not within the scope of practice of a LPN. It is the responsibility of the registered nurse to provide client education.

2. The nurse caring for the 6 month old client with a diagnosis of tetralogy of Fallot would monitor which of the following as an early indication of acute cyanosis?

   a. Respiratory rate of 12
   b. Heart rate of 72 and blood pressure of 88/62
   c. Loss of consciousness
   d. Increase in irritability and anxiousness

Correct: D

Rationale: The disorder known as tetralogy of Fallot consists of a ventral septal defect, pulmonary stenosis, right ventricular hypertrophy and the overriding of the aorta. This disorder leaves the affected child with episodes of cyanosis. During these episodes, the client will have an increase in respiratory rate. The early sign of the hypoxia is anxiety and irritability.
3. While caring for the 18 month old male with a diagnosis of Kawasaki syndrome, which of the following would be an indication of deterioration?
   a. Bradycardia
   b. Strep throat
   c. Cardiac arrhythmias
   d. Hypotension

Correct: C

Rationale: The diagnosis of Kawasaki syndrome is associated with a multisystem vasculitis. This disorder can also affect the coronary arteries. If cardiac deterioration occurs, the client will develop tachycardia, S3 heart sound or congestive heart failure. Hypotension and strep throat are not associated with Kawasaki syndrome.

4. The nurse preparing to administer digoxin (Lanoxin) to a 67-year old man with congestive heart failure, which of the following clinical manifestations would the nurse associate with digoxin toxicity?
   1. Cyanosis
   2. Visual disturbances
   3. Hypertension
   4. Inconsolability
   5. Weakness
   6. Headache

a. 2, 3
b. 4, 6
c. 1, 2, 4
d. 2, 5, 6
Correct: D

Rationale: The clinical manifestations associated with digoxin toxicity include, visual disturbances, weakness, headache, apathy and potentially psychosis.

5. When providing discharge instruction to the parents of a child with a diagnosis of rheumatic fever, the nurse is aware that which of the following statements indicates the parent’s understanding?
   a. “When she goes to the dentist, I must tell him about this hospital stay.”
   b. “She cannot return to after-school activities for 4 months.”
   c. “We will have to monitor her urine output every day.”
   d. “She will have to be on a low protein diet.”

Correct: A

Rationale: The disorder of rheumatic fever is thought to be related to an autoimmune response to a group A streptococcal infection. This disorder puts the child at risk for endocarditis. The child’s dentist should be informed of the potential complication. The child should return to regular activities as soon as it is tolerated. The child’s urine output does not require monitoring as renal failure is not a concern.

6. Following a lobectomy of the right upper lobe of the client’s lung, the nurse notes crepitus over the right clavicle and axillary areas. The priority nursing action at this time should be:
   a. Notifying the surgeon immediately
   b. Encourage the client to cough and deep breath
   c. Identify the outer boarder of the area and mark with a skin pen
   d. Anticipate the client returning to the operating room
Correct: C

Rationale: Crepitus is an accumulation of small air bubbles within the subcutaneous tissue. This is assessed through the palpation of the skin, where the nurse will note a crackling or popping sensation. This condition is sometimes referred to as subcutaneous emphysema. Progressive subcutaneous emphysema is a medical emergency that need to be addressed by the surgeon, however it is common to develop some subcutaneous emphysema following lobectomy.

7. The charge nurse creating the assignment on the pediatric unit would delegate which of the following tasks to a licensed practical nurse?

   a. Discharge instructions to the parents of a child with a diagnosis of pulmonary stenosis
   
   b. Instructing the parents of a 18 month old with a diagnosis of atroventricular canal the clinical manifestation associated with pulmonary edema
   
   c. Placing the child with the diagnosis of tetralogy of Fallot suffering from an acute hypoxic spell in a knee-chest position
   
   d. Assess the newly admitted client for failure to thrive

Correct: C

Rationale: It is the registered nurse is responsible for tasks such as instruction, informing and assessing. The licensed practical nurse can perform the task placing a client in a knee-chest position, but not education the parents on how to perform the procedure.

8. The nurse working in a pediatric clinic preforms an assessment on a 9 month old child. The child’s height and weight are below the fifth percentile, abdomen that protrudes, muscle that are wasting and wrinkled, dry skin. Based on the information provided, the priority nursing diagnosis at this time would be:
a. Social isolation related to poor parental bonding
b. Diarrhea related to poor nutrients
c. High risk for injury related to parental abuse
d. Failure to thrive related to unknown cause

Correct: D

Rationale: Based on the clinical manifestations described, failure to thrive is the appropriate diagnosis. There is no evidence of diarrhea or poor parental bonding, and not enough information to determine if parental abuse.

