NR224 FINAL EXAM PRACTICE ANSWERS

1. A nurse is removing personal protective equipment (PPE) after performing a procedure for a client who requires isolation precautions. Which of the following items of PPE should the nurse remove first?
    a. Gloves
    b. Gown
    c. Eyewear
    d. Mask
2. A nurse is admitting a client who has manifestations that suggest tuberculosis. Which of the following actions is the nurse's priority?
    a. Initiate airborne precautions
    b. Administer antimicrobial therapy
    c. Tell the client that the infection will be communicable for 2-3 weeks from the start of medication therapy
    d. Teach the client about the manifestations of tuberculosis
3. The nurse records the following subjective data in the client's medical record:
    a. Breath sounds clear to auscultation
    b. Amber urine in sufficient
    quantities c. Pain intensity 8 out of 10
    d. Skin warm and dry
4. A nurse is providing teaching to a client about a surgical procedure for later in the day. The client states that no one has spoken to her about the procedure before. Which of the following action should the nurse take?
    a. Continue the teaching, but check afterward with the surgeon about informed
    consent b. Stop the teaching and check with the surgeon about informed consent
    c. Stop the teaching and ask the client to sign an informed consent form
    d. Continue the teaching and check the client's medical record afterward for a signed consent form
5. A nurse is planning care for a patient going to surgery. Who is responsible for informing the patient about the surgery along with possible risks, complications, and benefits?
    a. Family member
    b. Surgeon
    c. Nurse
    d. Nurse manager
6. A nurse is reviewing informed consent with a client for a cardiac catheterization. Which of the following is the responsibility of the nurse?
    a. Explaining the procedure to the client
    b. Offering alternative treatments
    c. Informing the client of the consequences of refusing the procedure
    d. Verifying the client's understanding of the procedure being performed
7. A nurse is taking a client's vital signs. Which of the following findings should the nurse identify as outside the expected reference range?
    a. Pulse rate 90/min
    b. Rectal temperature 38℃ (100.4℉)
    c. Pulse oximetry 95%
    d. BP 145/90 mmHg
8. A nurse is obtaining vital signs from a client. Which of the following findings is the priority for the nurse to report to the provider?
    a. Oral temperature 37.8℃ (100℉)
    b. Respirations 30/min
    c. BP 148/88 mmHg
    d. Radial pulse rate 45 beats/30 seconds

9. A nurse is caring for a client who has a new prescription for levothyroidism. Which of the following findings should the nurse identify as an indication that the client requires intervention?
    a. Heart rate 106/min
    b. Dry skin
    c. Oral temperature 36.8℃ (98.2℉)
    d. Lethargy
10. A nurse is assessing the vital signs of a 1-month-old infant. Which of the following actions should the nurse perform?
    a. Use a cuff to auscultate blood pressure
    b. Determine heart rate by taking the radial pulse
    c. Count respirations before taking other vital signs
    d. Measure temperature by placing the thermometer in the infant's ear
11. A nurse is preparing to assess an 11-month-old infant during a well-child examination. Which of the following actions should the nurse take?
    a. Pull the infant's pinna up and back when examining the ears
    b. Palpate and count the infant's radial pulse for 15 seconds c. Examine the infant's throat at the end of the examination
    d. Check the infant's blood pressure in both arms
12. A nurse is assessing the vital signs of a 3-month-old infant. Which of the following actions should the nurse perform regarding the infant's heart rate?
    a. Assess the radial pulse for 1 full minute while the infant is sleeping
    b. Assess the apical pulse for 1 full minute while the infant is sleeping
    c. Assess the radial pulse for 1 full minute while the infant is awake
    d. Assess the apical pulse for 1 full minute while the infant is awake
13. Pre-operative assessment is necessary to:
    a. Ensure that the patient is fit to undergo surgery
    b. To highlight issues that the surgical/anesthetic team need to be aware of during the peri-operative period c. To ensure the patient's safety during their journey
        - To obtain baseline data
14. A nurse in the emergency department is assessing an infant who recently started taking digoxin to treat a supraventricular arrhythmia. Which of the following findings should the nurse identify as digoxin toxicity?
    a. Irritability
    b. Diaphoresis
    c. Vomiting
    d. Tachycardia
15. A nurse is preparing to administer digoxin to a client. Which of the following findings should the nurse identify as a contraindication to the client receiving this medication?
    a. Blood pressure 180/70 mmHg
    b. Oxygen saturation rate 94%
    c. Heart rate 51/min
    d. Respiratory rate 21/min
16. A nurse is providing teaching to a parent of an infant who has heart failure and a new prescription for digoxin elixir. Which of the following pieces of information should the nurse include?
    a. Withhold the medication if the infant's heart rate is less than 110/min
    b. Mix the medication in 120 mL (4 oz) of infant formula
    c. Expect the infant to vomit frequently while taking this medication
    d. Double the dose if the infant has increased edema

