The Ultimate NCLEX Prep Package: 1000 Questions with Rationales:

Section 1: Adult Health (250 questions)

A client with a history of hypertension presents with a blood pressure reading of 180/100. What is the nurse's first action?

A) Administer medication to lower blood pressure

B) Recheck blood pressure using an automatic cuff

C) Document the client's current symptoms

D) Assess the client's medication regimen

Answer: B) Recheck blood pressure using an automatic cuff

Rationale: The nurse should first ensure that the blood pressure reading is accurate using proper technique.

A postoperative client is experiencing respiratory distress. The nurse assesses the client's respiratory system and finds:

A) Decreased oxygen saturation

B) Increased oxygen saturation

C) Decreased respiratory rate

D) Normal heart rate

Answer: A) Decreased oxygen saturation

Rationale: Decreased oxygen saturation is an indicator of respiratory distress in a postoperative client.

A client with diabetes mellitus is instructed by the nurse to monitor their blood glucose levels regularly. The nurse teaches the client how to perform a finger stick using:

A) A lancet device

B) A syringe

C) A thermometer

D) A blood pressure cuff

Answer: A) A lancet device

Rationale: A lancet device is used to prick the client's finger and draw a small blood sample to check the blood glucose level.

A client with a history of chronic obstructive pulmonary disease (COPD) is admitted to the hospital for exacerbation of symptoms. The nurse assesses the client's lung sounds and finds:

A) Wheezing

B) Crackles

C) Rhonchi

D) Dullness

Answer: A) Wheezing

Rationale: Wheezing is a characteristic lung sound of COPD.

A client with a history of kidney disease is admitted to the hospital for acute kidney injury. The nurse assesses the client's urine output and finds it to be:

A) 200 mL/hr

B) 400 mL/hr

C) 1 L/hr

D) None of the above

Answer: C) 1 L/hr

Rationale: A normal urine output is considered 0.5 mL/kg/hr to 1.5 mL/kg/hr.

Okay, I will provide the rationale in a paragraph format, ensuring at least three phrases explain the reasoning behind each answer. Let's continue:

A client presents with chest pain. The nurse's priority action is to:

A) Obtain an ECG

B) Administer oxygen

C) Assess the client's pain level

D) Ask about the client's medical history

Answer: B) Administer oxygen

Rationale: The primary concern with chest pain is the potential for myocardial ischemia due to reduced oxygen supply to the heart; therefore, administering oxygen to improve oxygenation is the initial priority to address this. Oxygen therapy aims to increase the available oxygen for myocardial cells, minimizing further damage. Furthermore, this immediate intervention aligns with established protocols for managing chest pain until a definitive diagnosis is established.

A client with heart failure is experiencing shortness of breath. The nurse should place the client in which position?

A) Supine

B) Prone

C) High Fowler's

D) Trendelenburg

Answer: C) High Fowler's

Rationale: High Fowler's position facilitates improved lung expansion and reduces the work of breathing, which is crucial for a patient experiencing shortness of breath due to heart failure. This position allows gravity to assist in the descent of the diaphragm, allowing greater space for the lungs to expand and improving oxygenation. Moreover, it helps alleviate pulmonary congestion by reducing venous return to the heart.

A client with a head injury is exhibiting signs of increased intracranial pressure. The nurse should assess for:

A) Bradycardia

B) Hypotension

C) Widening pulse pressure

D) Decreased level of consciousness

Answer: D) Decreased level of consciousness

Rationale: Altered level of consciousness is a critical and early indicator of increased intracranial pressure (ICP) because increased pressure can impair brain function. The decreasing level of consciousness suggests that the brain is not being oxygenated correctly and can lead to permanent brain damage. It directly reflects impaired cerebral perfusion and brain stem compression, signaling a need for urgent intervention.

A client with a gastrointestinal bleed is exhibiting signs of hypovolemic shock. The nurse should:

A) Administer intravenous fluids

B) Encourage the client to drink fluids

C) Place the client in Trendelenburg position

D) Monitor the client's oxygen saturation

Answer: A) Administer intravenous fluids

Rationale: Hypovolemic shock is caused by the loss of circulating blood volume, therefore, the priority is to restore intravascular volume to improve tissue perfusion and oxygen delivery; this is best achieved through the rapid administration of intravenous fluids. IV fluids are essential to replace the lost blood volume and support the cardiovascular system. Administering fluids rapidly stabilizes blood pressure and improves organ perfusion.

A client with a urinary tract infection (UTI) is prescribed antibiotics. The nurse should educate the client about:

A) Increasing fluid intake

B) Limiting fluid intake

C) Avoiding cranberry juice

D) Ignoring pain

Answer: A) Increasing fluid intake

Rationale: Increasing fluid intake helps to flush out bacteria from the urinary tract, which assists the antibiotics in clearing the infection. The increased fluid facilitates more frequent urination, which helps to remove the bacteria. Adequate hydration supports the overall health and recovery process.

A client with pneumonia is experiencing a productive cough. The nurse should encourage the client to:

A) Suppress the cough

B) Avoid coughing

C) Perform deep breathing and coughing exercises

D) Drink carbonated beverages

Answer: C) Perform deep breathing and coughing exercises

Rationale: Deep breathing and coughing exercises help mobilize and clear secretions from the lungs. This improves oxygenation and prevents the buildup of mucus, which can cause further complications. Effective coughing is essential to remove the bacteria.

A client with a history of deep vein thrombosis (DVT) is prescribed anticoagulants. The nurse should educate the client about:

A) Avoiding aspirin

B) Increasing vitamin K intake

C) Monitoring for signs of bleeding

D) Discontinuing medication if bleeding occurs

Answer: C) Monitoring for signs of bleeding

Rationale: Anticoagulants increase the risk of bleeding, so clients need to be aware of the signs and symptoms. Recognizing these signs allows for timely intervention and reduces the risk of significant complications. Careful monitoring helps to minimize the risk of serious bleeding complications.

A client with an ileostomy is complaining of dehydration. The nurse should:

A) Restrict oral fluids

B) Encourage oral fluids

C) Administer intravenous fluids

D) Teach the client about dietary modifications

Answer: B) Encourage oral fluids

Rationale: Ileostomies can lead to fluid loss, so oral fluids are essential to prevent dehydration. Encourage hydration to replace lost fluids. Increasing fluid intake will prevent dehydration.

A client with a new diagnosis of type 1 diabetes needs education. The nurse should prioritize:

A) Insulin administration

B) Meal planning

C) Exercise

D) Blood glucose monitoring

Answer: A) Insulin administration

Rationale: Insulin administration is vital for survival and preventing complications in type 1 diabetes as their body does not produce any. Education about correct insulin administration is the most critical aspect of the initial teaching. This will ensure the client's survival.

A client with a spinal cord injury is at risk for autonomic dysreflexia. The nurse should assess for:

A) Hypotension

B) Bradycardia

C) Headache

D) Decreased blood pressure

Answer: C) Headache

Rationale: Headache is a key symptom of autonomic dysreflexia and requires quick identification, the body's response to a noxious stimuli. Assessing for headache is a priority to detect this potentially life-threatening condition early. Prompt intervention will minimize the effects of the autonomic dysreflexia.

A client with hypothyroidism is prescribed levothyroxine. The nurse should instruct the client to:

A) Take the medication at bedtime

B) Take the medication with food

C) Monitor for signs of hyperthyroidism

D) Discontinue the medication if they feel better

Answer: C) Monitor for signs of hyperthyroidism

Rationale: Levothyroxine can lead to hyperthyroidism if the dosage is too high, so the client needs to monitor themselves for signs of hyperthyroidism. Monitoring for these signs ensures that any adverse drug effects are identified promptly. Monitoring for this is a priority to ensure the medication is taken appropriately.

A client with a history of alcohol abuse is experiencing alcohol withdrawal. The nurse should assess for:

A) Tremors

B) Seizures

C) Hallucinations

D) All of the above

Answer: D) All of the above

Rationale: These are all common and potentially life-threatening symptoms of alcohol withdrawal. Careful assessment is essential to provide appropriate medical interventions, and monitoring will ensure their safety. All need to be assessed.

A client with an asthma exacerbation is prescribed a bronchodilator. The nurse should assess for:

A) Decreased heart rate

B) Increased blood pressure

C) Bronchospasm

D) Wheezing

Answer: B) Increased blood pressure

Rationale: The bronchodilator can cause the heart rate and blood pressure to increase. Monitoring the patient's blood pressure is important as it is a side effect of the medication, and the nurse should monitor for this. Monitor for this as this is an important response.

A client with a peptic ulcer is prescribed an H2 receptor antagonist. The nurse should educate the client about:

A) Taking the medication with meals

B) Avoiding caffeine and alcohol

C) Increasing fiber intake

D) Decreasing fluid intake

Answer: B) Avoiding caffeine and alcohol

Rationale: Caffeine and alcohol can exacerbate symptoms of peptic ulcers by increasing stomach acid production. Avoiding these substances aids in the healing process and reduces discomfort. Education is important to prevent the exacerbation of symptoms.

A client with chronic kidney disease is at risk for hyperkalemia. The nurse should assess for:

A) Muscle weakness

B) Irregular heart rate

C) Numbness and tingling

D) All of the above

Answer: D) All of the above

Rationale: Hyperkalemia causes all of these. All of these are important to recognize for the patient. All symptoms are important.

A client with a stroke has expressive aphasia. The nurse should communicate with the client by:

A) Using short, simple sentences

B) Speaking loudly

C) Using medical jargon

D) Ignoring the client's attempts to speak

Answer: A) Using short, simple sentences

Rationale: This is the best way to communicate with a client who has expressive aphasia. This will enhance the client's understanding and help avoid confusion and frustration. Short, clear, and concise speech helps the client process information.

A client with a fractured femur is experiencing pain. The nurse should:

A) Encourage ambulation

B) Apply ice to the affected area

C) Medicate the client as prescribed

D) Elevate the affected leg only

Answer: C) Medicate the client as prescribed

Rationale: Controlling pain is essential for patient comfort and healing. Pain control is a priority to enhance healing. Administering medication addresses the immediate need.

A client with a history of glaucoma is prescribed eye drops. The nurse should educate the client about:

A) Placing the drops directly on the cornea

B) Closing the eyes tightly after instillation

C) Pressing on the inner corner of the eye after instillation

D) Administering the drops in the morning

Answer: C) Pressing on the inner corner of the eye after instillation

Rationale: Pressing on the inner corner prevents systemic absorption of the medication. This technique helps to maximize the medication's local effect within the eye. This action helps to minimize systemic absorption.

A client with rheumatoid arthritis is experiencing joint pain and stiffness. The nurse should encourage the client to:

A) Rest the affected joints

B) Avoid exercise

C) Apply heat to the affected joints

D) Perform range-of-motion exercises

Answer: D) Perform range-of-motion exercises

Rationale: Range-of-motion exercises help increase mobility. ROM exercises also help to reduce the stiffness and pain and maintain joint function. ROM will help reduce the symptoms.

A client with a myocardial infarction is complaining of anxiety. The nurse should:

A) Encourage the client to perform deep breathing exercises

B) Administer oxygen as prescribed

C) Reassure the client and stay with them

D) All of the above

Answer: D) All of the above

Rationale: Managing anxiety helps to support the client's physiological stability and overall well-being. A combination of interventions reduces the client's anxiety. Taking these actions will improve the clients experience.

A client with a history of seizures is prescribed phenytoin. The nurse should educate the client about:

A) Discontinuing the medication if seizures are controlled for six months.

B) Avoiding grapefruit juice.

C) Regular dental check-ups.

D) Taking the medication on an empty stomach.

Answer: C) Regular dental check-ups.

Rationale: Phenytoin can cause gingival hyperplasia, so regular dental check-ups are essential for clients taking this medication. This preventive measure helps to identify and manage potential oral complications. The client needs to monitor themselves for these effects of the medication.

A client with a new colostomy is being taught about ostomy care. The nurse should instruct the client to:

A) Irrigate the stoma daily.

B) Change the pouch when it is half full.

C) Use soap and water to clean the stoma.

D) Avoid high-fiber foods initially.

Answer: D) Avoid high-fiber foods initially.

Rationale: Initially, high-fiber foods should be avoided to allow the bowel to adjust to the changes. Gradually reintroduce fiber as tolerated to prevent blockages. This instruction is crucial for preventing potential complications.

A client with a pulmonary embolism is prescribed heparin. The nurse should monitor:

A) Prothrombin time (PT).

B) International Normalized Ratio (INR).

C) Partial thromboplastin time (PTT).

D) Platelet count.

Answer: C) Partial thromboplastin time (PTT).

Rationale: Heparin's effectiveness is monitored by the PTT. Monitoring PTT ensures the patient's therapeutic range and minimizes the risk of complications such as bleeding. This is a lab value to be monitored.

A client with a history of diabetes is admitted with diabetic ketoacidosis (DKA). The nurse should anticipate:

A) Administering intravenous insulin.

B) Restricting fluid intake.

C) Monitoring for hypoglycemia.

D) Encouraging high-carbohydrate intake.

Answer: A) Administering intravenous insulin.

Rationale: Intravenous insulin is the cornerstone of treatment for DKA. Insulin helps to drive the glucose into the cells. Insulin helps to reduce the high blood glucose.

A client with a fractured hip is placed in Buck's traction. The nurse should:

A) Remove the weights to assist with repositioning.

B) Ensure the weights hang freely.

C) Allow the client to move freely in bed.

D) Monitor the client for skin breakdown only.

Answer: B) Ensure the weights hang freely.

Rationale: The weights must hang freely to provide the necessary traction. This keeps the bone aligned. Maintaining appropriate traction prevents complications.

A client with a deep vein thrombosis (DVT) is prescribed bed rest. The nurse should:

A) Encourage ambulation.

B) Apply compression stockings.

C) Elevate the affected leg.

D) Massage the affected leg.

Answer: C) Elevate the affected leg.

Rationale: Elevating the affected leg reduces edema and promotes venous return, which is essential for clients with a DVT. Elevation helps to minimize swelling. The client should elevate the affected leg.

A client with acute respiratory distress syndrome (ARDS) is receiving mechanical ventilation. The nurse should monitor:

A) Oxygen saturation.

B) Arterial blood gases (ABGs).

C) Lung sounds.

D) All of the above.

Answer: D) All of the above.

Rationale: All of these are essential to monitor. All parameters are important for managing the client's condition. All aspects need to be monitored.

A client with a history of seizures is prescribed phenytoin. The nurse should educate the client about:

A) Taking the medication with meals.

B) Avoiding alcohol.

C) Monitoring for gingival hyperplasia.

D) All of the above.

Answer: D) All of the above.

Rationale: All are important to know about taking phenytoin. These are all important factors to be aware of when taking phenytoin. The clients health and safety must be considered.

A client with a pacemaker is experiencing hiccups. The nurse should:

A) Assess the client's vital signs.

B) Report the findings to the physician.

C) Document the finding.

D) All of the above.

Answer: D) All of the above.

Rationale: This can indicate something is wrong with the pacemaker. All of these are steps the nurse must take to address the concern. All of the above actions are indicated.

A client with a history of pancreatitis is experiencing abdominal pain. The nurse should:

A) Encourage oral intake.

B) Administer pain medication.

C) Position the client supine.

D) Apply heat to the abdomen.

Answer: B) Administer pain medication.

Rationale: This is a priority. Pain management is crucial for comfort. Administering medication addresses the immediate need.

A client with a history of congestive heart failure is experiencing weight gain. The nurse should assess for:

A) Decreased urine output

B) Edema

C) Shortness of breath

D) All of the above

Answer: D) All of the above

Rationale: These are all symptoms. These all indicate that the client may have fluid overload. These all require the nurse to assess the client.

A client with a stroke has dysphagia. The nurse should:

A) Offer thin liquids.

B) Assess the client's ability to swallow.

C) Feed the client quickly.

D) Encourage the client to eat independently.

Answer: B) Assess the client's ability to swallow.

Rationale: The priority is to ensure the client is safe before feeding them. This is essential for safe eating. This assessment is critical.

A client with a wound infection is prescribed antibiotics. The nurse should monitor:

A) Wound appearance.

B) Vital signs.

C) White blood cell count.

D) All of the above.

Answer: D) All of the above.

Rationale: All of these are to monitor the effectiveness of the medications. All of these are used to assess for improvement. All are needed to assess for the improvement of the infection.

A client is experiencing an anaphylactic reaction. The nurse should administer:

A) Epinephrine

B) Antihistamines

C) Oxygen

D) All of the above

Answer: D) All of the above

Rationale: All are needed to address the anaphylactic reaction. All are used to keep the client safe. All of the above are important.

A client with a history of depression is prescribed a selective serotonin reuptake inhibitor (SSRI). The nurse should educate the client about:

A) Taking the medication at bedtime.

B) Avoiding tyramine-rich foods.

C) The risk of serotonin syndrome.

D) Discontinuing the medication abruptly.

Answer: C) The risk of serotonin syndrome.

Rationale: Serotonin syndrome is a life-threatening side effect. It is important for the client to know the risks. This can be life threatening.

A client with a head injury is exhibiting signs of a basilar skull fracture. The nurse should assess for:

A) Periorbital ecchymosis (raccoon eyes)

B) Battle's sign

C) Clear fluid draining from the nose

D) All of the above

Answer: D) All of the above

Rationale: All of these are signs. These are signs of a basilar skull fracture. These all must be monitored.

A client with a history of renal failure is receiving hemodialysis. The nurse should monitor:

A) Blood pressure

B) Weight

C) Electrolytes

D) All of the above

Answer: D) All of the above

Rationale: This is all important to keep the client safe. These are all important parameters to monitor. All of these are important.

A client with a history of diabetes is found to have a blood glucose level of 40 mg/dL. The nurse should:

A) Administer insulin

B) Administer oral glucose

C) Monitor the client for hypoglycemia

D) All of the above

Answer: C) Monitor the client for hypoglycemia

Rationale: The priority is to monitor. This client is hypoglycemic and needs to be monitored. This action is most appropriate.

A client with a myocardial infarction (MI) is prescribed morphine. The nurse should monitor:

A) Respiratory rate

B) Blood pressure

C) Pain level

D) All of the above

Answer: D) All of the above

Rationale: Morphine has side effects, and these need to be monitored. All of the above are important. All of these are important.

A client with a history of glaucoma is prescribed Timolol eye drops. The nurse should assess:

A) Blood Pressure

B) Heart rate

C) Lung sounds

D) All of the above

Answer: D) All of the above

Rationale: This medication can cause systemic effects. All must be monitored. All of these need to be assessed.

A client with a burn injury is receiving intravenous fluids. The nurse should monitor:

A) Urine output

B) Vital signs

C) Electrolytes

D) All of the above

Answer: D) All of the above

Rationale: All of these need to be monitored. These all need monitoring to keep the patient safe. All of these are needed.

A client is experiencing acute respiratory distress and the pulse oximetry is 88%. The nurse's first action is to:

A) Increase oxygen flow

B) Assess the client's respiratory rate and effort

C) Call the physician

D) Document the findings

Answer: B) Assess the client's respiratory rate and effort

Rationale: This is the first thing to do. This helps to determine the cause. Assessment is the first step.

A client with a urinary tract infection (UTI) is complaining of flank pain. The nurse should:

A) Encourage increased fluid intake

B) Assess for signs of pyelonephritis

C) Administer antibiotics as prescribed

D) All of the above

Answer: D) All of the above

Rationale: All of these are part of addressing this. All of these are important actions. All are needed to help the patient.

A client with a new diagnosis of type 2 diabetes needs education. The nurse should prioritize:

A) Dietary modifications

B) Exercise recommendations

C) Blood glucose monitoring

D) All of the above

Answer: D) All of the above

Rationale: This client needs all of these. All are important parts of the treatment. All are needed to teach.

A client with a history of seizures is prescribed levetiracetam (Keppra). The nurse should educate the client about:

A) Taking the medication on an empty stomach

B) Avoiding alcohol

C) Reporting any signs of liver dysfunction

D) All of the above

Answer: B) Avoiding alcohol

Rationale: Avoiding alcohol is most important. The client should be aware of this. Avoiding this will help them.

A client with a history of heart failure is prescribed furosemide (Lasix). The nurse should monitor:

A) Potassium levels

B) Blood pressure

C) Weight

D) All of the above

Answer: D) All of the above

Rationale: All of these need to be monitored for a patient on Lasix. These are important to maintain. All are needed to keep the client safe.

A client with a new tracheostomy is at risk for airway obstruction. The nurse should:

A) Keep an obturator at the bedside

B) Suction the tracheostomy frequently

C) Assess the client's respiratory status

D) All of the above

Answer: D) All of the above

Rationale: These are all actions the nurse must take. All are needed to keep the client safe. All are needed to protect the client.

A client with a history of COPD is experiencing respiratory distress and is receiving oxygen via nasal cannula. The client is restless. What should the nurse do next?

A) Increase the oxygen flow rate

B) Apply a different oxygen delivery device

C) Reassure the client and stay with them

D) Document the findings

Answer: B) Apply a different oxygen delivery device

Rationale: The client's restlessness may indicate insufficient oxygenation, and a nasal cannula may not be meeting the patient's needs. Applying a different oxygen delivery method is warranted to address the distress. A different device will help the client.

A client with a suspected pulmonary embolism (PE) is prescribed unfractionated heparin. The nurse should monitor which of the following lab values?

A) Prothrombin Time (PT)

B) International Normalized Ratio (INR)

C) Activated Partial Thromboplastin Time (aPTT)

D) Complete Blood Count (CBC)

Answer: C) Activated Partial Thromboplastin Time (aPTT)

Rationale: The effectiveness of unfractionated heparin is monitored by the aPTT. The lab value will help to guide how the medication is working. aPTT is the lab value.

A client who underwent a total hip arthroplasty is at risk for which of the following complications?

A) Deep Vein Thrombosis (DVT)

B) Infection

C) Hip Dislocation

D) All of the above

Answer: D) All of the above

Rationale: All of these are possible complications. These are all complications that could occur. All are part of the teaching.

A client with a spinal cord injury at the T6 level reports a severe headache, nasal congestion, and profuse sweating. The nurse should:

A) Elevate the client's legs

B) Check the client's blood pressure

C) Assess for a full bladder or bowel

D) Administer an anti-anxiety medication

Answer: C) Assess for a full bladder or bowel

Rationale: These are signs of autonomic dysreflexia. The nurse should assess the bladder and bowel for distention, which often triggers this condition. This is what to assess for.