9. In the post-operative period following the repair of a cleft palate, the nurse places the client in the side-lying position. The mother questions why. The nurse’s response is based on the know that this position:
   a. Allows for observation of the suture line
   b. Will allow the client to relax
   c. Will allow for drainage
   d. Allows for the best method for fluid intake

Correct: C

Rationale: In the initial period following a cleft palate repair, the nurse should anticipate increased salivation, which can increase the client’s risk for aspiration. Placing a client in the side-lying position, will maintain an open airway and allow for drainage of oral secretions.
10. The nurse caring for a 67 year old female with a diagnosis of congestive heart failure obtains the following assessment results. WEDGE pressure is 3 mm/Hg, lung sounds are clear, urine output is 75mL/hour, she denies shortness of breath and states “I feel better than when I got here.” Based on these finds the nurse should:

a. Prepare for the client’s transfer to a step-down unit
b. Document and notify physician that the client’s WEDGE pressure is low
c. Anticipate the physician ordering furosemide 40 mg IVP
d. Suspect that the pulmonary artery catheter is not functioning properly and obtain a chest x-ray

Correct: B

Rationale: The normal range for a pulmonary artery catheter’s WEDGE pressure is 4.5-13mm/Hg. A WEDGE pressure of 3mm/Hg is an indication that the client is volume depleted. The nurse should anticipate the doctor ordering an increase in fluids, not a diuretic. The client cannot be transferred to a step-down unit until volume status is further investigated and based on the information provided there is no need to suspect a malfunctioning catheter.

11. The nurse is aware that the most effective way to assess congestion within the lung tissue is which of the following?

a. Serum electrolyte levels
b. WEDGE pressure
c. Blood pressure
d. Total volume of urine output over a three hour period

Correct: B
Rationale: The nurse should be aware that the most effective method of assessing congestion within lung tissue is the WEDGE pressure. The other indicator can be influenced by external forces.

12. The nurse caring for the client following a motor vehicle accident notes that when inhaling and exhaling, one section of the client’s chest move independently and in the opposite direction of the rest of the chest wall. The nurse should inform the physician that he/she suspects:
   a. The client is suffering from respiratory fatigue
   b. Flail chest
   c. Pneumothorax
   d. Early onsets of ARDS

Correct: B

Rationale: The condition known as flail chest is associated with multiple fractures to adjacent ribs. This condition results in a free floating section of the rib cage that has paradoxical respirations. As the client inhales, the rib cage should expand, however the failed section will contact inwards. The reverse is true with exhalation.

13. An 11 year old male is playing with an archery set and is accidently shot in the left side of the chest. His neighbor, that is a nurse, notes the child is about to remove the arrow. The appropriate action at this time is:
   a. Assist the child in removal of the arrow
   b. Prevent the removal of the arrow, and secure with a clean towel to prevent dislodgement
   c. Reassure the mother that there is no serious damage since he is able to move
   d. The priority is to call 911, do not stop this action to prevent removal of arrow
Correct: B

Rationale: A foreign object should never be removed for the client, unless in a controlled secure environment. It is a priority to obtain emergency medical assistance from 911, but the child must be prevented from removing the arrow to avoid exsanguination.

14. When providing client education on relaxation techniques, which of the following statements should be included in the teaching plan?

   a. “This technique is most effective if you practice it regularly.”
   b. “You will need to monitor your heart very carefully.”
   c. “You cannot practice this with any children under the age of 12.”
   d. “It is important that you avoid becoming dependent, you should only practice this technique when you really need it.”

Correct: A

Rationale: For a client to become proficient at relaxing technique, it is important to practice it. A client’s heart rate will decrease if performing the technique correctly; however it is not necessary to monitor it. It is possible for young children to use relaxation techniques effectively.

15. The client taking a selective serotonin reuptake inhibitor (SSRI) tells the nurse that the physician told her that the medication will “fix my chemical imbalance”. The client is uncertain what that means. The nurse should respond:

   a. “The physician will have to explain it to you further so you can consent to take it.”
   b. “There are times that our brains do not make enough of a chemical called serotonin, this medication fixes the problem.”
   c. “What do you think it means?”
d. “It is just an expression; there is nothing wrong with the chemicals in your brain.”

Correct: B

Rationale: The nurse should inform the client about the purpose and function of medications. The administration of a SSRI does not require informed consent; therefore the physician is not required to explain the procedure. An open ended question is affective in creating an open dialogue, however in this situation, an honest and accurate answer would be appropriate.

16. When caring for the client with a cynophobia who has undergone desensitization to stimuli, the nurse is aware that the treatment is successful when:

a. The client states how the fear began, and expresses how the fear is irrational
b. The client is able to visit a dog shelter and walk in front of a caged dog
c. The client expresses a decrease in apprehension towards dogs
d. The client can pet a dog without excessive anxiety

Correct: D

Rationale: The goal of desensitization treatment is to allow the client to perform whatever activity an average person can without undue anxiety. It is common for a client to express that their fears are irrational and visiting a dog shelter and expressing diminished fears are steps to desensitization.
17. While performing the pre-operative check list on a client, the nurse notes that the client is having difficulty paying attention, increased heart rate and respirations and has sweaty palms with trembling hands. The client states, “All I can think about is the surgery and I keep wondering if everything will go alright.” Based on the information provided the nurse should classify the client’s anxiety at:

a. Mild  
b. Moderate  
c. Severe  
d. Panic

Correct: C

Rationale: The client in this scenario is displaying obvious signs of sympathetic nervous system stimulation. With the addition of client statements regarding the surgical procedure, the nurse should classify their anxiety as severe.