17. A nurse is planning to obtain the vital signs of a 2-year-old child who is experiencing diarrhea and may have a right ear infection. Which of the following routes should the nurse use to obtain the child's temperature?
    a. Rectal
    b. Tympanic
    c. Oral
    d. Temporal
18. A nurse is caring for a client who has a fractured hip and was placed on Buck's traction 4 hr ago. Which of the following actions should the nurse take?
    a. Inspect the client's skin underneath the boot every 12 hr
    b. Encourage the client to perform dorsiflexion of the affected extremity every 2 hr
    c. Remove the weights from the traction while repositioning the client in bed
    d. Loosen the ropes if the client reports muscle spasms in the affected extremity
19. A nurse is caring for a group of clients who has mobility issues. Which of the following clients is at the greatest risk for a complication?
    a. A 3-year-old client who has a burned foot
    b. An 80-year-old client who has a fractured hip
    c. A 30-year-old client who has a cast applied for a fractured ankle
    d. A 42-year-old client who has an indwelling urinary catheter
20. A nurse is caring for a client who has a pelvic fracture. The client reports sudden shortness of breath, stabbing chest pain, and feelings of doom. This client is experiencing which of the following complications?
    a. Pneumonia
    b. Pulmonary embolus
    c. Tension pneumothorax
    d. Tuberculosis
21. A nurse is caring for a client who states that she does not want to get out of bed due to pain from arthritis. Which of the following actions should the nurse take?
    a. Tell the client the provider does not want her to remain in bed
    b. Allow the client to remain in bed until her pain subsides
    c. Instruct the family to perform ADLs for the client
    d. Advise the client to perform range-of-motion exercises while in bed
22. A nurse is providing teaching about crutches to a client who has a fracture of the right foot. Which of the following instructions should the nurse include?
    a. "When you go up a flight of stairs, place your right foot on the first step" (up with the good, down with the bad) b. "Keep the rubber crutch tips securely in place"
    c. "When standing, keep the crutches 12 inches in front of you and 12 inches to the side" (6 inches in front & 6 inches to side)
    d. "Place your weight on the crutch pads at your armpits" (arms bear weight of body; not armpits)
23. A nurse is evaluating a client's use of crutches. The nurse should identify that which of the following actions by the client indicates safe use of the equipment?
    a. The client places a crutch on each side when assuming a sitting position (together in one hand & use other hand to grasp chair)
    b. The client moves the unaffected leg onto the step first when descending stairs (up with the good, down with the bad)
    c. The client places weight on the axillae when walking (arms bear weight of body; not armpits) d. The client has slightly flexed elbows when ambulating with the crutches
24. While your patient is ambulating with crutches he moves both crutches forward along with the injured leg and then moves the non-injured leg forward. When documenting, you will note that the patient used what type of gait while ambulating with crutches?
    a. Two-point gait
    b. Three-point gait
    c. Four-point gait
    d. Swing-to-gait

25. You're observing your patient using crutches. She is using the three-point gait. Which finding requires you to re-educate the patient on how to use the crutches?
    a. There is a 1.5-inch gap between the axillae and crutch rest pad during ambulation with the crutches
    b. The patient starts in the tripod position before ambulating with the crutches
    c. The patient leans on the crutch rest pads during ambulation
    d. The patient does not let the injured leg touch the ground while ambulating with the crutches
26. A nurse is teaching an older adult client who had a total hip arthroplasty about ambulating with a standard walker. Which of the following actions by the client indicates an understanding of the teaching?
    a. The client adjusts the height of the walker so the hand grips are at the level of his waist
    b. The client moves the walker ahead about 15.24 cm (6 in) and then steps into the walker
    c. The client uses the walker to pull himself from a sitting to a standing position
    d. The client uses the walker to climb the stairs
27. A nurse is teaching a client about the use of a straight-legged cane. Which of the following client actions indicates an understanding of the teaching?
    a. The client holds the cane on the unaffected side
    b. The client walks by stepping with the unaffected leg before the affected leg
    c. The client holds the cane directly next to the foot
    d. The client holds the cane with a straight elbow
28. A nurse is assisting a client who has right-sided weakness while ambulating with a cane. Which of the following action should indicate to the nurse that the client understands the procedure of cane walking?
    a. The client holds the cane on the affected side
    b. The client advances the unaffected leg followed by the cane
    c. The client supports his weight on the unaffected leg when moving the cane forward
    d. The client keeps 2 points of support on the ground
29. A nurse in a long-term care facility is teaching an older adult client about ambulating with a quad-cane. Which of the following statements should the nurse include in the teaching?
    a. "Adjust the height of the cane so you can flex your flex at 45 degrees"
    b. "Hold the cane in the hand on the stronger side of your body"
    c. "Place the flat side of the cane away from your foot"
    d. "Move the cane and your stronger leg at the same time"
30. A nurse observes an assistive personnel (AP) preparing to obtain blood pressure with a regular-sized cuff for a client who is obese. Which of the following explanations should the nurse give the AP?
    a. "The reading will be inaudible if the cuff is too small for the client"
    b. "The width of the cuff bladder should be 75% of the circumference of the client's arm"
    c. "As long as the cuff will circle the arm, the reading will be accurate?
    d. "Using a cuff that is too small will result in an inaccurately high reading"
31. A nurse is measuring a client's vital signs and notices an irregularity in the pulse. Which of the following actions should the nurse take?
    a. Measure the pulse using a Doppler ultrasound stethoscope
    b. Check the client's pedal pulses
    c. Count the apical pulse for 1 full min and describe the rhythm in the chart
    d. Take the pulse at each peripheral site and count the rate for 30 sec
32. A nurse is measuring a client's vital signs. The client's resting radial pulse rate is 55/min. Which of the following actions should the nurse take next?
    a. Document the finding
    b. Measure the client's apical pulse rate
    c. Talk with the client about factors that can affect the pulse rate
    d. Notify the provider about the client's radial pulse rate