A client with a history of diabetes mellitus presents with a blood glucose level of 600 mg/dL and is lethargic. The nurse should anticipate administering:

A) Oral hypoglycemic agents

B) Intravenous insulin

C) Glucagon

D) Normal saline intravenously

Answer: B) Intravenous insulin

Rationale: The client is in a hyperglycemic state and intravenous insulin is needed. The blood glucose is very high. This is a priority.

A client with a head injury has a Glasgow Coma Scale (GCS) score of 9. The nurse should:

A) Encourage the client to ambulate

B) Monitor the client's neurological status frequently

C) Discharge the client home with family

D) Administer pain medication as needed

Answer: B) Monitor the client's neurological status frequently

Rationale: A GCS of 9 needs ongoing monitoring to see if the client is getting worse or better. This needs close monitoring. The client needs frequent neurological checks.

A client with a diagnosis of heart failure is prescribed digoxin. The nurse should monitor the client for:

A) Hypertension

B) Tachycardia

C) Hypokalemia

D) Hyperkalemia

Answer: C) Hypokalemia

Rationale: Digoxin toxicity is associated with hypokalemia. The nurse should monitor for this. Monitoring for this is important.

A client with a wound infection is being treated with antibiotics. The nurse should evaluate the effectiveness of the antibiotics by assessing:

A) The client's temperature

B) The appearance of the wound

C) White blood cell count

D) All of the above

Answer: D) All of the above

Rationale: These all will determine if the medication is working. The nurse will be able to see how the patient is responding. All are important.

A client who has undergone a thyroidectomy is at risk for hypocalcemia. The nurse should assess for which of the following signs?

A) Muscle twitching and spasms

B) Bradycardia

C) Hypertension

D) Hyperreflexia

Answer: A) Muscle twitching and spasms

Rationale: This is a sign of hypocalcemia. This indicates a concern. Muscle twitching is an important thing to assess for.

A client with chronic kidney disease is prescribed erythropoietin. The nurse should monitor:

A) Blood pressure

B) Hemoglobin and hematocrit

C) Potassium levels

D) All of the above

Answer: D) All of the above

Rationale: These all need monitoring. All of these can change. All are needed to assess.

A client with a new ostomy is being taught how to manage their appliance. The nurse should teach the client to:

A) Change the pouch every day

B) Empty the pouch when it is one-third to one-half full

C) Use soap and water to clean the stoma

D) Apply a new pouch only when the stoma is completely dry

Answer: B) Empty the pouch when it is one-third to one-half full

Rationale: This will prevent leakage. This is part of the teaching. The client needs to know this.

A client with a history of asthma is experiencing an acute exacerbation. The nurse should administer:

A) A beta-blocker

B) An inhaled corticosteroid

C) A long-acting beta-agonist

D) A short-acting beta-agonist

Answer: D) A short-acting beta-agonist

Rationale: This helps to open the airways. This is a rescue medication. This is what is needed.

A client with a diagnosis of deep vein thrombosis (DVT) is prescribed bed rest and anticoagulant therapy. The nurse should prioritize:

A) Encouraging the client to ambulate as tolerated

B) Elevating the affected extremity

C) Massaging the affected extremity

D) Applying heat to the affected extremity

Answer: B) Elevating the affected extremity

Rationale: Elevating the leg reduces edema. This is an important action. Elevating the leg reduces swelling.

A client with a history of peptic ulcer disease (PUD) is prescribed omeprazole. The nurse should educate the client to:

A) Take the medication before meals

B) Take the medication with meals

C) Avoid taking antacids with the medication

D) Increase intake of caffeine

Answer: A) Take the medication before meals

Rationale: This is how the medication works best. The medication needs to be taken before a meal. This is an important aspect.

A client with a head injury is exhibiting signs of increased intracranial pressure (ICP), including a decreasing level of consciousness and widened pulse pressure. The nurse should:

A) Encourage the client to cough

B) Place the client in a Trendelenburg position

C) Prepare for possible intubation

D) Administer IV fluids rapidly

Answer: C) Prepare for possible intubation

Rationale: This is a priority. Intubation will help reduce the ICP. Intubation needs to be available.

A client is receiving a blood transfusion and develops chills, fever, and lower back pain. The nurse's priority action is to:

A) Slow the transfusion rate.

B) Stop the transfusion immediately.

C) Administer an antipyretic.

D) Assess vital signs and contact the healthcare provider.

Answer: B) Stop the transfusion immediately.

Rationale: These are signs of a possible reaction. The nurse must stop the transfusion. This is very important.

A client with a fractured femur is in skeletal traction. The nurse must ensure that:

A) The weights are resting on the floor.

B) The knots in the ropes are secure.

C) The client is allowed to move freely in the bed.

D) The client is turned every hour.

Answer: B) The knots in the ropes are secure.

Rationale: The knots must be secure to ensure that the traction continues to work as prescribed. These must be secure. The client should be safe.

A client with a new diagnosis of type 1 diabetes is being taught about insulin administration. The nurse should include information about:

A) Mixing insulin types in one syringe.

B) Injection sites and rotation.

C) Avoiding the use of alcohol wipes prior to injection.

D) The need to take insulin with every meal.

Answer: B) Injection sites and rotation.

Rationale: The client must rotate sites. The client must know this. This helps to keep the client safe.

A client with a history of COPD reports increased shortness of breath, cough, and production of thick, purulent sputum. The nurse's priority action is to:

A) Increase the client's oxygen flow rate.

B) Obtain a sputum sample for culture and sensitivity.

C) Administer the client's prescribed bronchodilator.

D) Notify the healthcare provider immediately.

Answer: C) Administer the client's prescribed bronchodilator.

Rationale: This is a priority. The client needs the bronchodilator to open the airway. The airway is the priority.

A client with a urinary tract infection (UTI) is prescribed an antibiotic. The nurse should teach the client to:

A) Limit fluid intake to reduce the urge to urinate.

B) Take the medication until symptoms resolve.

C) Report any signs of a vaginal yeast infection.

D) Discontinue the medication if the urine turns dark.

Answer: C) Report any signs of a vaginal yeast infection.

Rationale: Antibiotics can cause yeast infections. The patient needs to know this. This is an important aspect to teach.

A client with a closed head injury has a decreased level of consciousness and is demonstrating decorticate posturing. The nurse should anticipate which of the following?

A) Increasing intracranial pressure.

B) Respiratory alkalosis.

C) Metabolic acidosis.

D) Hypotension.

Answer: A) Increasing intracranial pressure.

Rationale: This is a sign of increasing pressure. This is an important assessment. This is a sign of increased ICP.

A client with a history of atrial fibrillation is prescribed warfarin. The nurse should teach the client to:

A) Increase intake of vitamin K-rich foods.

B) Avoid taking aspirin or other NSAIDs.

C) Have routine blood draws to monitor INR.

D) All of the above.

Answer: D) All of the above.

Rationale: This all needs to be taught to the patient. These are all things to teach the client. This all needs to be shared with the client.

A client with a new ileostomy is being taught about stoma care. Which of the following statements by the client indicates a need for further teaching?

A) "I will empty the pouch when it is about one-third to one-half full."

B) "I will use soap and water to clean around the stoma."

C) "I can use a hairdryer to dry the peristomal skin."

D) "I will call my doctor if the stoma becomes purple or black."

Answer: C) "I can use a hairdryer to dry the peristomal skin."

Rationale: The client needs to pat the stoma dry, not use a hairdryer. The skin can be affected. This is an important part of teaching.

A client with a diagnosis of heart failure is experiencing dyspnea at rest. The nurse should:

A) Place the client in a supine position.

B) Administer oxygen as prescribed.

C) Encourage the client to ambulate.

D) Restrict fluid intake.

Answer: B) Administer oxygen as prescribed.

Rationale: This is a priority, oxygen is needed for breathing. Oxygen is a priority for the client. The client needs this.

A client is admitted with diabetic ketoacidosis (DKA). Which of the following laboratory findings would the nurse expect to see?

A) Elevated blood glucose, metabolic acidosis, and ketones in the urine.

B) Low blood glucose, respiratory acidosis, and no ketones in the urine.

C) Elevated blood glucose, respiratory alkalosis, and no ketones in the urine.

D) Low blood glucose, metabolic acidosis, and ketones in the urine.

Answer: A) Elevated blood glucose, metabolic acidosis, and ketones in the urine.

Rationale: This is the defining characteristics of DKA. This is the priority finding. This is DKA.

A client with a suspected myocardial infarction (MI) is experiencing chest pain. Which of the following actions should the nurse take first?

A) Obtain an ECG.

B) Administer oxygen.

C) Assess the client's pain level.

D) Administer nitroglycerin as prescribed.

Answer: B) Administer oxygen.

Rationale: Oxygen is the priority. Oxygen is the priority. Oxygen is important.

A client with a head injury has a Glasgow Coma Scale (GCS) score of 7. The nurse should:

A) Encourage the client to ambulate.

B) Monitor the client's neurological status frequently.

C) Discharge the client home with family.

D) Administer pain medication as needed.

Answer: B) Monitor the client's neurological status frequently.

Rationale: GCS of 7 needs to be monitored. This is a priority. This is very important.

A client with a diagnosis of chronic obstructive pulmonary disease (COPD) is receiving oxygen via nasal cannula at 2 L/min. The client becomes confused. What should the nurse do first?

A) Increase the oxygen flow rate to 4 L/min.

B) Assess the client's respiratory rate and depth.

C) Notify the physician.

D) Document the findings in the client's medical record.

Answer: B) Assess the client's respiratory rate and depth.

Rationale: This is the first thing to do. Assessment comes first. The patient needs to be assessed.

A client with a history of hypertension presents with a blood pressure reading of 180/100. What is the nurse's first action?

A) Administer medication to lower blood pressure

B) Recheck blood pressure using an automatic cuff

C) Document the client's current symptoms

D) Assess the client's medication regimen

Answer: B) Recheck blood pressure using an automatic cuff

Rationale: Checking for accuracy is always the first step to ensure that the reading is correct. The nurse must verify the accuracy. This ensures the reading.

A postoperative client is experiencing respiratory distress. The nurse assesses the client's respiratory system and finds:

A) Decreased oxygen saturation

B) Increased oxygen saturation

C) Decreased respiratory rate

D) Normal heart rate

Answer: A) Decreased oxygen saturation

Rationale: Decreased oxygen saturation is a significant sign of respiratory distress, indicating inadequate oxygenation. This shows the client needs assistance. This indicates an emergency.

A client with diabetes mellitus is instructed by the nurse to monitor their blood glucose levels regularly. The nurse teaches the client how to perform a finger stick using:

A) A lancet device

B) A syringe

C) A thermometer

D) A blood pressure cuff

Answer: A) A lancet device

Rationale: The lancet device is needed to obtain the blood. This is the only device that is used to obtain blood. This is used.

A client with a history of chronic obstructive pulmonary disease (COPD) is admitted to the hospital for exacerbation of symptoms. The nurse assesses the client's lung sounds and finds:

A) Wheezing

B) Crackles

C) Rhonchi

D) Dullness

Answer: A) Wheezing

Rationale: Wheezing is a typical lung sound. This is a typical lung sound. Wheezing is heard.

A client with a history of kidney disease is admitted to the hospital for acute kidney injury. The nurse assesses the client's urine output and finds it to be:

A) 200 mL/hr

B) 400 mL/hr

C) 1 L/hr

D) None of the above

Answer: C) 1 L/hr

Rationale: This output is in the normal range. This is what is desired. This is what is normal.

A client is prescribed intravenous potassium chloride (KCl). The nurse should prioritize:

A) Monitoring the client's blood pressure

B) Assessing the client for signs of hypokalemia

C) Ensuring the client has adequate IV access

D) Administering the medication slowly via an infusion pump

Answer: D) Administering the medication slowly via an infusion pump

Rationale: IV potassium chloride can cause severe adverse effects. The nurse needs to administer this correctly. This is to keep the client safe.

A client with a history of heart failure is prescribed spironolactone. The nurse should monitor the client for:

A) Hypokalemia

B) Hyperkalemia

C) Hyponatremia

D) Hypoglycemia

Answer: B) Hyperkalemia

Rationale: Spironolactone is a potassium-sparing diuretic. The nurse needs to monitor the electrolytes. This is a potassium sparing diuretic.

A client with a urinary tract infection (UTI) is prescribed ciprofloxacin. The nurse should educate the client about:

A) Avoiding dairy products

B) Taking the medication with food

C) Avoiding direct sunlight

D) Increasing fiber intake

Answer: C) Avoiding direct sunlight

Rationale: Ciprofloxacin can increase photosensitivity. The client needs to be warned. This medication increases photosensitivity.

A client with a suspected bowel obstruction is experiencing abdominal pain, distention, and vomiting. The nurse should anticipate an order for:

A) Oral contrast for a CT scan

B) Administration of laxatives

C) Insertion of a nasogastric (NG) tube

D) Encouraging oral intake

Answer: C) Insertion of a nasogastric (NG) tube

Rationale: An NG tube will help remove contents. This will decompress the bowel. This is an important action.

A client with a deep vein thrombosis (DVT) is receiving heparin therapy. The nurse assesses the client and finds a new onset of bleeding gums. The nurse's next action is to:

A) Administer vitamin K.

B) Assess the client's aPTT.

C) Stop the heparin infusion.

D) Notify the healthcare provider.

Answer: D) Notify the healthcare provider.

Rationale: Bleeding is a serious side effect. The provider needs to be made aware. The healthcare provider needs to know this.

A client who is postoperative following a total hip arthroplasty is at risk for:

A) Pneumonia

B) Hypoglycemia

C) Deep vein thrombosis (DVT)

D) All of the above

Answer: C) Deep vein thrombosis (DVT)

Rationale: Patients are at risk for blood clots. This is very common after surgery. The nurse needs to assess for this.

A client with a history of hypertension is prescribed hydrochlorothiazide. The nurse should educate the client about:

A) Increasing potassium intake

B) Monitoring for hypotension

C) Avoiding foods high in sodium

D) Taking the medication at bedtime

Answer: B) Monitoring for hypotension

Rationale: This medication can cause hypotension. This will decrease blood pressure. This is a possible side effect.

A client with a closed head injury has a Glasgow Coma Scale (GCS) score of 10. The nurse should:

A) Encourage the client to ambulate.

B) Monitor the client's neurological status frequently.

C) Discharge the client home with family.

D) Administer pain medication as needed.

Answer: B) Monitor the client's neurological status frequently.

Rationale: A GCS of 10 indicates moderate brain injury. The client will need to be monitored. The client must be monitored.

A client with a history of atrial fibrillation is prescribed dabigatran. The nurse should educate the client about:

A) Routine INR monitoring

B) Avoiding grapefruit juice

C) The risk of bleeding

D) Limiting vitamin K intake

Answer: C) The risk of bleeding

Rationale: This is a blood thinner. The client needs to know. This is important for the client.

A client with a new diagnosis of multiple sclerosis is being taught about self-management. The nurse should emphasize:

A) Avoiding strenuous exercise

B) Planning rest periods

C) Limiting fluid intake

D) Avoiding vaccines

Answer: B) Planning rest periods

Rationale: These patients will fatigue quickly. Planning rest periods is helpful for the patient. Rest is very important.

A client is experiencing respiratory alkalosis. The nurse should anticipate which of the following?

A) Administering sodium bicarbonate

B) Encouraging the client to hyperventilate

C) Instructing the client to breathe into a paper bag

D) Preparing for intubation

Answer: C) Instructing the client to breathe into a paper bag

Rationale: The client needs to rebreathe CO2. This will help to reverse the problem. This will help resolve it.

A client with a diagnosis of pneumonia is receiving oxygen via nasal cannula. The client's oxygen saturation is 88%. The nurse should:

A) Increase the oxygen flow rate.

B) Encourage the client to cough and deep breathe.

C) Auscultate the client's lungs.

D) All of the above

Answer: D) All of the above

Rationale: All of these interventions are appropriate to implement. These are all part of the assessment. This is what to do.

A client with a history of glaucoma is prescribed pilocarpine eye drops. The nurse should educate the client about:

A) Blurred vision

B) Increased blood pressure

C) Dry eyes

D) Pupillary dilation

Answer: A) Blurred vision

Rationale: Blurred vision is a common side effect. The client must know this. Blurred vision is normal.

A client with a diagnosis of pancreatitis is prescribed NPO (nothing by mouth) status. The nurse should:

A) Encourage the client to ambulate as tolerated

B) Monitor the client's blood glucose levels

C) Provide frequent mouth care

D) All of the above

Answer: D) All of the above

Rationale: The client needs good mouth care. The client will ambulate. This all is important.

A client with a history of chronic kidney disease is undergoing hemodialysis. The nurse should assess for:

A) Hypotension

B) Muscle cramps

C) Disequilibrium syndrome

D) All of the above

Answer: D) All of the above

Rationale: All are possible complications. These are all important to watch for. All need to be watched for.

A client with a new tracheostomy is being suctioned. The nurse should:

A) Apply suction while inserting the catheter.

B) Suction for more than 15 seconds at a time.

C) Allow for rest periods between suctioning attempts.

D) Use sterile gloves to prevent infection.

Answer: C) Allow for rest periods between suctioning attempts.

Rationale: The client needs to rest between attempts. This is important to allow the client to rest. Rest is very important.

A client with a diagnosis of Addison's disease is experiencing hypotension and weakness. The nurse should anticipate:

A) Administering intravenous fluids.

B) Administering oral glucose.

C) Restricting fluid intake.

D) Administering a beta-blocker.

Answer: A) Administering intravenous fluids.

Rationale: These patients are low on steroids. The client needs fluids. Fluids are important.

A client with a history of diabetes is found to have a blood glucose of 400 mg/dL and is confused. The nurse's priority action is to:

A) Administer insulin

B) Check the client's urine for ketones

C) Assess the client's level of consciousness

D) Encourage the client to drink fluids

Answer: C) Assess the client's level of consciousness

Rationale: Assessment is always the first step. The nurse must assess the patient. The client must be assessed.

A client with a history of heart failure is experiencing pulmonary edema. The nurse should:

A) Place the client in a supine position.

B) Administer oxygen as prescribed.

C) Restrict fluid intake.

D) Encourage the client to cough.

Answer: B) Administer oxygen as prescribed.

Rationale: The client is having difficulty breathing. The client needs oxygen. This client needs oxygen.

A client with a closed head injury has a GCS score of 12. The nurse should:

A) Monitor the client closely

B) Encourage the client to ambulate

C) Administer pain medication

D) Discharge the client

Answer: A) Monitor the client closely

Rationale: This patient needs to be monitored closely. These patients need to be assessed. This patient must be monitored.

A client with a history of seizures is taking carbamazepine. The nurse should instruct the client to:

A) Avoid grapefruit juice

B) Monitor for signs of liver dysfunction

C) Take the medication with food

D) Discontinue the medication if the seizures are controlled

Answer: B) Monitor for signs of liver dysfunction

Rationale: This can affect the liver. This is an important side effect. The client must monitor for it.

A client with a new ileostomy is taught about self-care. Which statement indicates a need for more teaching?

A) "I should empty the pouch when it's one-third full."

B) "I will use soap and water to clean the stoma."

C) "I can irrigate the stoma to regulate bowel movements."

D) "I should call my doctor if my stoma is very dark or purple."

Answer: C) "I can irrigate the stoma to regulate bowel movements."

Rationale: Colostomies are irrigated. This is not the case with an ileostomy. This is a false statement.

A client with a history of hypertension is prescribed a beta-blocker. The nurse should monitor the client for:

A) Increased heart rate

B) Orthostatic hypotension

C) Hyperglycemia

D) Increased blood pressure

Answer: B) Orthostatic hypotension

Rationale: Beta-blockers can affect the heart. This is a possible side effect. The client must be monitored.

Section 2: Childbirth and Reproductive Health (250 Questions)

****Pregnancy & Antepartum Care (50 questions)****

1. A pregnant woman at 32 weeks gestation reports experiencing sudden, severe abdominal pain. The nurse should first:

A) Assess fetal heart rate.

B) Palpate the abdomen for contractions.

C) Ask about vaginal bleeding.

D) Prepare for an emergency delivery.

Answer: A) Assess fetal heart rate.

Rationale: Abdominal pain warrants immediate assessment of fetal well-being. Ruling out fetal distress is the priority action. This helps determine the next steps in care.

2. A client at 36 weeks' gestation is diagnosed with gestational diabetes. Which dietary recommendation is *most* important for the nurse to provide?

A) Increase carbohydrate intake.

B) Eat frequent, small meals.

C) Restrict fluid intake.

D) Avoid all sweets and fruits.

Answer: B) Eat frequent, small meals.

Rationale: Small, frequent meals help regulate blood glucose levels. This minimizes blood sugar spikes throughout the day. This reduces risk of complications.

3. During a prenatal visit, the nurse assesses a client at 16 weeks' gestation. Which finding is most concerning?

A) Quickening reported by the client.

B) Fundal height at 18 cm.

C) Fetal heart rate of 140 bpm.

D) Absence of fetal movement.

Answer: D) Absence of fetal movement.

Rationale: Fetal movement should be felt by 20 weeks' gestation. Absence of fetal movement at this time could indicate a problem. Further assessment, like ultrasound, is needed.

4. A pregnant client is Rh negative. To prevent isoimmunization, the nurse should anticipate administering:

A) Magnesium sulfate

B) Betamethasone

C) Rho(D) immune globulin

D) Oxytocin

Answer: C) Rho(D) immune globulin

Rationale: Rho(D) immune globulin prevents antibody formation. Administering this protects future pregnancies. It’s given around 28 weeks and after delivery.

5. A client in her first trimester reports experiencing nausea and vomiting. The nurse should advise her to:

A) Eat three large meals a day.

B) Avoid crackers and dry toast.

C) Drink fluids between meals.

D) Lie down after eating.

Answer: C) Drink fluids between meals.

Rationale: Fluids between meals can prevent overfilling the stomach. Small sips help prevent nausea. It also reduces dehydration.

6. A pregnant client with a history of hypertension asks about medication safety. The nurse should explain that which antihypertensive medication is commonly used and considered safe during pregnancy?

A) Lisinopril

B) Atenolol

C) Losartan

D) Enalapril

Answer: B) Atenolol

Rationale: Atenolol is a beta-blocker that's often safely used during pregnancy. Other medications are generally contraindicated. This is because they can harm the fetus.

7. A pregnant client reports a "gush of fluid" from her vagina. The nurse's *priority* action is to:

A) Assess fetal heart rate.

B) Perform a sterile vaginal exam.

C) Determine the color of the fluid.

D) Notify the healthcare provider.

Answer: A) Assess fetal heart rate.

Rationale: The priority is to evaluate fetal well-being first. Rupture of membranes raises concerns about cord prolapse. This can lead to fetal distress.

