

1. 1. Question

1 point(s)

Category: Pharmacological and Parenteral Therapies

The nurse is caring for a 65-year-old male client with a history of ischemic heart disease who has been admitted to the ICU following a myocardial infarction. The client is currently receiving lidocaine I.V. to manage his ventricular ectopy, which has been persistent. Which of the following factors would be most important for the nurse to consider in relation to the administration of this medication?

- 1 **A. Decrease in arterial oxygen saturation (SaO₂) when measured with a pulse oximeter**
- 2 B. Increase in systemic blood pressure
- 3 **C. Presence of premature ventricular contractions (PVCs) on a cardiac monitor**
- 4 D. Increase in intracranial pressure (ICP)
- 5 E. A drop in serum potassium levels as indicated in the latest lab results
- 6 F. Observation of a widening QRS complex on the ECG

Incorrect

Correct Answer: C. Presence of premature ventricular contractions (PVCs) on a cardiac monitor.

In the context of acute myocardial infarction, the priority is to manage life-threatening arrhythmias. Lidocaine is specifically indicated for the treatment of ventricular arrhythmias, such as PVCs, which can be indicative of an increased risk for more serious arrhythmias like ventricular tachycardia or ventricular fibrillation. The presence of PVCs on a cardiac monitor would be the most immediate concern that lidocaine can address in this scenario. While the other factors listed are important to monitor, they are not the primary indications for lidocaine administration in the context of arrhythmia management.

2. 2. Question

1 point(s)

Category: Pharmacological and Parenteral Therapies

A 72-year-old male patient with a history of atrial fibrillation and controlled hypertension has been initiated on warfarin therapy. Upon assessment of the patient's history, it was revealed that he

has a history of peptic ulcer. This patient also has a recent history of a peptic ulcer. Given the client's medical history and current medication regimen, which of the following instructions should the nurse prioritize when providing discharge teaching?

- A. Report incidents of diarrhea
- **B. Avoid foods high in vitamin K**
- C. Use a straight razor when shaving
- D. Take aspirin for pain relief
- E. Monitor for signs of bleeding, such as bruising or black tarry stools
- **F. Check blood pressure regularly at home**
- G. Inform all healthcare providers about the anticoagulant therapy

Incorrect

Correct Answer: B. Avoid foods high in vitamin K

Clients taking warfarin should be educated about maintaining a consistent intake of vitamin K, as it is necessary for the clotting cascade, and warfarin works by inhibiting the effects of vitamin K, thereby reducing the blood's ability to clot. Sudden increases in vitamin K intake can decrease the effectiveness of warfarin and increase the risk of clot formation. Clients should also be advised to report any incidents of diarrhea (A) since it can affect the absorption of the medication and potentially lead to unstable anticoagulation levels. Using a straight razor (C) is not advised due to the increased risk of bleeding; a safety razor or electric razor would be safer alternatives. Taking aspirin for pain relief (D) is not recommended without a physician's approval because aspirin can increase the risk of bleeding when taken with an anticoagulant. Monitoring for signs of bleeding (E), checking blood pressure regularly (F), and informing all healthcare providers about anticoagulant therapy (G) are also important instructions for a patient on warfarin therapy, but avoiding foods high in vitamin K is directly related to the effectiveness of the anticoagulant medication and is thus the priority teaching point.

3. 3. Question

1 point(s)

Category: Reduction of Risk Potential

In a busy surgical unit, a nurse is preparing to insert an I.V. catheter for a 33-year-old patient who is scheduled for elective surgery and has a notably hairy forearm where the I.V. is to be placed. The patient is allergic to a variety of adhesives and has sensitive skin that is prone to irritation. Given these considerations, how should the nurse manage excess hair at the intended catheter insertion site?

- A. Leaving the hair intact
- B. Shaving the area
- **C. Clipping the hair in the area**
- D. Removing the hair with a depilatory
- E. Applying a small amount of water-soluble gel to tame the hair without cutting
- **F. Use a sterile surgical scalpel to trim the hair as close to the skin as possible without causing abrasions**

Incorrect

Correct Answer: C. Clipping the hair in the area

Clipping is preferred over shaving in this scenario because it reduces the potential for creating microabrasions that can

increase infection risk, which is especially important in a patient with sensitive skin. Chemical depilatories (D) are not recommended due to the patient's history of allergies and sensitive skin. Leaving the hair intact (A) could interfere with the securement of the I.V. and increase the risk of infection. Water-soluble gel (E) is not standard practice for managing hair at an I.V. site and does not address the infection control issue. A sterile surgical scalpel (F) is not typically recommended for hair removal in preparation for I.V. insertion due to the risk of cuts and abrasions. Clipping is the safest option that balances the need to reduce infection risk with the patient's sensitivity and allergy