18. The nurse would question administration of alprazolam (Xanax) 0.5mg PO to a client based on which of the following?

a. History of alcohol abuse  
b. Client appears anxious  
c. History of ischemic stroke 1 year ago  
d. Client’s states diet high in vitamin C

Correct: A

Rationale: Alprazolam is a benzodiazepine, which is a schedule IV controlled substance. These are mediations are medically useful, although there is the potential for physical and mental dependency. The client with a history of alcohol abuse has shown tendency to dependency.
19. The nurse working in the psychiatric unit finds a client pacing the hallways. Which of the following statements to the client would be appropriate at this time?

a. “The television is on in the dayroom, would you like to go watch it?”

b. “I see that you are pacing. How are you feeling today?”

c. “I do not think the hallway is very comfortable. Why not go into your room?”

d. “I see you are upset. What is it?”

Correct: B

Rationale: The pacing behavior exhibited by the client indicates that he is currently upset. Distraction does not tend to be effective, and encouraging the client to return to his room could increase agitation as he is alone. Tell the client you notice he is upset and asking what is it, assumes that the client can verbalize the source. Asking the client “how are you feeling” allows for open communication.

20. While preforming the discharge assessment on the client 2 day post open cholecystectomy, the nurse notes tachypnea, restlessness and hemoptysis. The nurse should:

a. Evaluate the clients white blood cell count

b. Check client’s records for a positive TB test

c. Document findings, as physician assess client 45 minutes prior and determined the client was ready for discharge

d. Contact primary health care provider and report findings

Correct: D

Rationale: The client in the scenario is exhibiting potential signs of pulmonary embolism, a potential post-operative complication. It is possible that the client was not exhibiting these clinical manifestations previously and therefore the physician should be notified.
21. While preforming the admission assessment on a 72 year old female, the nurse asks about the client’s fears. The client responds with “I am afraid to go up and down the stairs since I broke my hip. I have the home health aide do the laundry.” The nurse should document this as:

a. Chronic anxiety
b. A phobic reaction
c. Manipulative behavior
d. Normal anxiety

Correct: D

Rationale: It is appropriate for a client to express anxiety in regards to a recent injury. There is no indication that the client is attempting to avoid household chores. There is no indication that the client fears the stairs themselves, or that this fear has persisted for a long time.

22. The client with generalized anxiety disorder informs the nurse that he stopped taking his buspirone (BuSpar) after being on it for one week because it did not work. The nurse should respond:

a. “BuSpar is not affective for anxiety.”
b. “The dosage may not be high enough. The doctor can increase it.”
c. “It can take up to 2-3 weeks to see the effects of this medication.”
d. “Have you been taking this on an empty stomach?”

Correct: C

Rationale: The medication buspirone (BuSpar) takes 2-3 weeks to achieve appropriate therapeutic level to show results. BuSpar is effective in the treatment of anxiety and it is not
possible to determine if the dosage is insufficient after only one week of taking the medication. There is no indication that BuSpar needs to be taken on an empty stomach.

23. The wife of a client diagnosed with acrophobia tells the nurse “I have signed my husband up for bungee jumping to get him over this silly fear he has!”

The nurse’s response should be:

a. “That kind of dramatic event may do more harm than good.”

b. “That might be helpful exposure.”

c. “You may want to make it a surprise.”

d. “Have you spoken to other family members about this?”

Correct: A

Rationale: With phobias, an exposure to the feared stimuli without planning or the client’s consent often results in an increase in the clinical manifestations associated with the disorder, in this scenario a fear of heights. By responding with an affirmation of the plan or suggesting it be a surprise, indicates a lack of understanding on the nurse’s part. The question of other family member’s evolvement in the plan is inconsequential.

24. When preparing the daily assignment for a psychiatric unit, which of the following tasks should the registered nurse delegate to the licensed practical nurse?

a. Develop a plan of care for the client with a social phobia

b. Monitor the blood laboratory results for the clients

c. Encourage the client with a generalized anxiety disorder to verbalize his fear

d. Take a detailed history of the newly admitted client
Correct: C

Rationale: It is the registered nurse’s responsibility to assess laboratory results, obtain a history and develop a plan of care for clients. The licensed practical nurse can encourage the client to verbalize fears.

25. While working in the psychiatric unit, one of the clients approaches the nurse, visibly agitated and states “I don’t understand what is going on, but I am sure something horrible is about to happen!” The nurse should respond:

   a. “There is nothing to worry about, you are safe here.”
   b. “Will you please tell me what you think is going to happen?”
   c. “Would you like something for anxiety?”
   d. “It appears that you are anxious.”

Correct: D

Rationale: By verbalizing that the client appears anxious, it will bring it to the client’s attention and allow them to explore the emotion. If the nurse tells the client there is nothing to worry about, he/she will be diminishing the lines of communication. The client has expressed a general feeling of impending doom, therefore it would not be appropriate to ask what is about to occur. The nurse should not offer medication to the client at this time as it would be premature.