8. A client at 38 weeks' gestation is experiencing contractions every 3 minutes lasting 60 seconds. Her cervix is dilated 4 cm. The nurse should:

A) Encourage the client to go home.

B) Monitor the client's fetal heart rate.

C) Administer medication to stop contractions.

D) Prepare for an immediate cesarean section.

Answer: B) Monitor the client's fetal heart rate.

Rationale: This client is in active labor. Fetal heart rate monitoring is essential. This ensures the fetus is tolerating labor.

9. A pregnant client is scheduled for an amniocentesis. The nurse should inform the client that the primary purpose of this procedure is to:

A) Determine fetal lung maturity.

B) Assess fetal movement.

C) Visualize the fetus.

D) Measure the size of the uterus.

Answer: A) Determine fetal lung maturity.

Rationale: Amniocentesis assesses fetal lung maturity. The result helps with delivery timing. This reduces the risk of respiratory distress.

10. A client at 20 weeks' gestation reports experiencing painless vaginal bleeding. The nurse should:

A) Document the findings.

B) Assess vital signs and fetal heart rate.

C) Instruct the client to take bed rest at home.

D) Prepare the client for a cervical exam.

Answer: B) Assess vital signs and fetal heart rate.

Rationale: Vaginal bleeding needs further evaluation. Assess maternal and fetal status quickly. This helps determine if the patient is stable.

11. During a prenatal visit, the nurse assesses the client's blood pressure to be 140/90 mmHg. The nurse should:

A) Document the finding as normal.

B) Retake the blood pressure after 5 minutes.

C) Instruct the client to avoid salt in her diet.

D) Inform the client that she is experiencing preeclampsia.

Answer: B) Retake the blood pressure after 5 minutes.

Rationale: One high blood pressure reading does not diagnose preeclampsia. Retake it to confirm sustained elevation. Further evaluation may be necessary.

12. A pregnant client is experiencing hyperemesis gravidarum. The nurse should prioritize which intervention?

A) Encouraging oral fluid intake.

B) Monitoring intake and output.

C) Providing antiemetic medication.

D) Assessing the client's weight.

Answer: B) Monitoring intake and output.

Rationale: This allows for tracking fluid balance. The intervention helps to assess the client's hydration. It aids in evaluating for signs of dehydration.

13. A pregnant client with gestational diabetes asks the nurse about exercise. The nurse should advise her that:

A) Exercise is not recommended.

B) Exercise should be avoided after meals.

C) Regular exercise can help control blood sugar.

D) Exercise should only be done after insulin administration.

Answer: C) Regular exercise can help control blood sugar.

Rationale: Regular exercise can improve insulin sensitivity. It assists in managing blood glucose levels. This also aids in avoiding complications.

14. A client at 34 weeks' gestation is diagnosed with placenta previa. The nurse should instruct the client to:

A) Avoid sexual intercourse.

B) Increase her fluid intake.

C) Monitor fetal movement daily.

D) Prepare for an induction of labor.

Answer: A) Avoid sexual intercourse.

Rationale: Sexual intercourse can lead to bleeding. Bleeding could worsen placenta previa. This protects the placenta.

15. A client at 30 weeks' gestation is admitted for preterm labor. The nurse anticipates administering:

A) Oxytocin.

B) Magnesium sulfate.

C) Betamethasone.

D) Misoprostol.

Answer: C) Betamethasone.

Rationale: Betamethasone promotes fetal lung maturity. Administering it helps prevent respiratory distress syndrome. This reduces neonatal morbidity.

16. A pregnant client is concerned about weight gain during pregnancy. The nurse should advise her that the recommended total weight gain for a woman with a normal BMI is:

A) 10-20 pounds

B) 15-25 pounds

C) 25-35 pounds

D) 35-45 pounds

Answer: C) 25-35 pounds

Rationale: This guideline promotes a healthy pregnancy. It supports fetal growth and development. This also minimizes maternal health risks.

17. The nurse is educating a pregnant client about warning signs that need immediate medical attention. Which of the following signs should be included in the teaching?

A) Mild swelling in the ankles.

B) Heartburn after meals.

C) Vaginal bleeding.

D) Increased frequency of urination.

Answer: C) Vaginal bleeding.

Rationale: Vaginal bleeding is an emergency. This can signal a complication. Immediate evaluation is required.

18. A client at 35 weeks' gestation is diagnosed with preeclampsia. The nurse anticipates:

A) Administering oxytocin.

B) Administering magnesium sulfate.

C) Initiating induction of labor.

D) Placing the client on bed rest.

Answer: B) Administering magnesium sulfate.

Rationale: Magnesium sulfate prevents seizures in preeclampsia. Administering this protects the client's safety. This also treats the severe symptoms.

19. The nurse is teaching a pregnant client about the importance of folic acid. Which of the following should be included in the teaching?

A) Folic acid helps reduce the risk of neural tube defects.

B) Folic acid helps prevent gestational diabetes.

C) Folic acid helps improve milk supply.

D) Folic acid prevents postpartum hemorrhage.

Answer: A) Folic acid helps reduce the risk of neural tube defects.

Rationale: Folic acid prevents neural tube defects in the fetus. It is crucial for early fetal development. This reduces the risk of birth defects.

20. A pregnant client reports feeling dizzy and lightheaded. The nurse should advise her to:

A) Continue with her daily activities.

B) Lie on her back.

C) Sit or lie down on her side.

D) Take a deep breath and continue walking.

Answer: C) Sit or lie down on her side.

Rationale: These actions can improve circulation. Side-lying prevents vena cava compression. This helps reduce symptoms of dizziness.

21. A pregnant client is experiencing contractions. The nurse notes that the contractions are 5 minutes apart, lasting 45 seconds, and of moderate intensity. What is the next action by the nurse?

A) Prepare the client for an immediate cesarean section.

B) Encourage the client to walk around.

C) Perform a sterile vaginal exam.

D) Administer pain medication.

Answer: C) Perform a sterile vaginal exam.

Rationale: This will assess the cervix. This determines the stage of labor. This guides further management.

22. A pregnant client is experiencing a non-stress test (NST). The nurse should explain to the client that the purpose of the NST is to:

A) Assess the fetal heart rate in response to fetal movement.

B) Determine the baby's gestational age.

C) Assess the mother's blood pressure.

D) Measure the amniotic fluid volume.

Answer: A) Assess the fetal heart rate in response to fetal movement.

Rationale: A reactive NST is a good sign. This indicates fetal well-being. This helps evaluate fetal oxygenation.

23. A client at 39 weeks' gestation asks about the signs of labor. The nurse should include which of the following in the teaching?

A) Decreased frequency of fetal movement.

B) Increased energy levels.

C) Rupture of membranes.

D) A decrease in vaginal discharge.

Answer: C) Rupture of membranes.

Rationale: Rupture of membranes is a sign of labor. Other signs include regular contractions. This requires a prompt assessment.

24. A pregnant client reports severe headache, visual disturbances, and epigastric pain. The nurse should:

A) Document the findings and reassure the client.

B) Assess the client's blood pressure.

C) Instruct the client to take an analgesic.

D) Prepare the client for a non-stress test.

Answer: B) Assess the client's blood pressure.

Rationale: These are signs of preeclampsia. Blood pressure must be measured. Immediate intervention may be needed.

25. A pregnant client is experiencing an ectopic pregnancy. The nurse recognizes that this condition occurs when:

A) The fetus is not viable.

B) The placenta is located in the lower uterus.

C) The fertilized egg implants outside the uterus.

D) The umbilical cord is wrapped around the fetus's neck.

Answer: C) The fertilized egg implants outside the uterus.

Rationale: This can be life-threatening for the client. Ectopic pregnancies often require intervention. This ensures client safety.

26. A pregnant client is diagnosed with iron-deficiency anemia. The nurse should advise the client to take which supplement?

A) Calcium

B) Vitamin C

C) Folic Acid

D) Iron

Answer: D) Iron

Rationale: Iron supplements treat anemia. The iron increases red blood cell production. Vitamin C enhances iron absorption.

27. A pregnant client is reporting fetal movement. When is the best time to instruct the client to count fetal movement?

A) Immediately after meals

B) After going to sleep

C) At the same time each day

D) Every hour of the day

Answer: C) At the same time each day

Rationale: Counting at a regular time is easiest. A consistent schedule helps track the fetal well-being. This also allows for comparison over time.

28. A client with a history of recurrent urinary tract infections (UTIs) is pregnant. Which instruction is most important for the nurse to provide?

A) Avoid drinking cranberry juice.

B) Increase fluid intake.

C) Limit the use of public restrooms.

D) Avoid wearing cotton underwear.

Answer: B) Increase fluid intake.

Rationale: This will assist with preventing UTIs. Increased fluids help flush the bladder. This also reduces bacterial growth.

29. A client is prescribed an oxytocin infusion. The nurse should closely monitor for which potential complication?

A) Fetal bradycardia

B) Uterine rupture

C) Hypertension

D) Postpartum hemorrhage

Answer: B) Uterine rupture

Rationale: Oxytocin increases uterine contractions. Excessive stimulation can lead to rupture. This is dangerous for the mother and baby.

30. A client at 39 weeks' gestation is admitted in labor. The nurse notes the client's membranes have ruptured. What is the first assessment the nurse should perform?

A) Take the client's temperature.

B) Palpate the client's abdomen.

C) Assess fetal heart rate.

D) Perform a sterile vaginal exam.

Answer: C) Assess fetal heart rate.

Rationale: This is the most important assessment. This confirms fetal well-being. This rules out cord prolapse.

31. A pregnant client is scheduled for a biophysical profile. The nurse should explain to the client that the purpose of this test is to:

A) Measure amniotic fluid volume

B) Assess fetal heart rate reactivity.

C) Evaluate fetal breathing movements.

D) All of the above.

Answer: D) All of the above.

Rationale: Biophysical profile evaluates fetal well-being. It combines several assessment criteria. This gives a comprehensive overview.

32. A client is 8 cm dilated and feels the urge to push. The nurse should:

A) Encourage the client to hold her breath and push with each contraction.

B) Encourage the client to pant and blow to prevent pushing.

C) Allow the client to push as she feels the urge.

D) Give pain medication to slow the contractions.

Answer: C) Allow the client to push as she feels the urge.

Rationale: The urge to push is natural. The client's body is ready to move. This action helps deliver the baby.

33. A client is receiving magnesium sulfate for preeclampsia. Which assessment is of *highest* priority?

A) Deep tendon reflexes

B) Blood pressure

C) Level of consciousness

D) Urine output

Answer: A) Deep tendon reflexes

Rationale: Magnesium toxicity affects reflexes. The loss of reflexes is concerning. Monitoring ensures the client's safety.

34. A pregnant client has a positive result for Group B Streptococcus (GBS). The nurse should anticipate administering which medication during labor?

A) Ampicillin

B) Ceftriaxone

C) Azithromycin

D) Vancomycin

Answer: A) Ampicillin

Rationale: Ampicillin treats GBS. It prevents neonatal infection. This reduces risk to the baby.

35. A client at 36 weeks' gestation reports decreased fetal movement. The nurse should advise the client to:

A) Drink a sugary drink and lie on her side.

B) Increase her daily caloric intake.

C) Call the provider for an immediate ultrasound.

D) Avoid caffeine and alcohol.

Answer: A) Drink a sugary drink and lie on her side.

Rationale: Sugar can increase fetal movement. Lying on side improves blood flow. Further assessment might be necessary.

36. A pregnant client is experiencing shoulder dystocia during delivery. The nurse's *priority* action is to:

A) Apply fundal pressure.

B) Assist with the McRoberts maneuver.

C) Call for the provider.

D) Assess the fetal heart rate.

Answer: B) Assist with the McRoberts maneuver.

Rationale: This maneuver helps resolve dystocia. Time is critical for delivery. This prevents fetal injury.

37. The nurse is assessing a pregnant client's fundal height at 24 weeks gestation. The nurse should expect to find the fundus at:

A) The level of the umbilicus.

B) 20 cm.

C) 24 cm.

D) Above the umbilicus.

Answer: C) 24 cm.

Rationale: Fundal height should match the gestational age. This is approximately in centimeters. This provides a good assessment.

38. A client is in the second stage of labor and is complaining of intense back pain. The nurse should:

A) Encourage the client to ambulate.

B) Assess the fetal heart rate.

C) Apply counter pressure to the client's sacrum.

D) Administer a sedative.

Answer: C) Apply counter pressure to the client's sacrum.

Rationale: Sacral pressure can relieve pain. It is a non-pharmacological intervention. This is particularly useful for back labor.

39. A pregnant client is diagnosed with gestational hypertension. The nurse should advise the client to:

A) Increase sodium intake.

B) Rest on her right side.

C) Monitor her blood pressure daily.

D) Drink alcohol in moderation.

Answer: C) Monitor her blood pressure daily.

Rationale: This is a critical monitoring step. Hypertension requires careful management. This helps prevent preeclampsia.

40. A pregnant client is experiencing signs of a breech presentation. The nurse anticipates:

A) An immediate cesarean section.

B) Monitoring the fetal heart rate.

C) Preparing for an external cephalic version.

D) Educating the client on pain medications.

Answer: C) Preparing for an external cephalic version.

Rationale: This may be an option to try turning. It improves chance of vaginal delivery. This intervention can improve the outcome.

41. A client at 39 weeks' gestation is reporting contractions. The nurse performs a vaginal exam and notes the client is 4 cm dilated, 80% effaced, and the presenting part is at 0 station. Which stage of labor is the client in?

A) Stage 1, latent phase.

B) Stage 1, active phase.

C) Stage 2, pushing phase.

D) Stage 3, placental phase.

Answer: B) Stage 1, active phase.

Rationale: These findings suggest active labor. This is indicated by dilation and effacement. This indicates progression in labor.

42. A pregnant client, who is 37 weeks pregnant, reports bright red vaginal bleeding. The nurse should:

A) Encourage the client to ambulate.

B) Perform a vaginal exam to assess cervical dilation.

C) Assess fetal heart tones.

D) Administer medication to stop the contractions.

Answer: C) Assess fetal heart tones.

Rationale: Bleeding can be caused by several issues. Assessing fetal heart tones helps to check fetal well being. This ensures an assessment of the baby.

43. A pregnant client asks about the risks of smoking during pregnancy. Which of the following should the nurse include in the teaching?

A) Increased risk of preeclampsia.

B) Increased risk of gestational diabetes.

C) Increased risk of preterm labor.

D) All of the above.

Answer: D) All of the above.

Rationale: Smoking during pregnancy is harmful. It increases various risks. Education is vital.

44. A client in the third trimester experiences shortness of breath and chest pain. The nurse should suspect:

A) An ectopic pregnancy.

B) Pulmonary embolism.

C) Preterm labor.

D) Placenta previa.

Answer: B) Pulmonary embolism.

Rationale: This is a medical emergency. It's a serious complication of pregnancy. Prompt action is needed.

45. A client is experiencing oligohydramnios. The nurse should anticipate:

A) The fetus being macrosomic.

B) The fetus being at risk for cord compression.

C) Increased fetal movement.

D) The need to induce labor.

Answer: B) The fetus being at risk for cord compression.

Rationale: Oligohydramnios means low amniotic fluid. This increases the risk of cord compression. This may need further monitoring.

46. A pregnant client is experiencing fetal distress. The nurse's initial action should be to:

A) Administer oxygen to the client.

B) Turn the client to the left lateral position.

C) Increase the oxytocin infusion.

D) Prepare for a cesarean section.

Answer: B) Turn the client to the left lateral position.

Rationale: This improves fetal oxygenation. It relieves pressure on the vena cava. This helps restore blood flow.

47. A client is 41 weeks pregnant. The nurse should be prepared to:

A) Encourage the client to drink more fluids.

B) Prepare the client for induction of labor.

C) Assess the fetal heart rate frequently.

D) Teach the client about the signs of preterm labor.

Answer: B) Prepare the client for induction of labor.

Rationale: Post term pregnancies have risks. Induction reduces the risk of complications. Induction should be considered.

48. A pregnant client is planning on traveling by air. The nurse should advise the client to:

A) Avoid wearing compression stockings.

B) Stay hydrated.

C) Walk the plane aisles as much as possible.

D) Sit in a window seat.

Answer: B) Stay hydrated.

Rationale: The air can be drying during flights. Dehydration increases the risk of complications. Hydration is very important.

49. A pregnant client reports signs and symptoms of a urinary tract infection (UTI). The nurse should anticipate:

A) Administering antibiotics.

B) Teaching the client about the importance of increased fluid intake.

C) Ordering a urine culture and sensitivity.

D) All of the above.

Answer: D) All of the above.

Rationale: UTIs require prompt attention. Proper treatment and education is key. This helps prevent further issues.

50. A client is receiving a tocolytic medication to stop preterm labor. The nurse should closely monitor the client for:

A) Uterine contractions

B) Hypotension

C) Fetal bradycardia

D) Maternal hypertension

Answer: B) Hypotension

Rationale: Tocolytics can cause side effects. Hypotension is a possible side effect. Monitoring is essential for safety.

Labor & Delivery (50 questions)

1. During the second stage of labor, the nurse should encourage the client to:

A) Breathe rapidly and shallowly.

B) Push with each contraction.

C) Avoid all physical activity.

D) Rest and conserve energy.

Answer: B) Push with each contraction.

Rationale: Pushing is essential for delivery. Coordinate pushing with contractions. This helps to deliver the baby.

2. The nurse is caring for a client during the latent phase of labor. The nurse should:

A) Encourage the client to ambulate.

B) Prepare for a cesarean section.

C) Administer pain medication to stop contractions.

D) Discourage the client from eating.

Answer: A) Encourage the client to ambulate.

Rationale: Ambulation can promote labor progress. Ambulation assists with dilation and descent. This can help to facilitate labor.

3. A client's amniotic membranes rupture. The priority nursing action is to:

A) Assess fetal heart rate.

B) Perform a vaginal exam.

C) Document the color of the fluid.

D) Encourage the client to walk.

Answer: A) Assess fetal heart rate.

Rationale: Fetal heart rate confirms fetal well-being. Rupture of membranes raises concern for cord prolapse. This is the priority assessment.

4. The nurse notes late decelerations on the fetal monitor. The nurse should immediately:

A) Continue to monitor the fetal heart rate.

B) Notify the healthcare provider.

C) Administer oxygen to the client.

D) Encourage the client to change positions.

Answer: C) Administer oxygen to the client.

Rationale: Late decelerations indicate fetal distress. Oxygen can improve fetal oxygenation. This is the initial intervention.

5. A client is in active labor and is experiencing back labor. The nurse should:

A) Apply fundal pressure.

B) Encourage the client to lie on her back.

C) Apply counter pressure to the client's sacrum.

D) Offer a cold compress to the perineum.

Answer: C) Apply counter pressure to the client's sacrum.

Rationale: Back labor causes back pain. Counter pressure provides relief. This comforts the client.

6. The nurse notes variable decelerations on the fetal monitor. The nurse should first:

A) Administer oxygen to the client.

B) Reposition the client.

C) Notify the healthcare provider.

D) Perform a vaginal exam.

Answer: B) Reposition the client.

Rationale: Variable decelerations can indicate cord compression. Repositioning can relieve compression. This is the first intervention.

7. A client is experiencing a prolapsed umbilical cord. The nurse's *immediate* action is to:

A) Administer oxygen to the client.

B) Place the client in Trendelenburg position.

C) Prepare for a cesarean section.

D) Apply fundal pressure.

Answer: cccccbgnngghcelhidfgkedcgcdunkrlrljnvidljrfg

Cccccbgnngghfhiljfubguihfdglcuevknrfkivtivhv

B) Place the client in Trendelenburg position.

Rationale: This position relieves cord pressure. It also maintains blood flow to the fetus. Time is critical.

8. A client is being induced with oxytocin. The nurse should monitor:

A) Fetal heart rate and uterine contractions.

B) The client's temperature.

C) The client's nutritional intake.

D) The client's intake and output.

Answer: A) Fetal heart rate and uterine contractions.

Rationale: Oxytocin increases uterine contractions. Monitoring ensures the safety of mother and baby. This helps prevent adverse events.

9. The nurse is assisting with a vaginal delivery. As the fetal head crowns, the nurse should:

A) Encourage the client to push.

B) Apply fundal pressure.

C) Instruct the client to pant and blow.

D) Tell the client to hold her breath.

Answer: C) Instruct the client to pant and blow.

Rationale: Panting helps control the delivery. It prevents rapid expulsion. This reduces perineal tearing.

10. A client has just delivered a baby. The nurse assesses for postpartum hemorrhage by:

A) Monitoring the client's blood pressure.

B) Assessing the fundus for firmness.

C) Asking the client if she is feeling well.

D) Counting the number of vaginal pads.

Answer: B) Assessing the fundus for firmness.

Rationale: A firm fundus indicates good uterine contraction. It prevents excessive bleeding. This assesses for postpartum hemorrhage.

11. The nurse is caring for a client who has had an episiotomy. The nurse should instruct the client to:

A) Apply a warm compress to the perineum.

B) Avoid sitz baths.

C) Use ice packs to the perineum.

D) Encourage frequent ambulation.

Answer: C) Use ice packs to the perineum.

Rationale: Ice packs reduce swelling and pain. This aids in healing and comfort. This promotes recovery.

12. A client is requesting an epidural. The nurse should explain that the primary purpose of the epidural is to:

A) Prevent the need for a cesarean section.

B) Relieve pain during labor.

C) Increase the speed of labor.

D) Make the client more alert.

Answer: B) Relieve pain during labor.

Rationale: The epidural is a pain management technique. It allows the client to have comfort. This assists the client during labor.

13. A client is in the third stage of labor. The nurse is monitoring for signs of placental separation. Which of the following is a sign of placental separation?

A) The fundus becomes soft.

B) A gush of dark red blood.

C) The fetal heart rate increases.

D) The mother develops a fever.

Answer: B) A gush of dark red blood.

Rationale: This is a sign the placenta has detached. It is followed by expulsion. This indicates the process is occurring.

14. A client is experiencing shoulder dystocia. The nurse should anticipate assisting with which maneuver?

A) Leopold's maneuver

B) McRoberts maneuver

C) Fundal pressure

D) External cephalic version

Answer: B) McRoberts maneuver

Rationale: This is a key intervention for dystocia. It involves positioning the client. This helps with delivery.

15. The nurse is assisting with a newborn resuscitation. Which of the following is the *priority* action?

A) Administering medications.

B) Providing warmth.

C) Stimulating the newborn.

D) Establishing an airway.

Answer: D) Establishing an airway.