4. 4. Question

1 point(s)

Category: Health Promotion and Maintenance

A nurse is tasked with the education of an elderly female patient who has been recently diagnosed with osteoporosis. The patient leads a sedentary lifestyle, has a diet low in calcium, has undergone menopause ten years prior, and has a visibly kyphotic posture. In planning the education for this patient, which of the following complications should the nurse emphasize as the most significant risk associated with osteoporosis, especially considering the patient's profile?

- **A. Increased susceptibility to bone fractures from minimal trauma**
- B. Consequences of long-term estrogen deficiency post-menopause
- C. The impact of sustained negative calcium balance on bone density
- D. The progression of spinal deformities such as a kyphotic curvature
- E. Potential for height loss over time due to vertebral compression
- F. Risk of developing chronic pain associated with skeletal weakness

Correct

Correct Answer: A. Increased susceptibility to bone fractures from minimal trauma.

Given the patient's diagnosis of osteoporosis, a sedentary lifestyle, and poor dietary habits, the most significant and immediate complication is the risk of bone fractures, particularly hip, wrist, and spine fractures, which can result from minimal stress. The patient's visible kyphosis also indicates a history of spinal bone loss, which compounds this risk. Estrogen deficiency (B) is a contributing factor to the development of osteoporosis but is not a direct complication. Negative calcium balance (C) is a concern that should be addressed as it contributes to bone density loss; however, it is not a complication but rather a contributing factor. Progression of spinal deformities (D), height loss (E), and chronic pain (F) are all concerns associated with osteoporosis. Still, the priority education should focus on preventing fractures, which can have immediate and severe consequences on the patient's mobility and quality of life.

5. 5. Question

1 point(s)

Category: Health Promotion and Maintenance

A community health nurse is conducting a workshop on breast health for a group of women with diverse backgrounds, ranging from those who have never performed Breast Self-Examination (BSE) to some who have had benign breast conditions in the past. As part of the educational session, the nurse emphasizes the importance of BSE for the early detection of potential breast anomalies. What should the nurse identify as the **primary goal** for these women in performing regular BSE?

- A. To detect any cancerous lumps early in their development
- B. To identify areas of thickness or fullness that differ from the rest of the breast tissue
- **C. To notice any changes in the breast tissue from what is normal for each individual**
- D. To differentiate between fibrocystic masses and other types of breast lumps
- E. To promote self-awareness of breast health and encourage routine health screening
- F. To understand the normal texture and appearance of their breast tissue for future comparison

Correct

Correct Answer: C. To notice any changes in the breast tissue from what is normal for each individual.

The primary purpose of BSE is for individuals to become familiar with their own breasts so they can detect any changes early, which could be indicative of breast cancer or other breast conditions. Detecting cancerous lumps (A) is an important aspect of BSE, but the emphasis is on noticing any change, not only cancer. Identifying areas of thickness or fullness (B) and differentiating types of masses (D) are part of noticing changes, but these are not the primary goals. Promoting self-awareness and encouraging routine screening (E), as well as understanding normal breast tissue (F), are also critical educational points, but the main goal remains the detection of any new or unusual changes since the last examination.

6. 6. Question

1 point(s)

Category: Basic Care and Comfort

A nurse is managing the care of a 32-year-old female client diagnosed with hyperthyroidism. The client reports experiencing palpitations, unintentional weight loss, and intermittent bouts of excessive sweating. The treatment plan includes antithyroid medications. In addition to administering medication, what nursing interventions **should be prioritized** to manage the client's condition best?

- A. Ensure the client is provided with extra blankets and clothing to maintain a warm environment due to heightened sensitivity to cold.
- B. Closely monitor the client for increased signs of restlessness, sweating, and significant weight loss.
- **C. Create a balance between the client's periods of activity and rest to manage fatigue without exacerbating symptoms.**
- D. Encourage increased physical activity to counteract the sedative effects of the medication and prevent constipation.
- E. Regularly check the client's temperature as they are prone to developing fevers.
- **F. Offer a low-iodine diet and coordinate with a dietitian to manage dietary influences on thyroid function.**