Rationale: Airway is the priority in resuscitation. It provides the most essential function. This provides ventilation and oxygenation.

16. A client is complaining of perineal pain after delivery. The nurse should:

A) Administer pain medication.

B) Encourage the client to ambulate.

C) Apply an ice pack to the perineum.

D) All of the above.

Answer: D) All of the above.

Rationale: This provides comprehensive pain relief. It helps to promote healing. This helps to manage comfort.

17. The nurse is caring for a client during the fourth stage of labor. The nurse should:

A) Monitor the mother's vital signs.

B) Encourage the mother to sleep.

C) Provide the mother with a heavy meal.

D) Begin to prepare the mother for discharge.

Answer: A) Monitor the mother's vital signs.

Rationale: This assesses the mother's stability. It identifies complications. This is essential care.

18. A client is being monitored with continuous fetal monitoring. Which of the following is a benefit of continuous fetal monitoring?

A) It restricts the client's mobility.

B) It increases the risk of cesarean sections.

C) It provides a continuous assessment of fetal well-being.

D) It requires frequent vaginal exams.

Answer: C) It provides a continuous assessment of fetal well-being.

Rationale: This allows for quick identification of any problems. This offers a comprehensive assessment of the baby. This helps prevent any complications.

19. A client is experiencing prolonged deceleration on the fetal monitor. The nurse should:

A) Continue to monitor the client.

B) Administer oxygen to the client.

C) Place the client in the supine position.

D) Encourage the client to push.

Answer: B) Administer oxygen to the client.

Rationale: This helps improve fetal oxygenation. This is a key intervention. This assists the baby.

20. A client is pushing during the second stage of labor. The nurse observes the client's face is becoming red and the client is holding her breath. The nurse should encourage the client to:

A) Push for a longer amount of time.

B) Continue to hold her breath.

C) Take a deep breath and push.

D) Stop pushing and rest.

Answer: C) Take a deep breath and push.

Rationale: Proper breathing helps pushing. This improves oxygenation. This will help delivery.

21. A client is experiencing uterine atony after delivery. The nurse's initial action is:

A) Administering intravenous fluids.

B) Massaging the fundus.

C) Checking the client's blood pressure.

D) Administering oxygen to the client.

Answer: B) Massaging the fundus.

Rationale: This is done to encourage contraction. This prevents excessive blood loss. This is a very important assessment.

22. A client is undergoing an amnioinfusion. The nurse should monitor the client for:

A) Uterine rupture

B) Fetal bradycardia

C) Signs of infection

D) All of the above

Answer: D) All of the above

Rationale: These are all potential complications. The amnioinfusion may increase risk. This helps determine client safety.

23. The nurse is caring for a client who is undergoing a vacuum-assisted delivery. The nurse should assess the newborn for:

A) Cephalohematoma

B) Caput succedaneum

C) Facial paralysis

D) All of the above

Answer: D) All of the above

Rationale: These are potential risks. The nurse can assess for any complications. This is a key part of the post-delivery process.

24. A client is experiencing precipitous labor. The nurse should:

A) Slow down the client's contractions.

B) Prepare for a prolonged labor.

C) Closely monitor the client and fetus.

D) Discourage the client from pushing.

Answer: C) Closely monitor the client and fetus.

Rationale: Labor is progressing very quickly. This requires constant assessment. This is essential to monitor for complications.

25. The nurse is caring for a client who is experiencing preterm labor. The nurse should instruct the client to:

A) Avoid lying on her side.

B) Limit fluid intake.

C) Report any vaginal bleeding.

D) Maintain a full bladder.

Answer: C) Report any vaginal bleeding.

Rationale: Vaginal bleeding can be a sign of problems. Reporting helps get treatment. This is essential to monitor for complications.

26. A client is scheduled for a cesarean delivery. The nurse should assess the client for:

A) The need for pain medication.

B) Allergies.

C) Signs and symptoms of active labor.

D) All of the above.

Answer: D) All of the above.

Rationale: All assessments help to determine the client's health. This is essential to prepare for surgery. This helps determine if the surgery can happen safely.

27. A client is receiving an epidural during labor. The nurse should monitor the client's:

A) Blood pressure.

B) Fetal heart rate.

C) Bladder distention.

D) All of the above.

Answer: D) All of the above.

Rationale: These are key monitoring areas. An epidural can affect these functions. This helps determine if the patient is stable.

28. A client is having a vaginal delivery. The nurse notices meconium-stained amniotic fluid. The nurse should:

A) Reassure the client.

A) Continue to monitor the fetal heart rate.

B) Prepare for an emergency cesarean section.

C) Administer oxygen to the client.

D) Notify the healthcare provider.

Answer: D) Notify the healthcare provider.

Rationale: This could indicate fetal distress. The provider must be notified. This allows the provider to assess the situation.

29. A client is experiencing a post-partum hemorrhage. The nurse is massaging the fundus. What other intervention should the nurse perform?

A) Administering oxygen

B) Checking vital signs

C) Assessing for bladder distention

D) All of the above

Answer: D) All of the above

Rationale: The nurse must take all actions. These actions will ensure the client's safety. These actions also help to assess the client.

30. A newborn's heart rate is 80 beats per minute. The nurse should:

A) Continue to monitor the newborn.

B) Begin resuscitation.

C) Stimulate the newborn.

D) Assess the newborn's respirations.

Answer: B) Begin resuscitation.

Rationale: 80 bpm is below the normal range. Resuscitation should start. This can improve the baby's health.

31. The nurse is teaching a client about the use of a fetal monitor. The nurse should explain that:

A) The fetal monitor will prevent the client from walking around.

B) The fetal monitor will only measure the client's contractions.

C) The fetal monitor can provide a continuous assessment of the baby.

D) The fetal monitor will decrease the need for vaginal exams.

Answer: C) The fetal monitor can provide a continuous assessment of the baby.

Rationale: Continuous monitoring can help provide the best care. This is also important for the health of the baby. This helps reduce complications.

32. A client has just given birth and is complaining of chills and shaking. The nurse should:

A) Offer the client a warm blanket.

B) Reassure the client this is normal.

C) Take the client's temperature.

D) All of the above.

Answer: D) All of the above.

Rationale: All actions are important. This reassures the client. This assesses if the client has a fever.

33. The nurse is caring for a client with an intrauterine fetal demise. The nurse should:

A) Avoid talking to the client about the baby.

B) Encourage the client to have an immediate induction.

C) Provide emotional support to the client.

D) Tell the client to stay positive.

Answer: C) Provide emotional support to the client.

Rationale: This is a difficult situation. The nurse must provide support. This allows the client to grieve.

34. A client is experiencing a prolonged second stage of labor. The nurse should:

A) Encourage the client to push harder.

B) Suggest that the client has a cesarean section.

C) Assess the fetal heart rate and the mother's vital signs.

D) Stop encouraging the client to push.

Answer: C) Assess the fetal heart rate and the mother's vital signs.

Rationale: These assessments will determine what is happening. Further action depends on the assessments. This helps decide how the client is doing.

35. A client's labor is being augmented with oxytocin. The nurse observes a sustained uterine contraction lasting longer than 90 seconds. The nurse should:

A) Continue the oxytocin infusion.

B) Increase the rate of the oxytocin infusion.

C) Stop the oxytocin infusion.

D) Notify the healthcare provider but continue the infusion.

Answer: C) Stop the oxytocin infusion.

Rationale: Prolonged contractions can be dangerous. This can compromise the fetus. Stopping oxytocin is the priority.

36. The nurse is assisting with a vaginal delivery. The fetal head is visible, but it retracts after each contraction. The nurse should suspect:

A) Shoulder dystocia.

B) Breech presentation.

C) Prolapsed cord.

D) Cephalopelvic disproportion (CPD).

Answer: A) Shoulder dystocia.

Rationale: This is turtle sign. This is the sign of shoulder dystocia. This is a medical emergency.

37. A client is in the third stage of labor. The nurse is waiting for the placenta to deliver. The nurse should:

A) Encourage the client to push.

B) Assess the fundus for signs of separation.

C) Administer oxytocin to stop the contractions.

D) Apply fundal pressure to deliver the placenta.

Answer: B) Assess the fundus for signs of separation.

Rationale: Signs will indicate placental separation. This helps manage the third stage of labor. This helps the nurse determine when to act.

38. A client has just delivered via cesarean section. The nurse should assess the incision for:

A) Redness.

B) Swelling.

C) Drainage.

D) All of the above.

Answer: D) All of the above.

Rationale: These are all signs of infection. The nurse has to assess the incision. This can determine if the patient is doing well.

39. A client delivers a newborn with a nuchal cord. The nurse should:

A) Cut the cord immediately.

B) Clamp and cut the cord.

C) Attempt to slip the cord over the head.

D) Call for help.

Answer: C) Attempt to slip the cord over the head.

Rationale: The cord must be moved. This will free the baby's neck. This is a priority action.

40. A client is receiving magnesium sulfate for preeclampsia. The nurse should monitor the client for which of the following signs of magnesium toxicity?

A) Hypertension

B) Hyperreflexia

C) Decreased respiratory rate

D) Increased urine output

Answer: C) Decreased respiratory rate

Rationale: This is a sign of toxicity. This indicates the medication level is too high. This requires immediate action.

41. The nurse notes the newborn has a bluish discoloration of the skin. The nurse knows this finding is called:

A) Acrocyanosis.

B) Jaundice.

C) Erythema toxicum.

D) Lanugo.

Answer: A) Acrocyanosis.

Rationale: This term is for bluish discoloration. It is often seen in newborns. This is an important assessment.

42. A client is experiencing a postpartum hemorrhage. The nurse should:

A) Monitor vital signs.

B) Palpate the fundus for firmness.

C) Assess the amount of vaginal bleeding.

D) All of the above.

Answer: D) All of the above.

Rationale: Assessment is very important. These assessments help to provide care. These actions help to assess the situation.

43. A client is experiencing a uterine prolapse. The nurse's first action is to:

A) Administer oxygen.

B) Assess vital signs.

C) Notify the healthcare provider.

D) Place the client in a supine position.

Answer: C) Notify the healthcare provider.

Rationale: This is a critical event. This allows the provider to take action. This requires immediate action.

44. A newborn is experiencing respiratory distress. The nurse should:

A) Encourage the mother to breastfeed.

B) Auscultate the lungs.

C) Assess for a nuchal cord.

D) Obtain a blood glucose level.

Answer: B) Auscultate the lungs.

Rationale: This assesses the baby's lung sounds. This can determine if the baby needs help. This helps to check for any issues.

45. The nurse is assisting with a vaginal delivery. The client is pushing and the fetal head is crowning. The nurse should:

A) Encourage the client to take short breaths.

B) Apply fundal pressure.

C) Instruct the client to push when they feel the urge.

D) Tell the client to hold her breath.

Answer: C) Instruct the client to push when they feel the urge.

Rationale: Allow the client to push. This can help with the delivery. This is a key part of this stage.

46. A newborn is experiencing cold stress. The nurse should:

A) Place the newborn under a radiant warmer.

B) Give the newborn a bath.

C) Avoid stimulating the newborn.

D) Decrease the newborn's fluid intake.

Answer: A) Place the newborn under a radiant warmer.

Rationale: Warming the baby is a priority. This helps the baby's temperature. This improves the baby's health.

47. A client is experiencing uterine inversion. The nurse should:

A) Massage the fundus.

B) Assess the client's blood pressure.

C) Administer oxygen.

D) All of the above.

Answer: D) All of the above.

Rationale: The nurse needs to take all actions. This will improve the client's health. This will assess the situation.

48. The nurse is assisting with a vaginal delivery. The client is experiencing a third-degree laceration. The nurse should:

A) Encourage the client to ambulate.

B) Apply ice packs to the perineum.

C) Assess the client's bowel sounds.

D) Teach the client about perineal care.

Answer: B) Apply ice packs to the perineum.

Rationale: Ice packs reduce swelling. The laceration needs care. This will assist with healing.

49. A client has had a cesarean section. The nurse is teaching the client about wound care. The nurse should instruct the client to:

A) Keep the incision site clean and dry.

B) Apply a heating pad to the incision site.

C) Soak in a tub bath.

D) Avoid walking.

Answer: A) Keep the incision site clean and dry.

Rationale: This helps to prevent infection. This will promote healing. This is a very important part of care.

50. A client is receiving epidural anesthesia. The nurse should monitor the client for:

A) Hypotension

B) Headache

C) Respiratory distress

D) All of the above

Answer: D) All of the above

Rationale: All of these can occur with an epidural. This will improve the patient's safety. This helps determine if the patient is stable.

Postpartum Care & Newborn Care (50 questions)

1. A postpartum client is experiencing heavy lochia rubra. The nurse should:

A) Document the finding.

B) Assess the client's fundus.

C) Encourage ambulation.

D) Instruct the client to empty her bladder.

Answer: B) Assess the client's fundus.

Rationale: The fundus controls bleeding. Heavy bleeding requires assessment. This can help to determine the cause.

2. The nurse is teaching a new mother about breastfeeding. Which instruction is most important?

A) Offer both breasts at each feeding.

B) Avoid supplementing with formula.

C) Feed the baby on demand.

D) Give the baby water after feeding.

Answer: C) Feed the baby on demand.

Rationale: This ensures the baby is fed enough. It also helps to establish milk supply. This is an important part of care.

3. A postpartum client reports perineal pain. The nurse should advise her to:

A) Apply a warm compress.

B) Sit in a warm tub bath.

C) Apply ice packs to the perineum.

D) Avoid sitting for long periods.

Answer: C) Apply ice packs to the perineum.

Rationale: This helps to reduce swelling. Ice packs offer pain relief. This promotes comfort.

4. The nurse is assessing a newborn's Apgar score. Which of the following is assessed?

A) Gestational age

B) Head circumference

C) Heart rate

D) Bilirubin level

Answer: C) Heart rate

Rationale: Apgar assesses newborn adaptation. Heart rate is a key component. This allows for a full assessment.

5. A postpartum client is experiencing engorgement. The nurse should advise her to:

A) Apply warm compresses.

B) Avoid frequent feedings.

C) Wear a tight bra.

D) Use ice packs and feed frequently.

Answer: D) Use ice packs and feed frequently.

Rationale: This will provide the most relief. Ice reduces swelling. Frequent feeding prevents buildup.

6. The nurse is educating a new mother on how to care for the umbilical cord. The nurse should instruct her to:

A) Keep the cord covered with a diaper.

B) Cleanse the cord with alcohol.

C) Avoid bathing the baby until the cord falls off.

D) Report any signs of infection, like redness.

Answer: D) Report any signs of infection, like redness.

Rationale: Infections are always concerning. Early reporting is essential. This helps with early treatment.

7. A newborn is exhibiting signs of hypoglycemia. The nurse should:

A) Administer oxygen.

B) Assess the newborn's temperature.

C) Feed the newborn.

D) Obtain a blood glucose level.

Answer: C) Feed the newborn.

Rationale: Feeding helps raise blood sugar. This provides energy to the baby. This is the priority intervention.

8. A postpartum client reports feeling overwhelmed and tearful. The nurse should:

A) Document the findings as normal.

B) Assess for signs of postpartum depression.

C) Reassure the client that it is a common feeling.

D) Encourage the client to take a nap.

Answer: B) Assess for signs of postpartum depression.

Rationale: Overwhelm and tearfulness can signal depression. Further assessment is needed. This helps with early diagnosis.

9. The nurse is assessing a newborn. Which finding requires immediate intervention?

A) Acrocyanosis

B) Heart rate of 110 bpm

C) Grunting respirations

D) Presence of lanugo

Answer: C) Grunting respirations

Rationale: This indicates respiratory distress. Immediate intervention is needed. This ensures that the baby is doing ok.

10. A postpartum client has a temperature of 100.4°F (38°C). The nurse should:

A) Encourage the client to drink more fluids.

B) Document the findings.

C) Assess for other signs of infection.

D) Administer an antipyretic medication.

Answer: C) Assess for other signs of infection.

Rationale: The temperature could indicate infection. Further assessment is important. This helps determine the cause.

11. The nurse is teaching the client about the benefits of breastfeeding. Which of the following benefits should the nurse include in the teaching?

A) It helps to prevent postpartum hemorrhage.

B) It provides the baby with passive immunity.

C) It decreases the mother's risk of gestational diabetes.

D) It prevents the baby from developing allergies.

Answer: B) It provides the baby with passive immunity.

Rationale: Breast milk offers immune protection. This is an important benefit. This is crucial for the newborn.

12. A newborn is being discharged home. The nurse should teach the parents to:

A) Give the baby a bath every day.

B) Place the baby on their stomach to sleep.

C) Place the baby on their back to sleep.

D) Swaddle the baby tightly.

Answer: C) Place the baby on their back to sleep.

Rationale: This reduces the risk of SIDS. This is a very important safety measure. This is the best position for sleeping.

13. A postpartum client is experiencing a deep vein thrombosis (DVT). The nurse should assess for which of the following signs and symptoms?

A) Pain and tenderness in the calf.

B) Edema in the ankles.

C) Redness and warmth of the leg.

D) All of the above.

Answer: D) All of the above.

Rationale: These are all signs of DVT. Further assessment is required. This helps provide care.

14. The nurse is caring for a newborn with hyperbilirubinemia. The nurse should anticipate:

A) Administering vitamin K.

B) Performing phototherapy.

C) Encouraging the mother to breastfeed frequently.

D) Providing the newborn with formula feedings.

Answer: B) Performing phototherapy.

Rationale: Phototherapy reduces bilirubin levels. This is the most effective treatment. This protects the newborn's brain.

15. A postpartum client is experiencing afterpains. The nurse should advise her to:

A) Avoid breastfeeding.

B) Apply heat to the abdomen.

C) Take ibuprofen.

D) All of the above.

Answer: D) All of the above.

Rationale: All can provide relief. These are all safe interventions. This offers options for the client.

16. A newborn is experiencing respiratory distress syndrome (RDS). The nurse should anticipate:

A) Administering oxygen.

B) Assessing the newborn's blood glucose.

C) Providing the newborn with formula.

D) Encouraging the mother to breastfeed.

Answer: A) Administering oxygen.

Rationale: RDS requires immediate intervention. Oxygen improves oxygenation. This will assist the baby.

17. The nurse is teaching the client about the signs and symptoms of mastitis. Which of the following should the nurse include in the teaching?

A) Breast tenderness

B) Flu-like symptoms

C) Redness and warmth of the breast

D) All of the above

Answer: D) All of the above

Rationale: These are all signs of mastitis. The client should be aware. This helps with early diagnosis and treatment.

18. A newborn is receiving phototherapy. The nurse should:

A) Cover the newborn's eyes.

B) Avoid feeding the newborn.

C) Apply lotion to the newborn's skin.

D) Encourage the mother to stop breastfeeding.

Answer: A) Cover the newborn's eyes.

Rationale: This protects the eyes from the light. This is very important during phototherapy. This prevents any damage to the eyes.

19. A postpartum client is concerned about her episiotomy. The nurse should advise her to:

A) Soak in a warm tub bath.

B) Keep the area clean and dry.

C) Avoid using a peri bottle.

D) Apply a heating pad.

Answer: B) Keep the area clean and dry.

Rationale: This promotes healing. This prevents infection. This is essential for recovery.

20. A newborn is experiencing hypoglycemia. The nurse should assess for which of the following signs and symptoms?

A) Jaundice

B) Irritability

C) Lethargy

D) All of the above

Answer: D) All of the above

Rationale: These can be signs of hypoglycemia. Assessment is very important. This helps to determine the next steps.

21. The nurse is teaching a client about contraception. Which of the following methods is *most* effective at preventing pregnancy?

A) Condoms

B) Oral Contraceptives

C) Withdrawal

D) Fertility awareness

Answer: B) Oral Contraceptives

Rationale: Oral contraceptives have high efficacy. This is if taken correctly. This is a very effective method.

22. A postpartum client is experiencing urinary incontinence. The nurse should:

A) Encourage the client to limit fluid intake.

B) Teach the client Kegel exercises.

C) Tell the client that this is a normal finding.

D) Avoid encouraging ambulation.

Answer: B) Teach the client Kegel exercises.

Rationale: Kegels strengthen pelvic muscles. This helps control incontinence. This is a very helpful intervention.

23. A newborn is receiving an intramuscular injection of vitamin K. The nurse should explain to the parents that the purpose of this medication is to:

A) Prevent infection.

B) Promote blood clotting.

C) Prevent jaundice.

D) Provide pain relief.

Answer: B) Promote blood clotting.

Rationale: Vitamin K prevents bleeding problems. This will help to prevent issues. This is crucial in newborns.

24. The nurse is assessing a postpartum client. Which finding requires further investigation?

A) Lochia serosa

B) Fundus at the umbilicus

C) Pedal edema

D) Temperature of 101°F (38.3°C)

Answer: D) Temperature of 101°F (38.3°C)

Rationale: This can indicate an infection. Further assessment is needed. This can lead to treatment.

25. A newborn is being circumcised. The nurse should:

A) Monitor for bleeding.

B) Teach the parents how to care for the circumcision site.

C) Apply petroleum jelly to the site.

D) All of the above

Answer: D) All of the above

Rationale: All actions are important. This protects the baby. This helps for healing.

26. A postpartum client is experiencing constipation. The nurse should advise her to:

A) Avoid drinking fluids.

B) Limit ambulation.

C) Increase fiber intake.

D) Take an antidiarrheal medication.

Answer: C) Increase fiber intake.

Rationale: This helps with bowel regularity. This is a helpful non-pharmacological intervention. This can help with comfort.

27. The nurse is assessing a newborn's head. The nurse notes a swelling on the scalp that crosses the suture lines. The nurse knows this finding is called:

A) Caput succedaneum.

B) Cephalohematoma.

C) Molding.

D) Subgaleal hemorrhage.

Answer: A) Caput succedaneum.

Rationale: This is a common finding. This is due to the delivery process. This is a key assessment.

28. A postpartum client is experiencing a postpartum hemorrhage. The nurse should:

A) Assess the client's vital signs.

B) Massage the fundus.

C) Assess for signs of shock.

D) All of the above.

Answer: D) All of the above.

Rationale: All actions are important. The nurse needs to provide care. The nurse needs to assess the situation.

29. A newborn is receiving a heel stick. The nurse should:

A) Use the inner aspect of the heel.

B) Apply a warm compress to the heel.

C) Cleanse the heel with alcohol.

D) All of the above.

Answer: D) All of the above.

Rationale: These actions are all correct. This makes the process easier. This is an important part of care.

30. A postpartum client is experiencing a positive Homans' sign. The nurse should:

A) Encourage the client to ambulate.

B) Elevate the client's legs.

C) Assess for signs of DVT.

D) Tell the client this is normal.

Answer: C) Assess for signs of DVT.

Rationale: This can be a sign of DVT. Assessment is very important. This can help with treatment.

31. The nurse is teaching a client about how to prevent mastitis. Which of the following should be included in the teaching?

A) Empty the breasts completely during feedings.

B) Wear a tight-fitting bra.

C) Avoid frequent feedings.

D) Stop breastfeeding if mastitis develops.

Answer: A) Empty the breasts completely during feedings.

Rationale: This prevents milk buildup. Milk buildup is a major cause. This can prevent infection.

32. A newborn is receiving a bath. The nurse should:

A) Use hot water.

B) Wash the newborn's face with soap.

C) Support the newborn's head and neck.

D) Submerge the newborn completely in water.

Answer: C) Support the newborn's head and neck.

Rationale: Newborns need head support. This helps to keep the baby safe. This is a key step.

33. A postpartum client is experiencing a perineal hematoma. The nurse should:

A) Encourage the client to ambulate.

B) Apply ice packs.

C) Administer an enema.

D) Tell the client this is normal.

Answer: B) Apply ice packs.

Rationale: Ice packs reduce swelling. This will help to ease pain. This is a safe intervention.

34. The nurse is assessing a newborn's skin. The nurse notes a rash on the newborn's skin. The nurse knows this finding is called:

A) Lanugo.

B) Vernix caseosa.

C) Erythema toxicum.

D) Milia.

Answer: C) Erythema toxicum.

Rationale: This rash is common in newborns. This is usually harmless. This is an important assessment.

35. A postpartum client is experiencing postpartum psychosis. The nurse should:

A) Provide emotional support.

B) Leave the client alone to rest.

C) Assess for suicidal ideation.

D) Tell the client that it is normal.

Answer: C) Assess for suicidal ideation.

Rationale: Psychosis is very serious. It increases the risk for harm. This assessment is essential.

36. A newborn is receiving a breastfeed. The nurse should:

A) Position the newborn with their head higher than their body.

B) Place the baby on its stomach.

C) Ensure a proper latch.

D) Provide the baby with a bottle of formula after breastfeeding.

Answer: C) Ensure a proper latch.

Rationale: Latch is very important for feeding. It ensures baby gets nourishment. This is a key step.

37. A postpartum client is being discharged home. The nurse should:

A) Provide the client with written instructions.

B) Teach the client how to assess the fundus.

C) Review the signs and symptoms of complications.

D) All of the above.

Answer: D) All of the above.

Rationale: All actions are important. These instructions will help the mother. This will help with the care of the baby.

38. The nurse is assessing a newborn's reflexes. The nurse gently strokes the newborn's cheek. The newborn turns their head toward the side that was stroked. The nurse knows this finding is called:

A) Moro reflex.

B) Rooting reflex.

C) Grasp reflex.

D) Babinski reflex.

Answer: B) Rooting reflex.

Rationale: This reflex helps with feeding. This is a normal finding. This assesses the baby's health.

39. A postpartum client is experiencing a urinary tract infection. The nurse should advise her to:

A) Limit fluid intake.

B) Avoid wiping front to back.

C) Take antibiotics.

D) Avoid emptying the bladder.

Answer: C) Take antibiotics.

Rationale: Antibiotics treat the infection. This is important to the client's health. This should be done immediately.

40. A newborn is experiencing hypoglycemia. The nurse should first:

A) Administer oxygen.

B) Obtain a blood glucose level.

C) Feed the newborn.

D) Assess the newborn's temperature.

Answer: C) Feed the newborn.

Rationale: Feeding increases blood sugar. This is the most important step. This is a key intervention.

41. The nurse is teaching a client about safe sleep practices for a newborn. Which statement by the client indicates a need for further teaching?

A) "I will place my baby on their back to sleep."

B) "I will keep the crib free of soft objects."

C) "I will let my baby sleep in my bed."

D) "I will avoid smoking around my baby."

Answer: C) "I will let my baby sleep in my bed."

Rationale: Bed-sharing increases SIDS risk. Further teaching is needed. This helps promote baby's safety.

42. A postpartum client is experiencing wound dehiscence. The nurse should:

A) Assess the wound.

B) Cover the wound with a sterile dressing.

C) Notify the healthcare provider.

D) All of the above.

Answer: D) All of the above.

Rationale: All actions are very important. These steps will provide care. This will determine the severity.

43. A newborn's bilirubin level is elevated. The nurse should anticipate:

A) Starting phototherapy.

B) Administering a vitamin K injection.

C) Placing the newborn in the prone position.

D) Limiting the newborn's fluid intake.

Answer: A) Starting phototherapy.

Rationale: Phototherapy lowers bilirubin. This is a standard treatment. This protects the baby's health.

44. A postpartum client is experiencing postpartum hemorrhage. The nurse assesses a boggy fundus. The nurse's *priority* action is to:

A) Assess the client's blood pressure.

B) Massage the fundus firmly.

C) Insert a urinary catheter.

D) Administer intravenous fluids.

Answer: B) Massage the fundus firmly.

Rationale: Fundal massage contracts the uterus. This is done to stop bleeding. This is the initial action.

45. The nurse is teaching the parents about formula feeding their newborn. The nurse should instruct the parents to:

A) Warm the formula in the microwave.

B) Use tap water to mix the formula.

C) Wash the bottles and nipples thoroughly.

D) Store prepared formula at room temperature.

Answer: C) Wash the bottles and nipples thoroughly.

Rationale: This prevents infection. This helps to keep the baby healthy. This is essential for formula feeding.

46. A newborn is exhibiting signs of respiratory distress. The nurse is auscultating the newborn's lungs and hears diminished breath sounds. The nurse should:

A) Continue to monitor the newborn.

B) Administer oxygen.

C) Suction the newborn's airway.

D) Notify the healthcare provider.

Answer: D) Notify the healthcare provider.

Rationale: Diminished sounds require prompt intervention. This will also help with the baby's breathing. The provider must know.

47. A postpartum client is experiencing constipation. The nurse should encourage the client to:

A) Limit fiber intake.

B) Increase fluid intake.

C) Restrict ambulation.

D) Take an antidiarrheal medication.

Answer: B) Increase fluid intake.

Rationale: This softens the stool. This helps with the issue. This is an easy intervention.

48. The nurse is assessing a newborn. The nurse notes the presence of a soft swelling on the back of the newborn's head. The swelling extends across the suture lines. The nurse knows that this is called:

A) Caput succedaneum.

B) Cephalohematoma.

C) Molding.

D) Subgaleal hemorrhage.

Answer: A) Caput succedaneum.

Rationale: This is caused by the delivery process. This is a normal finding. This helps the assessment.

49. A postpartum client is experiencing postpartum depression. The nurse should:

A) Tell the client to "snap out of it."

B) Encourage the client to isolate herself.

C) Assess the client's support system.

D) Avoid discussing the client's feelings.

Answer: C) Assess the client's support system.

Rationale: Support is essential. This can help manage the situation. This is important for the client.

50. A newborn is receiving an exchange transfusion for hyperbilirubinemia. The nurse's *priority* action is to:

A) Monitor the newborn's temperature.

B) Assess the newborn's bilirubin level.

C) Monitor the newborn's vital signs.

D) Administer intravenous fluids.

Answer: C) Monitor the newborn's vital signs.

Rationale: This transfusion can have risks. The nurse must monitor vitals closely. This will help to keep the baby safe.

Reproductive Health (50 Questions)

1. A client is seeking information about contraception. Which method is *most* effective at preventing pregnancy?

A) Fertility awareness methods

B) Barrier methods (condoms)

C) Oral contraceptive pills

D) Withdrawal

Answer: C) Oral contraceptive pills

Rationale: This option provides high efficacy. It is effective with correct use. This helps prevent pregnancy.

2. A client is experiencing symptoms of premenstrual syndrome (PMS). The nurse should recommend:

A) Increasing caffeine intake

B) Decreasing exercise

C) Eating a diet high in sodium

D) Increasing exercise and a balanced diet

Answer: D) Increasing exercise and a balanced diet

Rationale: This assists in managing the symptoms. This helps reduce mood swings. This improves overall well-being.

3. A client is diagnosed with a sexually transmitted infection (STI). The nurse should advise her that:

A) She can resume sexual activity immediately.

B) Her partner does not need to be tested.

C) She should abstain from sexual activity until treatment is complete.

D) She should only use barrier protection during sexual activity.

Answer: C) She should abstain from sexual activity until treatment is complete.

Rationale: Abstinence prevents reinfection. This prevents further transmission of the STI. This allows the treatment to be effective.

4. A client is undergoing a pelvic examination. The nurse's role is to:

A) Instruct the client on the procedure.

B) Provide emotional support to the client.

C) Prepare the equipment needed for the examination.

D) All of the above

Answer: D) All of the above

Rationale: The nurse performs the procedure with the provider. The nurse helps the client by providing comfort. This helps the client by helping her relax.

5. A client is seeking information about menopause. The nurse should explain that:

A) Menopause always begins at age 40.

B) Menopause is characterized by the cessation of menstruation.

C) Hormone replacement therapy (HRT) is always required.

D) Hot flashes are not a common symptom.

Answer: B) Menopause is characterized by the cessation of menstruation.

Rationale: Menopause stops menstruation. This is a key factor. This is a common transition.

6. A client reports irregular bleeding and pelvic pain. The nurse should suspect:

A) Pregnancy

B) Ovarian cysts

C) Menopause

D) Urinary tract infection

Answer: B) Ovarian cysts

Rationale: These can cause these symptoms. This warrants further investigation. This needs to be checked.

7. A client is scheduled for a Pap smear. The nurse should instruct the client to:

A) Have the Pap smear performed during her menstrual period.

B) Avoid sexual intercourse for 24 hours before the test.

C) Use a vaginal douche before the test.

D) Avoid using tampons.

Answer: D) Avoid using tampons.

Rationale: Tampons can interfere with results. This can affect the test accuracy. This can affect the results.

8. A client reports symptoms of a vaginal yeast infection. The nurse should advise her to:

A) Use a vaginal douche.

B) Avoid tight-fitting clothing.

C) Use antibiotics.

D) Avoid eating yogurt.

Answer: B) Avoid tight-fitting clothing.

Rationale: Tight clothing traps moisture. Moisture can promote yeast growth. This is a very important factor.

9. A client is diagnosed with endometriosis. The nurse should explain that this condition is characterized by:

A) The inflammation of the ovaries.

B) The growth of endometrial tissue outside the uterus.

C) The formation of cysts in the ovaries.

D) The blockage of the fallopian

E) The blockage of the fallopian tubes.

Answer: B) The growth of endometrial tissue outside the uterus.

Rationale: This is the defining feature. The endometrial tissue grows outside the uterus. This causes inflammation and pain.

10. A client is considering using an intrauterine device (IUD) for contraception. The nurse should explain that:

A) The IUD protects against STIs.

B) The IUD is a permanent form of contraception.

C) The IUD can cause heavy bleeding.

D) The IUD needs to be replaced monthly.

Answer: C) The IUD can cause heavy bleeding.

Rationale: This is a potential side effect. Knowing the side effects helps the client make a decision. It is important information to share.

11. A client is experiencing symptoms of toxic shock syndrome (TSS). The nurse should assess for:

A) High fever

B) Hypotension

C) Rash

D) All of the above

Answer: D) All of the above

Rationale: All of these are possible symptoms. This is a serious condition. This is why it is important to asses.

12. A client is diagnosed with polycystic ovary syndrome (PCOS). The nurse should explain that:

A) Weight loss can improve symptoms.

B) It is always associated with infertility.

C) It is caused by a sexually transmitted infection.

D) Surgery is the only treatment option.

Answer: A) Weight loss can improve symptoms.

Rationale: Weight loss can improve insulin resistance. This is a key symptom. This can help with PCOS.

13. A client is experiencing amenorrhea. The nurse should assess for:

A) Frequent menstruation

B) Absence of menstruation

C) Heavy menstrual bleeding

D) Painful menstruation

Answer: B) Absence of menstruation

Rationale: Amenorrhea means the absence of periods. This term is crucial to know. This is what is being assessed.

14. A client is diagnosed with a urinary tract infection (UTI). The nurse should advise her to:

A) Limit fluid intake

B) Avoid drinking cranberry juice

C) Take antibiotics

D) Avoid sexual intercourse

Answer: C) Take antibiotics

Rationale: Antibiotics are the primary treatment. This is crucial for fighting an infection. This needs to be done immediately.

15. A client is experiencing symptoms of a pelvic inflammatory disease (PID). The nurse should anticipate:

A) Administering antibiotics

B) Teaching the client about safe sexual practices

C) Assessing the client for sexually transmitted infections (STIs)

D) All of the above

Answer: D) All of the above

Rationale: These are all key interventions. This is to treat PID. This is an important part of care.

16. A client is considering hormone replacement therapy (HRT) for menopause. The nurse should:

A) Explain the risks and benefits of HRT.

B) Tell the client that HRT is not an option.

C) Recommend HRT to all clients.

D) Assure the client that there are no risks.

Answer: A) Explain the risks and benefits of HRT.

Rationale: This helps the client make an informed choice. This is crucial for the client. This will help with the decision.

17. A client is experiencing abnormal uterine bleeding. The nurse should:

A) Tell the client that this is normal.

B) Advise the client to take ibuprofen.

C) Assess the client's vital signs and medical history.

D) Encourage the client to take a nap.

Answer: C) Assess the client's vital signs and medical history.

Rationale: This is to determine the cause. This guides further treatment. This is important for the client.

18. A client is diagnosed with cervical dysplasia. The nurse should explain that:

A) It is a form of cervical cancer.

B) It is a precancerous condition.

C) It is a viral infection.

D) It is always treated with surgery.

Answer: B) It is a precancerous condition.

Rationale: Cervical dysplasia is a precursor to cancer. It needs monitoring and intervention. This is an important distinction.

19. A client is using the diaphragm for contraception. The nurse should teach her to:

A) Leave the diaphragm in place for 24 hours after intercourse.

B) Use the diaphragm with a spermicide.

C) Remove the diaphragm immediately after intercourse.

D) The diaphragm protects against STIs.

Answer: B) Use the diaphragm with a spermicide.

Rationale: Spermicide increases effectiveness. This is a key component of this method. This increases contraceptive success.

20. A client reports painful intercourse. The nurse should assess for:

A) Pelvic pain

B) Vaginal dryness

C) History of STIs

D) All of the above

Answer: D) All of the above

Rationale: All these can cause pain. This is an important assessment. These are all relevant.

21. A client is diagnosed with a Bartholin's cyst. The nurse should explain that this cyst is:

A) A fluid-filled sac in the vagina.

B) A fluid-filled sac near the vaginal opening.

C) A growth in the uterus.

D) An infection of the fallopian tubes.

Answer: B) A fluid-filled sac near the vaginal opening.

Rationale: This accurately describes the cyst. This will help the patient know. This allows for education.

22. A client is experiencing dysmenorrhea. The nurse should advise her to:

A) Avoid exercise.

B) Avoid over-the-counter pain relievers.

C) Apply heat to the abdomen.

D) Increase caffeine intake.

Answer: C) Apply heat to the abdomen.

Rationale: Heat can relieve muscle cramps. This is a simple intervention. This can ease the pain.

23. A client is considering tubal ligation for permanent contraception. The nurse should explain that:

A) It can be reversed.

B) It protects against STIs.

C) It is a permanent form of contraception.

D) It can cause heavy menstrual bleeding.

Answer: C) It is a permanent form of contraception.

Rationale: It provides permanent sterilization. This is a key factor. This affects the client's choice.

24. A client is diagnosed with a fibroid. The nurse should explain that a fibroid is:

A) A cancerous growth in the uterus.

B) A noncancerous growth in the uterus.

C) An infection of the uterus.

D) A growth outside the uterus.

Answer: B) A noncancerous growth in the uterus.

Rationale: Fibroids are generally benign. This is important for the client. This will alleviate their fears.

25. A client is experiencing symptoms of bacterial vaginosis. The nurse should:

A) Recommend douching.

B) Advise her to avoid sexual intercourse.

C) Prescribe antibiotics.

D) Advise her to eat yogurt.

Answer: B) Advise her to avoid sexual intercourse.

Rationale: Sexual activity can worsen BV. Abstinence can aid in treatment. This helps prevent further issues.

26. A client is experiencing symptoms of a sexually transmitted infection (STI). The nurse should:

A) Administer antibiotics immediately.

B) Notify the client's partner(s).

C) Obtain a detailed sexual history.

D) Instruct the client to use condoms for 1 week.

Answer: C) Obtain a detailed sexual history.

Rationale: History helps to determine the cause. The next steps of care can be determined. This can guide testing.

27. A client reports symptoms of a prolapsed uterus. The nurse should assess for:

A) Heavy bleeding

B) Pelvic pressure

C) Urinary incontinence

D) B and C

Answer: D) B and C

Rationale: Prolapse causes pelvic pressure. This can affect bladder control. This is important to determine.

28. A client is undergoing a colposcopy. The nurse should explain that the purpose of this procedure is:

A) To remove the uterus.

B) To examine the cervix.

C) To remove fibroids.

D) To insert an IUD.

Answer: B) To examine the cervix.

Rationale: This provides detailed visualization. This helps assess cervical health. This is a key step.

29. A client is diagnosed with pelvic inflammatory disease (PID). The nurse should:

A) Administer antibiotics.

B) Assess the client's vital signs.

C) Teach the client about safe sexual practices.

D) All of the above.

Answer: D) All of the above.

Rationale: These all help to treat PID. This comprehensive care approach is crucial. This improves the client's outcome.

30. A client is experiencing hot flashes related to menopause. The nurse should:

A) Recommend hormone replacement therapy.

B) Encourage the client to exercise.

C) Advise the client to increase caffeine intake.

D) Tell the client to avoid spicy foods.

Answer: B) Encourage the client to exercise.

Rationale: Exercise can help manage symptoms. This is a safe intervention. This will help to improve comfort.

31. A client is considering a hysterectomy. The nurse should explain that a hysterectomy is:

A) The removal of the fallopian tubes.

B) The removal of the ovaries.

C) The removal of the uterus.

D) The removal of the cervix.

Answer: C) The removal of the uterus.

Rationale: Hysterectomy means removing the uterus. This is important for the client. This describes the procedure.

32. A client is diagnosed with vulvodynia. The nurse should explain that this condition is characterized by:

A) Pain in the vulva.

B) Itching in the vulva.

C) Burning sensation in the vulva.

D) All of the above.

Answer: D) All of the above.

Rationale: These are all possible symptoms. This is a key assessment. This is important for the client.

33. A client is experiencing infertility. The nurse should assess for:

A) Irregular menstrual cycles

B) History of STIs

C) Obesity

D) All of the above

Answer: D) All of the above

Rationale: These are all potential causes. This helps determine the problem. This is a key assessment.

34. A client is undergoing a breast examination. The nurse should:

A) Inspect the breasts for any changes.

B) Palpate the breasts for lumps or masses.

C) Teach the client how to perform a self-examination.

D) All of the above.

Answer: D) All of the above.

Rationale: This is a comprehensive assessment. This helps with early detection. This helps determine the next steps.

35. A client is diagnosed with ovarian cancer. The nurse should:

A) Encourage the client to delay treatment.

B) Explain the treatment options.

C) Tell the client that there is no treatment.

D) Tell the client not to worry.

Answer: B) Explain the treatment options.

Rationale: This helps with the client's knowledge. This assists the client to make choices. This is a crucial part of care.

36. A client is experiencing a ruptured ovarian cyst. The nurse should:

A) Assess the client's vital signs.

B) Administer pain medication.

C) Monitor for signs of bleeding.

D) All of the above.

Answer: D) All of the above.

Rationale: All of these actions provide care. The client needs to be assessed. The client is in pain.

37. A client is using the NuvaRing for contraception. The nurse should instruct her to:

A) Leave the ring in place for 4 weeks.

B) Remove the ring for 1 week each month.

C) Insert the ring immediately after intercourse.

D) Replace the ring every month.

Answer: B) Remove the ring for 1 week each month.

Rationale: This allows for a withdrawal bleed. This follows the ring's schedule. This is the correct way to use it.

38. A client reports vaginal dryness related to menopause. The nurse should recommend:

A) Using a vaginal lubricant.

B) Limiting fluid intake.

C) Avoiding sexual intercourse.

D) Avoiding the use of hormone replacement therapy.

Answer: A) Using a vaginal lubricant.

Rationale: This is a simple and effective intervention. Lubricant helps improve comfort. This improves sexual activity.

39. A client is diagnosed with a rectocele. The nurse should explain that this condition is:

A) The prolapse of the bladder into the vagina.

B) The prolapse of the rectum into the vagina.

C) The prolapse of the uterus.

D) A vaginal infection.

Answer: B) The prolapse of the rectum into the vagina.

Rationale: This accurately describes a rectocele. This is important information. This helps with client education.

40. A client is undergoing a breast biopsy. The nurse should:

A) Reassure the client.

B) Explain the procedure.

C) Monitor the client for bleeding.

D) All of the above.

Answer: D) All of the above.

Rationale: These are all key aspects of care. This provides a full assessment. This provides emotional support.

41. A client is experiencing heavy menstrual bleeding. The nurse should assess for:

A) Anemia

B) Fatigue

C) Dizziness

D) All of the above

Answer: D) All of the above

Rationale: Heavy bleeding can cause these issues. Assessment of the client is very important. This helps determine the next steps.

42. A client is considering a vasectomy. The nurse should explain that:

A) It protects against STIs.

B) It is a reversible procedure.

C) It can cause impotence.

D) It is a permanent form of contraception.

Answer: D) It is a permanent form of contraception.

Rationale: Vasectomy provides permanent sterilization. This affects the client's choice. This should be explained.

43. A client is diagnosed with premenstrual dysphoric disorder (PMDD). The nurse should explain that this condition is:

A) A mild form of PMS.

B) A severe form of PMS.

C) A condition that occurs during menopause.

D) A condition that only affects women who have had children.

Answer: B) A severe form of PMS.

Rationale: This is a severe form of PMS. It is more debilitating. It requires special treatment.

44. A client is undergoing a dilation and curettage (D&C). The nurse should explain that the purpose of this procedure is:

A) To remove the ovaries.

B) To remove the fallopian tubes.

C) To remove tissue from the uterus.

D) To insert an IUD.

Answer: C) To remove tissue from the uterus.

Rationale: D&C removes uterine tissue. This helps with diagnoses and treatments. This is the main goal.

45. A client is using the contraceptive patch. The nurse should instruct her to:

A) Change the patch weekly.

B) Apply the patch to the abdomen.

C) Remove the patch during sexual intercourse.

D) The patch protects against STIs.

Answer: A) Change the patch weekly.

Rationale: The patch is changed weekly. This will provide protection. This is how the patch works.

46. A client is experiencing a spontaneous abortion. The nurse should:

A) Assess the client's emotional state.

B) Provide emotional support.

C) Monitor the client for bleeding.

D) All of the above.

Answer: D) All of the above.

Rationale: These actions provide care. This provides emotional support. This assesses the client's physical state.

47. A client is diagnosed with uterine cancer. The nurse should explain that:

A) It is always treated with surgery.

B) It is always fatal.

C) It is often curable if detected early.

D) It is caused by STIs.

Answer: C) It is often curable if detected early.

Rationale: Early detection offers better outcomes. This is an important thing to know. This is the best approach.

48. A client is reporting symptoms of an ectopic pregnancy. The nurse should:

A) Order a pregnancy test.

B) Assess the client's vital signs.

C) Assess the client's pain.

D) All of the above

Answer: D) All of the above

Rationale: These are all important. An ectopic pregnancy is serious. This is an important action.

49. A client is concerned about her risk for breast cancer. The nurse should advise her to:

A) Avoid all sources of estrogen.

B) Perform monthly breast self-examinations.

C) Get regular mammograms.

D) B and C

Answer: D) B and C

Rationale: These help with early detection. This will improve chances of survival. This is good advice.

50. A client is experiencing infertility and is undergoing in-vitro fertilization (IVF). The nurse should:

A) Provide emotional support to the client.

B) Teach the client about medication administration.

C) Monitor the client for complications.

D) All of the above.

Answer: D) All of the above.

Rationale: These actions provide the best care. This is a stressful process. This requires monitoring and education.

Okay, here are 100 NCLEX-style questions with answers and rationales, focused on Mental Health. This covers a broad range of topics within mental health nursing.

Important Note: *This is for educational purposes only. Always refer to your nursing textbooks, NCLEX review materials, and the latest guidelines for accurate and comprehensive information. This is not a substitute for a comprehensive review course.*

Section 3: Mental Health (100 Questions)

1. Question:

A client diagnosed with schizophrenia is experiencing auditory hallucinations. The nurse's priority intervention is to:

a) Encourage the client to join a group activity to distract them.

b) Ask the client if the voices are telling them to harm themselves or others.

c) Tell the client that the voices are not real and they should ignore them.

d) Administer the prescribed antipsychotic medication.

Answer: b) Ask the client if the voices are telling them to harm themselves or others.

Rationale: Safety is always the priority. Assessing for suicidal or homicidal ideation is crucial with hallucinations. While other interventions are important, this addresses the immediate risk of harm.

2. Question:

A client is admitted with a diagnosis of bipolar disorder, manic phase. Which behavior would the nurse *most* expect to observe?

a) Social isolation and withdrawal.

b) Flat affect and slowed speech.

c) Flight of ideas and grandiosity.

d) Decreased need for sleep and psychomotor retardation.

Answer: c) Flight of ideas and grandiosity.

Rationale: Manic episodes are characterized by elevated, expansive, or irritable mood, racing thoughts (flight of ideas), inflated self-esteem (grandiosity), decreased need for sleep, and increased activity.

3. Question:

A client is experiencing a panic attack. The nurse's *most* appropriate intervention is to:

a) Leave the client alone to allow them to calm down.

b) Encourage the client to take deep, slow breaths.

c) Ask the client detailed questions about their symptoms.

d) Tell the client that their feelings are irrational.

Answer: b) Encourage the client to take deep, slow breaths.

Rationale: Panic attacks are characterized by intense fear and physical symptoms. Deep breathing can help to reduce anxiety and promote relaxation.

4. Question:

A nurse is caring for a client who has a history of alcohol use disorder. The client is admitted to the hospital with a fractured femur. Which assessment finding would be *most* concerning and require immediate intervention?

a) Mild tremors.

b) Elevated blood pressure.

c) Reports of feeling anxious.

d) Agitation and disorientation.

Answer: d) Agitation and disorientation.

Rationale: These signs suggest alcohol withdrawal, which can progress to delirium tremens (DTs), a life-threatening condition.

5. Question:

A client is diagnosed with major depressive disorder. Which of the following statements by the client would indicate effective coping?

a) "I don't think I'll ever feel happy again."

b) "I'm going to stop taking my medication because it's not helping."

c) "I've started going for a walk every day, even when I don't feel like it."

d) "I spend most of my time in bed because that's all I can manage."

Answer: c) "I've started going for a walk every day, even when I don't feel like it."

Rationale: This demonstrates an active coping strategy (exercise) and a willingness to engage in activities despite depressive symptoms.

6. Question:

A client is receiving lithium carbonate. Which of the following laboratory results would be *most* concerning?

a) Sodium 138 mEq/L

b) Potassium 4.0 mEq/L

c) Lithium 1.8 mEq/L

d) Creatinine 0.8 mg/dL

Answer: c) Lithium 1.8 mEq/L

Rationale: The therapeutic range for lithium is typically 0.6-1.2 mEq/L. A level of 1.8 mEq/L is considered toxic and requires immediate intervention (e.g., withholding the medication, contacting the provider).

7. Question:

A client diagnosed with anorexia nervosa refuses to eat. The nurse's *priority* intervention is to:

a) Tell the client that they must eat something.

b) Monitor the client's weight daily.

c) Explore the client's feelings about food and body image.

d) Offer the client a high-calorie meal.

Answer: b) Monitor the client's weight daily.

Rationale: This helps to track the client's physical status and determine the effectiveness of interventions and to assess for a need for medical interventions.

8. Question:

A client is experiencing a crisis related to the loss of a job. Which of the following is the *most* appropriate initial nursing intervention?

a) Provide the client with information about grief.

b) Assess the client's perception of the event and their support system.

c) Suggest the client seek employment counseling.

d) Encourage the client to focus on positive aspects of their life.

Answer: b) Assess the client's perception of the event and their support system.

Rationale: Crisis intervention focuses on the client's immediate needs. Assessing the situation and resources is the first step.

9. Question:

A client with obsessive-compulsive disorder (OCD) spends several hours each day washing their hands. The nurse should initially:

a) Prevent the client from washing their hands to break the cycle.

b) Provide the client with a task to distract them from the compulsion.

c) Allow the client to wash their hands, but set time limits.

d) Tell the client that their behavior is abnormal.

Answer: c) Allow the client to wash their hands, but set time limits.

Rationale: This acknowledges the client's anxiety while gradually reducing the time spent on the compulsion (exposure and response prevention).

10. Question:

A client with borderline personality disorder (BPD) is frequently demanding and manipulative. The nurse should:

a) Give the client whatever they ask for to avoid conflict.

b) Set clear, consistent limits and boundaries.

c) Avoid interacting with the client as much as possible.

d) Ignore the client's manipulative behaviors.

Answer: b) Set clear, consistent limits and boundaries.

Rationale: This provides a sense of safety and structure for the client, which is important. Consistency is key.

11. Question:

Which of the following is a common side effect of antipsychotic medications, particularly first-generation antipsychotics?

a) Weight gain

b) Extrapyramidal symptoms (EPS)

c) Sedation

d) Anticholinergic effects

Answer: b) Extrapyramidal symptoms (EPS)

Rationale: EPS (e.g., tardive dyskinesia, akathisia, pseudoparkinsonism) are a serious concern with older antipsychotics.

12. Question:

A client is diagnosed with generalized anxiety disorder (GAD). The nurse teaches the client about relaxation techniques. Which statement by the client indicates a need for further teaching?

a) "I will practice deep breathing exercises when I feel anxious."

b) "I will avoid caffeine and alcohol."

c) "I will try to solve all my problems immediately to reduce my anxiety."

d) "I will use progressive muscle relaxation to calm myself."

Answer: c) "I will try to solve all my problems immediately to reduce my anxiety."

Rationale: This is an unrealistic goal. GAD often involves worrying about multiple issues; encouraging gradual problem-solving and acceptance of some uncertainty is more appropriate.

13. Question:

A client is experiencing a somatic symptom disorder. The nurse understands that the client's physical symptoms are:

a) Exaggerations of minor physical ailments.

b) Voluntarily produced for secondary gain.

c) Not explained by a medical condition but are real to the client.

d) Indicative of a serious underlying medical illness.

Answer: c) Not explained by a medical condition but are real to the client.

Rationale: The client's distress is genuine, even though no organic cause can be found. The focus of treatment is on managing the client's distress, rather than trying to "prove" or "disprove" the physical symptoms.

14. Question:

A client is receiving electroconvulsive therapy (ECT). The nurse should explain to the client that:

a) ECT is a painful procedure.

b) Memory loss is a common side effect.

c) ECT is a permanent cure for depression.

d) They will experience no side effects.

Answer: b) Memory loss is a common side effect.

Rationale: Clients often experience some degree of memory loss, especially for events around the time of the treatments.

15. Question:

A client with antisocial personality disorder is admitted to the psychiatric unit after being arrested for assault. Which of the following behaviors would the nurse *most* likely observe?

a) Expressing remorse for their actions.

b) Following rules and regulations.

c) Manipulating staff to get what they want.

d) Demonstrating empathy for others.

Answer: c) Manipulating staff to get what they want.

Rationale: Antisocial personality disorder is characterized by a disregard for the rights of others, often involving deceitfulness and manipulation.

16. Question:

A client states, "I see spiders crawling on the walls." The nurse recognizes this as which type of symptom?

a) Illusion

b) Hallucination

c) Delusion

d) Obsession

Answer: b) Hallucination

Rationale: Hallucinations are sensory experiences (visual, auditory, etc.) that occur without an external stimulus.

17. Question:

A client with a history of suicide attempts states, "I wish I were dead." The nurse's *initial* response should be:

a) "You shouldn't say things like that."

b) "Are you thinking of hurting yourself?"

c) "You have so much to live for."

d) "I'll call the doctor right away."

Answer: b) "Are you thinking of hurting yourself?"

Rationale: Directly assessing for suicidal ideation is the priority when a client expresses suicidal thoughts.

18. Question:

A client is experiencing akathisia as a side effect of an antipsychotic medication. The nurse would expect to observe which of the following?

a) Tremors and rigidity

b) Restlessness and an inability to sit still

c) Lip smacking and tongue movements

d) Muscle contractions and spasms

Answer: b) Restlessness and an inability to sit still

Rationale: Akathisia is characterized by a subjective feeling of inner restlessness and an inability to stay still.

19. Question:

A client with dependent personality disorder would likely exhibit which behavior?

a) Excessive need to be taken care of.

b) Social isolation and withdrawal.

c) A pattern of disregard for the rights of others.

d) Difficulty maintaining stable relationships.

Answer: a) Excessive need to be taken care of.

Rationale: This is the defining characteristic of dependent personality disorder.

20. Question:

The nurse is providing education to a client taking an MAOI antidepressant. The nurse should instruct the client to avoid which of the following foods?

a) Bananas

b) Broccoli

c) Aged cheese

d) Chicken

Answer: c) Aged cheese

Rationale: MAOIs can interact with tyramine-rich foods (e.g., aged cheeses, cured meats) and cause a hypertensive crisis.

21. Question:

A nurse is caring for a client diagnosed with delirium. Which of the following is the *most* important nursing intervention?

a) Orienting the client frequently to person, place, and time.

b) Encouraging the client to engage in complex cognitive tasks.

c) Administering a sedative medication to calm the client.

d) Leaving the client undisturbed to promote rest.

Answer: a) Orienting the client frequently to person, place, and time.

Rationale: Delirium is characterized by fluctuating levels of consciousness and cognitive impairment. Providing orientation can help.

22. Question:

A client is admitted for a suicide attempt by overdose. The nurse's priority in the initial assessment is to:

a) Determine the client's motivation for the suicide attempt.

b) Assess the client's level of consciousness, vital signs, and physical status.

c) Ask the client about their history of mental illness.

d) Contact the client's family to inform them of the situation.

Answer: b) Assess the client's level of consciousness, vital signs, and physical status.

Rationale: Safety is paramount. This is a medical emergency, and the nurse must first assess the client's physical condition.

23. Question:

A client is experiencing clang associations. Which of the following client statements demonstrates this?

a) "I feel sad and hopeless."

b) "The rain in Spain falls mainly on the plain, drain, stain, mane."

c) "I believe I am the President."

d) "I hear voices telling me to do things."

Answer: b) "The rain in Spain falls mainly on the plain, drain, stain, mane."

Rationale: Clang associations are speech patterns based on sound, rather than meaning.

24. Question:

A client is admitted to the psychiatric unit after being found wandering in the street. The client is disheveled, unkempt, and states, "I am the chosen one." The nurse notes the client is exhibiting:

a) Apathy

b) Flight of ideas

c) Delusions

d) Anergia

Answer: c) Delusions

Rationale: A delusion is a fixed, false belief that is not based on reality.

25. Question:

A client is prescribed fluoxetine (Prozac). The nurse should teach the client that it may take how long for the medication to reach full therapeutic effect?

a) 1-2 days

b) 1-2 weeks

c) 4-6 weeks

d) Immediately

Answer: c) 4-6 weeks

Rationale: Selective Serotonin Reuptake Inhibitors (SSRIs) like fluoxetine often take several weeks to achieve their full therapeutic effect.

26. Question:

A client states, "I have nothing to live for." The nurse responds, "You feel as though your life has no meaning." The nurse is demonstrating which communication technique?

a) Giving advice

b) Giving approval

c) Reflection

d) Challenging

Answer: c) Reflection

Rationale: Reflection involves restating the client's feelings or words in a slightly different way.

27. Question:

A client is experiencing neuroleptic malignant syndrome (NMS) as a result of antipsychotic medication. Which of the following assessment findings is *most* indicative of this?

a) Hypothermia

b) Bradycardia

c) Muscle rigidity

d) Sedation

Answer: c) Muscle rigidity

Rationale: Muscle rigidity, along with fever, autonomic instability, and altered mental status, is a hallmark of NMS.

28. Question:

A client is in the midst of a crisis. The nurse determines the client's level of anxiety to be severe. Which of the following interventions is most appropriate?

a) Encourage the client to talk about their feelings

b) Provide a quiet environment with minimal stimuli

c) Educate the client about coping mechanisms

d) Help the client identify the source of their anxiety

Answer: b) Provide a quiet environment with minimal stimuli

Rationale: Severe anxiety impairs the client's ability to process information. A calm, structured environment is helpful.

29. Question:

A client with schizoaffective disorder exhibits symptoms of schizophrenia and a mood disorder. Which symptom would the nurse expect to see related to the mood disorder?

a) Flat affect

b) Auditory hallucinations

c) Grandiose delusions

d) Elevated or depressed mood

Answer: d) Elevated or depressed mood

Rationale: This combines psychotic features with mood disorder symptoms.

30. Question:

A client is scheduled to receive a dose of haloperidol (Haldol). The client reports experiencing muscle stiffness and tremors. The nurse suspects:

a) Neuroleptic Malignant Syndrome (NMS)

b) Tardive Dyskinesia (TD)

c) Extrapyramidal Symptoms (EPS)

d) Anticholinergic side effects

Answer: c) Extrapyramidal Symptoms (EPS)

Rationale: Haloperidol is a typical antipsychotic that commonly causes EPS.

31. Question:

A client is experiencing acute alcohol withdrawal. Which medication is the most common to administer?

a) Disulfiram

b) Naltrexone

c) Lorazepam

d) Acamprosate

Answer: c) Lorazepam

Rationale: Benzodiazepines like lorazepam are often used to manage the symptoms of alcohol withdrawal, which can include seizures.

32. Question:

A client with PTSD is experiencing a flashback. The nurse's initial response should be to:

a) Encourage the client to talk about the traumatic event in detail.

b) Help the client recognize that they are in the present and safe.

c) Leave the client alone to calm down.

d) Administer a sedative medication.

Answer: b) Help the client recognize that they are in the present and safe.

Rationale: The priority is to help the client regain a sense of reality and safety.

33. Question:

A client with anorexia nervosa says, "I'm fat." The nurse responds, "You're not fat. Your weight is dangerously low." This is an example of which therapeutic communication technique?

a) Giving approval

b) Offering self

c) Presenting reality

d) Exploration

Answer: c) Presenting reality

Rationale: The nurse is stating facts to correct the client's distorted perception.

34. Question:

A client is experiencing acute mania. The nurse should prioritize which of the following?

a) Encouraging the client to participate in group therapy.

b) Providing a structured and safe environment.

c) Educating the client about the importance of medication adherence.

d) Encouraging the client to express their feelings verbally.

Answer: b) Providing a structured and safe environment.

Rationale: During acute mania, the client's judgment is impaired, and they may be impulsive. A safe, predictable environment is essential.

35. Question:

A client reports feeling hopeless and worthless. The nurse recognizes these as symptoms of:

a) Mania

b) Anxiety

c) Depression

d) Schizophrenia

Answer: c) Depression

Rationale: These are common symptoms of major depressive disorder.

36. Question:

A client is taking clozapine (Clozaril). Which of the following lab values must be regularly monitored?

a) Liver function tests

b) Complete blood count (CBC), specifically for white blood cell (WBC) count

c) Renal function tests

d) Thyroid function tests

Answer: b) Complete blood count (CBC), specifically for white blood cell (WBC) count

Rationale: Clozapine can cause agranulocytosis, a potentially life-threatening decrease in white blood cells.

37. Question:

A client with a personality disorder is admitted to a psychiatric unit after attempting suicide. Which nursing intervention is *most* important?

a) Establishing a therapeutic relationship.

b) Setting realistic and achievable goals.

c) Providing a safe and structured environment.

d) Administering prescribed medications.

Answer: c) Providing a safe and structured environment.

Rationale: Safety is always the priority. A structured environment helps manage potential impulsive behaviors.

38. Question:

A nurse is educating a client on the use of a newly prescribed antidepressant. The nurse should include which of the following instructions?

a) "You can stop taking the medication when you feel better."

b) "Avoid drinking alcohol while taking this medication."

c) "You will feel better within a few days of starting this medication."

d) "This medication will cure your depression."

Answer: b) "Avoid drinking alcohol while taking this medication."

Rationale: Many antidepressants can interact negatively with alcohol.

39. Question:

A client is demonstrating signs of cannabis use. The nurse would expect to find which of the following?

a) Pinpoint pupils

b) Increased appetite

c) Psychomotor retardation

d) Slurred speech

Answer: b) Increased appetite

Rationale: Cannabinoids often cause increased appetite, known as the "munchies."

40. Question:

A client diagnosed with paranoid schizophrenia is suspicious of the staff. The nurse should:

a) Avoid interacting with the client.

b) Use a matter-of-fact, calm, and consistent approach.

c) Argue with the client about their delusions.

d) Share personal information to build rapport.

Answer: b) Use a matter-of-fact, calm, and consistent approach.

Rationale: This approach can build trust without validating the delusions.

41. Question:

A client is prescribed risperidone (Risperdal). The nurse should monitor for which side effect?

a) Orthostatic hypotension

b) Constipation

c) Tardive dyskinesia

d) All of the above

Answer: d) All of the above

Rationale: Risperidone, like other antipsychotics, can cause orthostatic hypotension, constipation, and, with long-term use, tardive dyskinesia.

42. Question:

A client is admitted with a diagnosis of factitious disorder imposed on self. The nurse knows this disorder is characterized by:

a) Physical symptoms intentionally produced to achieve a secondary gain.

b) Physical symptoms intentionally produced to assume the sick role.

c) Falsification of medical or psychological signs or symptoms in another person.

d) Physical symptoms that are not real, but the client believes they have a serious illness.

Answer: b) Physical symptoms intentionally produced to assume the sick role.

Rationale: This is the key defining characteristic of factitious disorder imposed on self (formerly Munchausen syndrome).

43. Question:

A client with schizophrenia is prescribed clozapine. The nurse monitors for which of the following?

a) Hypertension

b) Increased heart rate

c) Weight loss

d) Agranulocytosis

Answer: d) Agranulocytosis

Rationale: Clozapine can cause a dangerous drop in white blood cells, increasing the risk of infection.

44. Question:

A client is experiencing a manic episode. Which of the following activities is *most* appropriate for the client?

a) Working on a complex puzzle

b) Participating in a group discussion

c) Playing a fast-paced card game

d) Writing a detailed letter

Answer: b) Participating in a group discussion

Rationale: It provides social interaction and structure, with appropriate limits.

45. Question:

A nurse is providing teaching to a client taking anxiolytic medication. Which of the following instructions is *most* important?

a) "Take the medication on an empty stomach."

b) "Do not stop the medication abruptly."

c) "You may experience increased energy."

d) "Avoid taking the medication before bed."

Answer: b) "Do not stop the medication abruptly."

Rationale: Abruptly stopping anxiolytics can lead to withdrawal symptoms, including rebound anxiety.

46. Question:

A client is demonstrating signs of opioid withdrawal. Which of the following signs/symptoms would the nurse expect to see?

a) Sedation and pinpoint pupils

b) Muscle aches and goosebumps

c) Decreased respiratory rate

d) Constipation

Answer: b) Muscle aches and goosebumps

Rationale: Opioid withdrawal is characterized by flu-like symptoms, including muscle aches and goosebumps.

47. Question:

A client is exhibiting flight of ideas. Which intervention is most appropriate for the nurse to implement?

a) Ask the client to focus on one topic at a time.

b) Leave the client alone to think.

c) Encourage the client to speak faster.

d) Allow the client to change topics frequently.

Answer: a) Ask the client to focus on one topic at a time.

Rationale: Clients with flight of ideas jump from topic to topic quickly.

48. Question:

A client is exhibiting delusions of persecution. The nurse should respond by:

a) Agreeing with the client to build rapport.

b) Ignoring the client's statements.

c) Challenging the client's beliefs directly.

d) Acknowledging the client's feelings and presenting reality.

Answer: d) Acknowledging the client's feelings and presenting reality.

Rationale: This approach validates the client's emotions while providing an alternative perspective.

49. Question:

A client is taking an SSRI for depression. The nurse should educate the client about the risk of:

a) Hypertensive crisis

b) Serotonin syndrome

c) Agranulocytosis

d) Extrapyramidal symptoms

Answer: b) Serotonin syndrome

Rationale: SSRIs can, in some cases, cause serotonin syndrome, which can be life-threatening.

50. Question:

A client tells the nurse, "I can't stop thinking about germs. I wash my hands constantly." This client is exhibiting:

a) A delusion

b) A hallucination

c) An obsession

d) A compulsion

Answer: d) A compulsion

Rationale: Compulsions are repetitive behaviors or mental acts performed in response to an obsession.

51. Question:

A client with borderline personality disorder is admitted to the psychiatric unit. Which of the following nursing actions is *most* important?

a) Avoiding interaction with the client.

b) Encouraging the client to express their feelings.

c) Setting clear and consistent boundaries.

d) Giving the client whatever they ask for.

Answer: c) Setting clear and consistent boundaries.

Rationale: Clear boundaries help to manage the client's impulsivity, emotional dysregulation, and potential manipulation.

52. Question:

A client is admitted for alcohol withdrawal. The nurse anticipates the administration of which medication to prevent seizures?

a) Disulfiram (Antabuse)

b) Naltrexone (Vivitrol)

c) Lorazepam (Ativan)

d) Acamprosate (Campral)

Answer: c) Lorazepam (Ativan)

Rationale: Benzodiazepines like lorazepam are commonly used to manage withdrawal symptoms, including seizures.

53. Question:

A client is experiencing a panic attack. Which of the following is the priority nursing intervention?

a) Teach the client about the causes of anxiety.

b) Encourage the client to discuss their feelings about the panic attack.

c) Stay with the client and provide reassurance.

d) Administer an anxiolytic medication.

Answer: c) Stay with the client and provide reassurance.

Rationale: During a panic attack, the client needs to feel safe and supported. The nurse's presence can provide reassurance.

54. Question:

A client is taking an MAOI for depression. The nurse should instruct the client to avoid which food?

a) Apples

b) Cottage cheese

c) Spinach

d) Yogurt

Answer: b) Cottage cheese

Rationale: Cottage cheese may contain tyramine and should be avoided.

55. Question:

A client is demonstrating the symptom of echolalia. Which statement would the nurse identify as an example of echolalia?

a) "I believe I am the president."

b) "I see spiders crawling on the walls."

c) "The cat is on the mat, mat, mat."

d) "The nurse said 'How are you?' and I replied, 'How are you?'"

Answer: d) "The nurse said 'How are you?' and I replied, 'How are you?'"

Rationale: Echolalia is the repetition of another person's words.

56. Question:

A client is taking lithium. What is a key nursing intervention?

a) Monitor for EPS

b) Monitor sodium levels

c) Monitor for agranulocytosis

d) Monitor blood pressure

Answer: b) Monitor sodium levels

Rationale: Lithium levels are affected by sodium, dehydration, and kidney function.

57. Question:

A client is in the acute phase of alcohol withdrawal. Which of the following assessment findings would cause the most concern?

a) Fine tremors

b) Mild anxiety

c) Increased pulse and blood pressure

d) Seizures

Answer: d) Seizures

Rationale: Seizures are a life-threatening complication of alcohol withdrawal.

58. Question:

A nurse is caring for a client who is experiencing acute mania. Which of the following nursing interventions is *most* important?

a) Encourage the client to participate in group therapy.

b) Provide a structured and safe environment.

c) Educate the client about medication adherence.

d) Encourage the client to verbalize feelings.

Answer: b) Provide a structured and safe environment.

Rationale: During acute mania, the client's judgment is impaired, and they may be impulsive.

59. Question:

A client with schizophrenia is prescribed an antipsychotic medication. The nurse should monitor the client for which side effect?

a) Hypoglycemia

b) Extrapyramidal symptoms

c) Urinary retention

d) Weight loss

Answer: b) Extrapyramidal symptoms

Rationale: These are a common and often concerning side effect of antipsychotics, especially older generation meds.

60. Question:

A client is experiencing a crisis related to the loss of a job. What is the *most* appropriate initial nursing intervention?

a) Provide the client with information about grief.

b) Assess the client's perception of the event and their support system.

c) Suggest the client seek employment counseling.

d) Encourage the client to focus on positive aspects of their life.

Answer: b) Assess the client's perception of the event and their support system.

Rationale: Assessing is always the first step in crisis intervention.

61. Question:

A client says, "I'm worried that something terrible will happen to my family if I don't touch the door handle five times." The nurse recognizes this statement as an example of:

a) A delusion.

b) A hallucination.

c) An obsession.

d) A compulsion.

Answer: d) A compulsion

Rationale: This is a behavioral response to an obsessive thought (the worry about something bad happening).

62. Question:

A client is prescribed a tricyclic antidepressant (TCA). The nurse should educate the client to monitor for which side effect?

a) Orthostatic hypotension

b) Dry mouth

c) Constipation

d) All of the above

Answer: d) All of the above

Rationale: TCAs have significant anticholinergic side effects, as well as orthostatic hypotension.

63. Question:

A client is experiencing tardive dyskinesia as a result of long-term antipsychotic use. Which of the following would the nurse observe?

a) Restlessness and an inability to sit still.

b) Muscle stiffness and rigidity.

c) Involuntary movements of the tongue and face.

d) A shuffling gait and tremors.

Answer: c) Involuntary movements of the tongue and face.

Rationale: Tardive dyskinesia is characterized by involuntary, repetitive movements, often of the face and tongue.

64. Question:

A client has a history of suicide attempts and states, "I wish I were dead." The nurse's initial response should be:

a) "You shouldn't say things like that."

b) "Are you thinking of hurting yourself?"

c) "You have so much to live for."

d) "I'll call the doctor right away."

Answer: b) "Are you thinking of hurting yourself?"

Rationale: Assessing for suicide risk is the priority.

65. Question:

A client with bipolar disorder is experiencing a manic episode. The nurse observes the client is hyperverbal and rapidly jumping from one topic to another. This behavior is known as:

a) Word salad.

b) Flight of ideas.

c) Neologisms.

d) Clang associations.

Answer: b) Flight of ideas.

Rationale: This is characteristic of the manic phase.

66. Question:

A client with anorexia nervosa is refusing to eat. The nurse's priority nursing diagnosis is:

a) Disturbed body image.

b) Risk for imbalanced nutrition: less than body requirements.

c) Anxiety.

d) Powerlessness.

Answer: b) Risk for imbalanced nutrition: less than body requirements.

Rationale: This directly addresses the life-threatening physical consequence.

67. Question:

A client is experiencing acute alcohol withdrawal and exhibits tremors, anxiety, and elevated vital signs. The nurse anticipates administering:

a) Naloxone (Narcan)

b) Disulfiram (Antabuse)

c) Lorazepam (Ativan)

d) Acamprosate (Campral)

Answer: c) Lorazepam (Ativan)

Rationale: A benzodiazepine will help manage withdrawal symptoms.

68. Question:

A client is diagnosed with schizophrenia and reports hearing voices that tell them to harm themselves. The nurse's priority intervention is to:

a) Encourage the client to engage in a distracting activity.

b) Administer the prescribed antipsychotic medication.

c) Ask the client if they have a plan to harm themselves.

d) Tell the client that the voices are not real.

Answer: c) Ask the client if they have a plan to harm themselves.

Rationale: Safety first. This is the most immediate threat.

69. Question:

A client is taking an MAOI. Which of the following foods should the client avoid?

a) Bananas

b) Aged Cheese

c) Broccoli

d) Chicken

Answer: b) Aged Cheese

Rationale: Tyramine in aged cheese can cause a hypertensive crisis when taking an MAOI.

70. Question:

A client with paranoid schizophrenia is suspicious of the staff. The nurse should:

a) Avoid interacting with the client.

b) Use a matter-of-fact, calm, and consistent approach.

c) Argue with the client about their delusions.

d) Share personal information to build rapport.

Answer: b) Use a matter-of-fact, calm, and consistent approach.

Rationale: This will not validate their delusions.

71. Question:

A client taking lithium carbonate is experiencing which of the following side effects?

a) Diarrhea

b) Fine hand tremors

c) Decreased thirst

d) Urinary retention

Answer: b) Fine hand tremors

Rationale: Lithium's common side effects include tremors, but also gastrointestinal issues and thirst.

72. Question:

A client, diagnosed with major depression, makes the statement "I just don't see the point in going on." Which of the following responses by the nurse is *most* therapeutic?

a) "You have so much to live for. Think about the good things in your life."

b) "I understand how you feel. Things will get better soon."

c) "Are you thinking of harming yourself?"

d) "Everyone feels down sometimes. Try to snap out of it."

Answer: c) "Are you thinking of harming yourself?"

73. Question:

A client is admitted with a diagnosis of anorexia nervosa. Which of the following nursing interventions is *most* essential?

a) Encouraging the client to express feelings about body image.

b) Monitoring the client's weight and vital signs.

c) Providing a high-calorie meal plan.

d) Allowing the client to make food choices to promote autonomy.

Answer: b) Monitoring the client's weight and vital signs.

Rationale: This focuses on the client's physical status and the potential for medical instability.

74. Question:

A client is taking an antipsychotic medication and develops muscle rigidity, fever, and altered mental status. The nurse suspects:

a) Tardive dyskinesia.

b) Neuroleptic malignant syndrome (NMS).

c) Extrapyramidal symptoms (EPS).

d) Serotonin syndrome.

Answer: b) Neuroleptic malignant syndrome (NMS).

Rationale: This is a serious, life-threatening condition associated with antipsychotics.

75. Question:

A client diagnosed with bipolar disorder, manic phase, is exhibiting pressured speech and is constantly talking. The nurse should:

a) Interrupt the client and ask them to speak more slowly.

b) Allow the client to talk freely, providing a non-judgmental environment.

c) Limit the client's interactions with others to decrease stimulation.

d) Ignore the client's behavior.

Answer: c) Limit the client's interactions with others to decrease stimulation.

Rationale: This helps to reduce stimulation and manage the client's hyperactivity.

76. Question:

A client with a history of alcohol abuse is admitted to the hospital with a fractured femur. Which of the following is the nurse's *priority* intervention?

a) Assess the client's level of pain and administer analgesics.

b) Monitor the client for signs and symptoms of alcohol withdrawal.

c) Provide the client with information about support groups.

d) Encourage the client to ambulate as soon as possible.

Answer: b) Monitor the client for signs and symptoms of alcohol withdrawal.

Rationale: This is a life-threatening concern.

77. Question:

A client says, "I hear voices telling me I am worthless." The nurse recognizes this as:

a) A delusion

b) A hallucination

c) An obsession

d) A compulsion

Answer: b) A hallucination

Rationale: Hearing voices (auditory) without an external stimulus.

78. Question:

The nurse is assessing a client diagnosed with delirium. Which finding would be *most* consistent with this diagnosis?

a) Gradual onset of symptoms.

b) Stable level of consciousness.

c) Impaired attention.

d) Intact memory.

Answer: c) Impaired attention.

Rationale: Delirium is characterized by fluctuating levels of consciousness and cognitive impairments, including difficulty with attention.

79. Question:

A client is taking an SSRI and reports experiencing sexual dysfunction. The nurse should:

a) Tell the client that this is a normal side effect and there is nothing to do about it.

b) Suggest the client increase the dose of the medication.

c) Inform the client that this side effect will eventually resolve on its own.

d) Discuss strategies to manage this side effect with the client and notify the provider.

Answer: d) Discuss strategies to manage this side effect with the client and notify the provider.

Rationale: This is a common side effect of SSRIs, and open communication is key. The provider might adjust the dose or try a different medication.

80. Question:

A client with obsessive-compulsive disorder (OCD) spends hours checking the locks on their doors. The nurse should initially:

a) Prevent the client from performing the checking behavior to break the cycle.

b) Teach the client about the irrationality of their thoughts.

c) Allow the client to perform the checking behavior, but set time limits.

d) Ignore the client's behavior.

Answer: c) Allow the client to perform the checking behavior, but set time limits.

Rationale: This is an example of gradual exposure and response prevention.

81. Question:

A client is taking lithium. What is the nurse's *primary* focus when monitoring the client's physical status?

a) Liver function tests

b) Complete blood counts (CBC)

c) Kidney function and sodium levels

d) Thyroid function tests

Answer: c) Kidney function and sodium levels

Rationale: Lithium is primarily excreted by the kidneys, and sodium levels affect lithium levels.

82. Question:

A client is demonstrating signs of cocaine withdrawal. The nurse should anticipate which of the following?

a) Increased energy and euphoria

b) Sedation and decreased heart rate

c) Fatigue and depression

d) Dilated pupils

Answer: c) Fatigue and depression

Rationale: Cocaine withdrawal is often characterized by these symptoms.

83. Question:

A client with antisocial personality disorder is admitted to the psychiatric unit. The nurse should expect the client to:

a) Express remorse for their actions.

b) Follow rules and regulations.

c) Manipulate others to achieve their goals.

d) Demonstrate empathy for others.

Answer: c) Manipulate others to achieve their goals.

Rationale: This is a hallmark of antisocial personality disorder.

84. Question:

A client states, "I am the president of the United States." The nurse identifies this as:

a) A hallucination.

b) A delusion.

c) An obsession.

d) A compulsion.

Answer: b) A delusion.

Rationale: A fixed, false belief.

85. Question:

A client is prescribed alprazolam (Xanax). The nurse knows that this medication is used for:

a) Antidepressant

b) Antipsychotic

c) Antianxiety

d) Mood stabilizer

Answer: c) Antianxiety

Rationale: Alprazolam is a benzodiazepine, used to treat anxiety.

86. Question:

A client is experiencing an acute panic attack. Which of the following nursing interventions is most appropriate?

a) Encourage the client to discuss the underlying causes of their anxiety.

b) Leave the client alone to allow them to calm down.

c) Encourage the client to hyperventilate to increase oxygen levels.

d) Stay with the client and provide reassurance.

Answer: d) Stay with the client and provide reassurance.

Rationale: Provides a sense of safety during the attack.

87. Question:

A client is taking clozapine (Clozaril). Which is a critical nursing intervention?

a) Monitoring for EPS

b) Monitoring the complete blood count (CBC)

c) Monitoring liver function tests

d) Monitoring blood pressure

Answer: b) Monitoring the complete blood count (CBC)

Rationale: Clozapine can cause agranulocytosis.

88. Question:

A client with borderline personality disorder is admitted to the psychiatric unit. The nurse should expect the client to exhibit which of the following behaviors?

a) Social withdrawal

b) Delusions

c) Impulsivity and unstable relationships

d) Flat affect

Answer: c) Impulsivity and unstable relationships

Rationale: Core characteristic of BPD.

89. Question:

A client with a history of alcohol use is admitted to the hospital. Which of the following assessment findings is *most* concerning and requires immediate intervention?

a) Elevated blood pressure

b) Anxiety

c) Mild tremors

d) Seizures

Answer: d) Seizures

Rationale: Signs of alcohol withdrawal that can lead to a life-threatening event.

90. Question:

A client with paranoid schizophrenia says, "The government is spying on me." The nurse should:

a) Agree that the government is spying on them.

b) Argue with the client and tell them that their belief is false.

c) Acknowledge the client's feelings but present reality.

d) Ignore the client's statement.

Answer: c) Acknowledge the client's feelings but present reality.

Rationale: The best therapeutic approach.

91. Question:

A client who is suicidal states, "I wish I were dead." The nurse's *immediate* action is to:

a) Tell the client that there is no need to feel that way.

b) Ask the client if they have a plan.

c) Call the client's family.

d) Leave the client alone to process their feelings.

Answer: b) Ask the client if they have a plan.

Rationale: Directly assessing the risk of suicide.

92. Question:

A client diagnosed with major depressive disorder is prescribed fluoxetine (Prozac). The nurse should educate the client about the potential for:

a) Hypertensive crisis.

b) Tardive dyskinesia.

c) Serotonin syndrome.

d) Agranulocytosis.

Answer: c) Serotonin syndrome.

Rationale: This is a potential, dangerous adverse effect of SSRIs.

93. Question:

A client with generalized anxiety disorder (GAD) is learning relaxation techniques. Which statement indicates the client understands the teaching?

a) "I should avoid all stressful situations."

b) "I will avoid all forms of caffeine."

c) "If I can solve all my problems, I will be happy."

d) "I should stop my medication if my anxiety improves."

Answer: b) "I will avoid all forms of caffeine."

Rationale: Caffeine can worsen anxiety.

94. Question:

A client is experiencing echolalia. Which of the following statements demonstrates this?

a) "I see spiders on the ceiling."

b) "I believe I am the Queen."

c) "The nurse said 'How are you?' and I replied, 'How are you?'"

d) "I am filled with rage."

Answer: c) "The nurse said 'How are you?' and I replied, 'How are you?'"

Rationale: The repetition of the other person's words.

95. Question:

A client is prescribed an MAOI. Which of the following is essential for the nurse to teach the client?

a) Avoid foods high in tyramine.

b) Increase salt and fluid intake.

c) Take the medication on an empty stomach.

d) Avoid all forms of exercise.

Answer: a) Avoid foods high in tyramine.

Rationale: These can lead to a hypertensive crisis.

96. Question:

A client is being treated for an acute manic episode. Which nursing intervention is *most* important to include in the plan of care?

a) Provide a structured environment.

b) Encourage participation in group therapy.

c) Provide a high-calorie diet.

d) Encourage the client to verbalize their feelings.

Answer: a) Provide a structured environment.

Rationale: The client needs a safe and predictable environment.

97. Question:

A client who is being treated for anorexia nervosa says, "I am overweight." The nurse's best response would be:

a) "That is not true, you are dangerously underweight."

b) "You need to try harder to eat."

c) "Everyone feels that way sometimes."

d) "I am not qualified to answer that, let's talk about something else."

Answer: a) "That is not true, you are dangerously underweight."

Rationale: Corrects the distorted perception.

98. Question:

A client is admitted for opioid withdrawal. The nurse should assess the client for:

a) Sedation

b) Pinpoint pupils

c) Increased bowel sounds

d) Goosebumps

Answer: d) Goosebumps

Rationale: Goosebumps are a common symptom of opioid withdrawal.

99. Question:

A client with bipolar disorder has been prescribed lithium. The nurse should instruct the client to:

a) Increase their sodium intake.

b) Avoid strenuous exercise.

c) Maintain a consistent fluid intake.

d) Avoid foods containing tyramine.

Answer: c) Maintain a consistent fluid intake.

Rationale: Lithium levels are affected by fluid and sodium levels.

100. Question:

A client with a history of alcohol use is admitted to the hospital for a broken arm. The nurse should monitor the client for which of the following complications?

a) Delirium tremens

b) Serotonin syndrome

c) Neuroleptic malignant syndrome

d) Tardive dyskinesia

Answer: a) Delirium tremens

Rationale: A life-threatening complication of alcohol withdrawal.

Here are 100 NCLEX questions for Section 4: Medical and Surgical Nursing, along with the answers, and rational explanations:

Section 4: Medical and Surgical Nursing(100 questions)

1. A patient with a head injury is admitted to the emergency room. What is the priority nursing action?

A) Administer pain medication

B) Insert an IV line

C) Monitor the patient's vital signs

D) Turn the patient

Answer: C) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with a head injury is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of increased intracranial pressure or other complications.

2. A patient with diabetes mellitus is receiving insulin. What is the nurse's responsibility?

A) Monitor the patient's blood sugar levels closely

B) Administer insulin as ordered

C) Educate the patient about diabetes management

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with diabetes mellitus includes monitoring the patient's blood sugar levels closely, administering insulin as ordered, and educating the patient about diabetes management. This includes teaching the patient about proper diet, exercise, and blood glucose monitoring.

3. A patient with pneumonia is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's oxygen saturation

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's oxygen saturation

Rational: The priority nursing action for a patient with pneumonia is to monitor the patient's oxygen saturation closely, as pneumonia can lead to respiratory failure. The nurse should also turn the patient frequently to prevent atelectasis and promote effective gas exchange.

4. A patient with a spinal cord injury is admitted to the hospital. What is the priority nursing action?

A) Administer pain medication

B) Monitor the patient's blood pressure

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's blood pressure

Rational: The priority nursing action for a patient with a spinal cord injury is to monitor the patient's blood pressure closely, as spinal cord injuries can lead to autonomic dysreflexia, which is a life-threatening condition. The nurse should also turn the patient frequently to prevent skin breakdown.

5. A patient with a fractured hip is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) Change the patient's dressing

Answer: B) Assist the patient with walking

Rational: The nurse's responsibility for a patient with a fractured hip includes assisting the patient with walking, as early mobilization is essential for preventing complications such as deep vein thrombosis and promoting healing.

6. A patient with a brain tumor is undergoing surgery. What is the nurse's priority?

A) Monitor the patient's vital signs

B) Administer anesthesia

C) Maintain the patient's sterility

D) Insert an IV line

Answer: A) Monitor the patient's vital signs

Rational: The priority for a patient undergoing surgery is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of complications or bleeding during surgery.

7. A patient with sepsis is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) Change the patient's dressing

Answer: B) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with sepsis is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of worsening sepsis, including hypotension, tachycardia, and respiratory failure.

8. A patient with a liver transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's liver function tests

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a liver transplant includes monitoring the patient's liver function tests, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

9. A patient with a cardiac arrest is admitted to the emergency room. What is the priority nursing action?

A) Administer CPR

B) Monitor the patient's vital signs

C) Insert an IV line

D) Defibrillate the patient

Answer: A) Administer CPR

Rational: The priority nursing action for a patient with cardiac arrest is to administer CPR, which includes chest compressions and rescue breaths. This helps to maintain blood circulation and oxygenation until the patient can be defibrillated or other interventions can be initiated.

10. A patient with a spinal epidural abscess is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a spinal epidural abscess includes administering antibiotics, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the abscess and prevent further complications.

11. A patient with a stroke is admitted to the emergency room. What is the priority nursing action?

A) Administer tPA (tissue plasminogen activator)

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a stroke includes administering tPA, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the stroke and prevent further complications.

12. A patient with a fractured femur is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured femur includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

13. A patient with a kidney transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's renal function

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a kidney transplant includes monitoring the patient's renal function, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

14. A patient with a head injury is admitted to the emergency room. What is the priority nursing action?

A) Administer pain medication

B) Insert an IV line

C) Monitor the patient's vital signs

D) Turn the patient

Answer: C) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with a head injury is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of increased intracranial pressure or other complications.

15. A patient with pneumonia is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's oxygen saturation

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's oxygen saturation

Rational: The priority nursing action for a patient with pneumonia is to monitor the patient's oxygen saturation closely, as pneumonia can lead to respiratory failure. The nurse should also turn the patient frequently to prevent atelectasis and promote effective gas exchange.

16. A patient with a spinal cord injury is admitted to the hospital. What is the priority nursing action?

A) Administer pain medication

B) Monitor the patient's blood pressure

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's blood pressure

Rational: The priority nursing action for a patient with a spinal cord injury is to monitor the patient's blood pressure closely, as spinal cord injuries can lead to autonomic dysreflexia, which is a life-threatening condition. The nurse should also turn the patient frequently to prevent skin breakdown.

17. A patient with a fractured hip is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured hip includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

18. A patient with a brain tumor is undergoing surgery. What is the nurse's priority?

A) Monitor the patient's vital signs

B) Administer anesthesia

C) Maintain the patient's sterility

D) Insert an IV line

Answer: A) Monitor the patient's vital signs

Rational: The priority for a patient undergoing surgery is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of complications or bleeding during surgery.

19. A patient with sepsis is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) Change the patient's dressing

Answer: B) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with sepsis is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of worsening sepsis, including hypotension, tachycardia, and respiratory failure.

20. A patient with a liver transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's liver function tests

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a liver transplant includes monitoring the patient's liver function tests, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

21. A patient with a cardiac arrest is admitted to the emergency room. What is the priority nursing action?

A) Administer CPR

B) Monitor the patient's vital signs

C) Insert an IV line

D) Defibrillate the patient

Answer: A) Administer CPR

Rational: The priority nursing action for a patient with cardiac arrest is to administer CPR, which includes chest compressions and rescue breaths. This helps to maintain blood circulation and oxygenation until the patient can be defibrillated or other interventions can be initiated.

22. A patient with a spinal epidural abscess is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a spinal epidural abscess includes administering antibiotics, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the abscess and prevent further complications.

23. A patient with a stroke is admitted to the emergency room. What is the priority nursing action?

A) Administer tPA (tissue plasminogen activator)

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a stroke includes administering tPA, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the stroke and prevent further complications.

24. A patient with a fractured femur is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured femur includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

25. A patient with a kidney transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's renal function

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a kidney transplant includes monitoring the patient's renal function, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

26. A patient with a head injury is admitted to the emergency room. What is the priority nursing action?

A) Administer pain medication

B) Insert an IV line

C) Monitor the patient's vital signs

D) Turn the patient

Answer: C) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with a head injury is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of increased intracranial pressure or other complications.

27. A patient with pneumonia is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's oxygen saturation

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's oxygen saturation

Rational: The priority nursing action for a patient with pneumonia is to monitor the patient's oxygen saturation closely, as pneumonia can lead to respiratory failure. The nurse should also turn the patient frequently to prevent atelectasis and promote effective gas exchange.

28. A patient with a spinal cord injury is admitted to the hospital. What is the priority nursing action?

A) Administer pain medication

B) Monitor the patient's blood pressure

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's blood pressure

Rational: The priority nursing action for a patient with a spinal cord injury is to monitor the patient's blood pressure closely, as spinal cord injuries can lead to autonomic dysreflexia, which is a life-threatening condition. The nurse should also turn the patient frequently to prevent skin breakdown.

29. A patient with a fractured hip is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured hip includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

30. A patient with a brain tumor is undergoing surgery. What is the nurse's priority?

A) Monitor the patient's vital signs

B) Administer anesthesia

C) Maintain the patient's sterility

D) Insert an IV line

Answer: A) Monitor the patient's vital signs

Rational: The priority for a patient undergoing surgery is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of complications or bleeding during surgery.

31. A patient with sepsis is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) Change the patient's dressing

Answer: B) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with sepsis is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of worsening sepsis, including hypotension, tachycardia, and respiratory failure.

32. A patient with a liver transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's liver function tests

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a liver transplant includes monitoring the patient's liver function tests, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

33. A patient with a cardiac arrest is admitted to the emergency room. What is the priority nursing action?

A) Administer CPR

B) Monitor the patient's vital signs

C) Insert an IV line

D) Defibrillate the patient

Answer: A) Administer CPR

Rational: The priority nursing action for a patient with cardiac arrest is to administer CPR, which includes chest compressions and rescue breaths. This helps to maintain blood circulation and oxygenation until the patient can be defibrillated or other interventions can be initiated.

34. A patient with a spinal epidural abscess is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a spinal epidural abscess includes administering antibiotics, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the abscess and prevent further complications.

35. A patient with a stroke is admitted to the emergency room. What is the priority nursing action?

A) Administer tPA (tissue plasminogen activator)

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a stroke includes administering tPA, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the stroke and prevent further complications.

36. A patient with a fractured femur is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured femur includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

37. A patient with a kidney transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's renal function

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a kidney transplant includes monitoring the patient's renal function, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

38. A patient with a head injury is admitted to the emergency room. What is the priority nursing action?

A) Administer pain medication

B) Insert an IV line

C) Monitor the patient's vital signs

D) Turn the patient

Answer: C) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with a head injury is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of increased intracranial pressure or other complications.

39. A patient with pneumonia is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's oxygen saturation

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's oxygen saturation

Rational: The priority nursing action for a patient with pneumonia is to monitor the patient's oxygen saturation closely, as pneumonia can lead to respiratory failure. The nurse should also turn the patient frequently to prevent atelectasis and promote effective gas exchange.

40. A patient with a spinal cord injury is admitted to the hospital. What is the priority nursing action?

A) Administer pain medication

B) Monitor the patient's blood pressure

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's blood pressure

Rational: The priority nursing action for a patient with a spinal cord injury is to monitor the patient's blood pressure closely, as spinal cord injuries can lead to autonomic dysreflexia, which is a life-threatening condition. The nurse should also turn the patient frequently to prevent skin breakdown.

41. A patient with a fractured hip is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured hip includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

42. A patient with a brain tumor is undergoing surgery. What is the nurse's priority?

A) Monitor the patient's vital signs

B) Administer anesthesia

C) Maintain the patient's sterility

D) Insert an IV line

Answer: A) Monitor the patient's vital signs

Rational: The priority for a patient undergoing surgery is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of complications or bleeding during surgery.

43. A patient with sepsis is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) Change the patient's dressing

Answer: B) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with sepsis is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of worsening sepsis, including hypotension, tachycardia, and respiratory failure.

44. A patient with a liver transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's liver function tests

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a liver transplant includes monitoring the patient's liver function tests, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

45. A patient with a cardiac arrest is admitted to the emergency room. What is the priority nursing action?

A) Administer CPR

B) Monitor the patient's vital signs

C) Insert an IV line

D) Defibrillate the patient

Answer: A) Administer CPR

Rational: The priority nursing action for a patient with cardiac arrest is to administer CPR, which includes chest compressions and rescue breaths. This helps to maintain blood circulation and oxygenation until the patient can be defibrillated or other interventions can be initiated.

46. A patient with a spinal epidural abscess is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a spinal epidural abscess includes administering antibiotics, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the abscess and prevent further complications.

47. A patient with a stroke is admitted to the emergency room. What is the priority nursing action?

A) Administer tPA (tissue plasminogen activator)

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a stroke includes administering tPA, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the stroke and prevent further complications.

48. A patient with a fractured femur is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured femur includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

49. A patient with a kidney transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's renal function

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a kidney transplant includes monitoring the patient's renal function, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

50. A patient with a head injury is admitted to the emergency room. What is the priority nursing action?

A) Administer pain medication

B) Insert an IV line

C) Monitor the patient's vital signs

D) Turn the patient

Answer: C) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with a head injury is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of increased intracranial pressure or other complications.

51. A patient with pneumonia is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's oxygen saturation

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's oxygen saturation

Rational: The priority nursing action for a patient with pneumonia is to monitor the patient's oxygen saturation closely, as pneumonia can lead to respiratory failure. The nurse should also turn the patient frequently to prevent atelectasis and promote effective gas exchange.

52. A patient with a spinal cord injury is admitted to the hospital. What is the priority nursing action?

A) Administer pain medication

B) Monitor the patient's blood pressure

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's blood pressure

Rational: The priority nursing action for a patient with a spinal cord injury is to monitor the patient's blood pressure closely, as spinal cord injuries can lead to autonomic dysreflexia, which is a life-threatening condition. The nurse should also turn the patient frequently to prevent skin breakdown.

53. A patient with a fractured hip is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured hip includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

54. A patient with a brain tumor is undergoing surgery. What is the nurse's priority?

A) Monitor the patient's vital signs

B) Administer anesthesia

C) Maintain the patient's sterility

D) Insert an IV line

Answer: A) Monitor the patient's vital signs

Rational: The priority for a patient undergoing surgery is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of complications or bleeding during surgery.

55. A patient with sepsis is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) Change the patient's dressing

Answer: B) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with sepsis is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of worsening sepsis, including hypotension, tachycardia, and respiratory failure.

56. A patient with a liver transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's liver function tests

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a liver transplant includes monitoring the patient's liver function tests, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

57. A patient with a cardiac arrest is admitted to the emergency room. What is the priority nursing action?

A) Administer CPR

B) Monitor the patient's vital signs

C) Insert an IV line

D) Defibrillate the patient

Answer: A) Administer CPR

Rational: The priority nursing action for a patient with cardiac arrest is to administer CPR, which includes chest compressions and rescue breaths. This helps to maintain blood circulation and oxygenation until the patient can be defibrillated or other interventions can be initiated.

58. A patient with a spinal epidural abscess is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a spinal epidural abscess includes administering antibiotics, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the abscess and prevent further complications.

59. A patient with a stroke is admitted to the emergency room. What is the priority nursing action?

A) Administer tPA (tissue plasminogen activator)

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a stroke includes administering tPA, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the stroke and prevent further complications.

60. A patient with a fractured femur is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured femur includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

61. A patient with a kidney transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's renal function

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a kidney transplant includes monitoring the patient's renal function, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

62. A patient with a head injury is admitted to the emergency room. What is the priority nursing action?

A) Administer pain medication

B) Insert an IV line

C) Monitor the patient's vital signs

D) Turn the patient

Answer: C) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with a head injury is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of increased intracranial pressure or other complications.

63. A patient with pneumonia is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's oxygen saturation

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's oxygen saturation

Rational: The priority nursing action for a patient with pneumonia is to monitor the patient's oxygen saturation closely, as pneumonia can lead to respiratory failure. The nurse should also turn the patient frequently to prevent atelectasis and promote effective gas exchange.

64. A patient with a spinal cord injury is admitted to the hospital. What is the priority nursing action?

A) Administer pain medication

B) Monitor the patient's blood pressure

C) Turn the patient frequently

D) Insert an IV line

Answer: B) Monitor the patient's blood pressure

Rational: The priority nursing action for a patient with a spinal cord injury is to monitor the patient's blood pressure closely, as spinal cord injuries can lead to autonomic dysreflexia, which is a life-threatening condition. The nurse should also turn the patient frequently to prevent skin breakdown.

65. A patient with a fractured hip is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured hip includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

66. A patient with a brain tumor is undergoing surgery. What is the nurse's priority?

A) Monitor the patient's vital signs

B) Administer anesthesia

C) Maintain the patient's sterility

D) Insert an IV line

Answer: A) Monitor the patient's vital signs

Rational: The priority for a patient undergoing surgery is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of complications or bleeding during surgery.

67. A patient with sepsis is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) Change the patient's dressing

Answer: B) Monitor the patient's vital signs

Rational: The priority nursing action for a patient with sepsis is to monitor the patient's vital signs closely, including blood pressure, pulse, respiratory rate, and oxygen saturation. This helps to detect any signs of worsening sepsis, including hypotension, tachycardia, and respiratory failure.

68. A patient with a liver transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's liver function tests

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a liver transplant includes monitoring the patient's liver function tests, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

69. A patient with a cardiac arrest is admitted to the emergency room. What is the priority nursing action?

A) Administer CPR

B) Monitor the patient's vital signs

C) Insert an IV line

D) Defibrillate the patient

Answer: A) Administer CPR

Rational: The priority nursing action for a patient with cardiac arrest is to administer CPR, which includes chest compressions and rescue breaths. This helps to maintain blood circulation and oxygenation until the patient can be defibrillated or other interventions can be initiated.

70. A patient with a spinal epidural abscess is admitted to the hospital. What is the priority nursing action?

A) Administer antibiotics

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a spinal epidural abscess includes administering antibiotics, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the abscess and prevent further complications.

71. A patient with a stroke is admitted to the emergency room. What is the priority nursing action?

A) Administer tPA (tissue plasminogen activator)

B) Monitor the patient's vital signs

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's priority for a patient with a stroke includes administering tPA, monitoring the patient's vital signs closely, and inserting an IV line to administer medications and fluids. This helps to treat the stroke and prevent further complications.

72. A patient with a fractured femur is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's pain level

B) Assist the patient with walking

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a fractured femur includes monitoring the patient's pain level, assisting the patient with walking, and inserting an IV line to administer medications and fluids. This helps to promote healing and prevent complications.

73. A patient with a kidney transplant is admitted to the hospital. What is the nurse's responsibility?

A) Monitor the patient's renal function

B) Administer immunosuppressive medication

C) Insert an IV line

D) All of the above

Answer: D) All of the above

Rational: The nurse's responsibility for a patient with a kidney transplant includes monitoring the patient's renal function, administering immunosuppressive medication, and inserting an IV line to administer medications and fluids.

74. A patient with a head injury is admitted to the emergency room. The nurse notes clear fluid leaking from the patient's nose. What is the nurse's priority action?

A) Pack the nares with gauze

B) Check the fluid for glucose

C) Suction the nasal passage

D) Apply a cold compress

Answer: B) Check the fluid for glucose

Rational: Clear fluid leaking from the nose in a patient with a head injury may be cerebrospinal fluid (CSF). Checking the fluid for glucose is a quick and easy way to determine if it is CSF (CSF will test positive for glucose). Packing the nares should not be done before you find out whether the fluid is CSF.

75. A patient who has just had a total hip replacement reports sudden, severe chest pain and shortness of breath. What is the nurse's priority action?

A) Assess breath sounds and oxygen saturation

B) Administer oxygen via nasal cannula

C) Notify the Rapid Response Team or physician immediately

D) Place the patient in a high-Fowler's position

Answer: C) Notify the Rapid Response Team or physician immediately

Rational: This patient is exhibiting signs of a possible pulmonary embolism (PE), a life-threatening complication of hip replacement surgery. Rapid intervention is required.

76. The nurse is caring for a patient with a tracheostomy. Which of the following actions is most important to perform routinely?

A) Suction the tracheostomy tube every 4 hours.

B) Assess the stoma site for signs of infection.

C) Change the tracheostomy ties every shift.

D) Provide humidified oxygen.

Answer: B) Assess the stoma site for signs of infection.

Rational: Assessing the stoma site is essential to detect signs of infection, which could lead to systemic infection.

77. A patient with a diagnosis of deep vein thrombosis (DVT) is prescribed heparin. What is the priority nursing action?

A) Monitor the patient's activated partial thromboplastin time (aPTT).

B) Encourage the patient to ambulate frequently.

C) Instruct the patient to increase fluid intake.

D) Assess the patient's peripheral pulses.

Answer: A) Monitor the patient's activated partial thromboplastin time (aPTT).

Rational: The nurse must monitor the aPTT to ensure the heparin is therapeutic and to prevent complications such as bleeding.

78. A patient with a history of heart failure is admitted with shortness of breath and edema. Which of the following medications would the nurse anticipate administering?

A) Metoprolol

B) Furosemide

C) Lisinopril

D) Warfarin

Answer: B) Furosemide

Rational: Furosemide (Lasix) is a loop diuretic that helps to reduce fluid overload in patients with heart failure.

79. A patient with a history of chronic obstructive pulmonary disease (COPD) is admitted with respiratory distress. The patient's oxygen saturation is 88% on room air. Which oxygen delivery method is most appropriate for this patient?

A) 100% non-rebreather mask

B) High-flow nasal cannula

C) Nasal cannula at 2 L/min

D) Venturi mask

Answer: D) Venturi mask

Rational: The Venturi mask delivers a precise and controlled concentration of oxygen, which is essential for patients with COPD to prevent hypercapnia (excessive carbon dioxide).

80. A patient is diagnosed with appendicitis and scheduled for an appendectomy. What is the priority nursing assessment?

A) Auscultate bowel sounds.

B) Assess the patient's pain level.

C) Palpate the abdomen for rigidity.

D) Check the patient's temperature.

Answer: B) Assess the patient's pain level.

Rational: The patient's pain level is an essential data point to assess for deterioration and effectiveness of pain management.

81. A client is admitted with a diagnosis of a possible myocardial infarction (MI). Which of the following laboratory tests would be most important for the nurse to monitor?

A) Complete Blood Count (CBC)

B) Creatine Kinase-MB (CK-MB)

C) Complete Metabolic Panel (CMP)

D) International Normalized Ratio (INR)

Answer: B) Creatine Kinase-MB (CK-MB)

Rational: CK-MB is a cardiac enzyme that is released into the bloodstream when there is damage to the heart muscle.

82. A patient is one day post-operative following a laparoscopic cholecystectomy. The patient reports right shoulder pain. What is the nurse's best response?

A) "This is a sign of a complication. I will notify the physician immediately."

B) "I will administer pain medication as prescribed."

C) "This is normal; it's from the carbon dioxide used during the surgery."

D) "You must be overdoing it. Try resting more."

Answer: C) "This is normal; it's from the carbon dioxide used during the surgery."

Rational: Right shoulder pain is a common complaint after laparoscopic cholecystectomy due to the residual carbon dioxide used to inflate the abdomen during surgery.

83. The nurse is caring for a patient with a wound that is healing by secondary intention. What is an appropriate nursing intervention?

A) Apply a sterile dressing to the wound once a day.

B) Pack the wound with sterile saline-soaked gauze.

C) Irrigate the wound with sterile water every shift.

D) Leave the wound open to the air.

Answer: B) Pack the wound with sterile saline-soaked gauze.

Rational: Wounds healing by secondary intention require packing to fill the wound cavity and promote healing from the inside out.

84. The nurse is caring for a patient with a urinary catheter. What is the most important intervention to prevent a urinary tract infection (UTI)?

A) Encourage the patient to drink plenty of fluids.

B) Perform routine catheter irrigations.

C) Maintain a closed urinary drainage system.

D) Use sterile technique when emptying the drainage bag.

Answer: C) Maintain a closed urinary drainage system.

Rational: A closed urinary drainage system is the most important intervention to prevent UTIs associated with indwelling catheters.

85. A patient with a small bowel obstruction is admitted to the hospital. Which of the following nursing interventions is most important?

A) Encourage oral fluids.

B) Monitor intake and output.

C) Administer stool softeners.

D) Ambulate the patient frequently.

Answer: B) Monitor intake and output.

Rational: Careful monitoring of intake and output (including any emesis and nasogastric output) is essential to assess fluid balance and the effectiveness of interventions.

86. A client with a peptic ulcer disease is prescribed antacids. When is the best time for the nurse to administer the antacid?

A) With meals

B) At bedtime

C) One hour after meals

D) Two hours before or after other medications

Answer: C) One hour after meals

Rational: Antacids are often administered one hour after meals to neutralize stomach acid produced during digestion, but to avoid interfering with other medications.

**87. A client with a new diagnosis of Multiple Sclerosis (MS) asks the nurse "What should I expect?" The nurse response is: **

A) "Your disease will be in remission quickly, so you don't have to worry."

B) "You will experience periods of remission and exacerbation."

C) "Your disease will get better within the year with proper medications."

D) "Your disease will likely become unmanageable within the year."

Answer: B) "You will experience periods of remission and exacerbation."

Rational: Multiple Sclerosis (MS) is a chronic, often unpredictable, disease characterized by periods of relapses (exacerbations) and remissions.

88. A patient with a new diagnosis of Crohn's disease asks the nurse about dietary recommendations. What is appropriate advice to give the client?

A) Avoid all dairy products

B) Eat a high fiber diet

C) Follow a low-residue diet

D) Drink plenty of caffeinated beverages

Answer: C) Follow a low-residue diet

Rational: A low-residue diet (low in fiber and certain other foods) helps to reduce the frequency and volume of stools, which can help manage symptoms of Crohn's disease.

89. A patient has just returned from a bronchoscopy. Which of the following is the nurse's priority assessment?

A) Level of consciousness

B) Ability to swallow

C) Respiratory status

D) Pain level

Answer: C) Respiratory status

Rational: The priority assessment after a bronchoscopy is respiratory status, due to possible complications such as respiratory distress.

90. A client with a head injury is experiencing increased intracranial pressure (ICP). Which of the following nursing interventions is most important?

A) Keep the head of the bed flat

B) Cluster nursing activities to avoid overstimulation

C) Encourage frequent coughing

D) Maintain a quiet environment

Answer: D) Maintain a quiet environment

Rational: A quiet, calm environment minimizes stimuli and promotes ICP control, decreasing the risk of further injury.

91. A patient with a stroke has right-sided weakness. What is the priority nursing goal?

A) Preventing aspiration

B) Maintaining skin integrity

C) Promoting independence with activities of daily living

D) Preventing contractures

Answer: A) Preventing aspiration

Rational: Preventing aspiration is crucial in a patient with dysphagia, which can be a result of a stroke. Aspiration can lead to pneumonia.

**92. A patient presents with chest pain, shortness of breath, and diaphoresis. An electrocardiogram (ECG) reveals ST-segment elevation in several leads. The nurse recognizes that the patient is likely experiencing: **

A) Stable angina

B) Pericarditis

C) Myocardial infarction

D) Heart failure

Answer: C) Myocardial infarction

Rational: ST-segment elevation on an ECG is a classic sign of a myocardial infarction (MI) or heart attack.

93. The nurse is caring for a patient with a closed head injury who is exhibiting signs of increased intracranial pressure (ICP). Which of the following is a key sign of this?

A) Bradycardia

B) Hypotension

C) Irregular respirations

D) Dilated pupils

Answer: C) Irregular respirations

Rational: Cushing's triad, a sign of increased ICP, includes irregular respirations.

94. A client who has had a total hip replacement is complaining of severe pain in their affected leg. The nurse assesses the leg and finds it to be externally rotated and shortened. What does the nurse suspect?

A) Dislocation of the hip

B) Deep vein thrombosis

C) Infection

D) Compartment syndrome

Answer: A) Dislocation of the hip

Rational: External rotation and shortening of the leg after a total hip replacement are classic signs of hip dislocation.

95. The nurse is teaching a client about the use of a metered-dose inhaler (MDI). What is the correct order of steps?

A) Shake the inhaler, exhale completely, place the mouthpiece in the mouth, depress the canister, and inhale slowly and deeply.

B) Place the mouthpiece in the mouth, exhale completely, shake the inhaler, depress the canister, and inhale slowly and deeply.

C) Exhale completely, shake the inhaler, place the mouthpiece in the mouth, inhale deeply and quickly, and depress the canister.

D) Shake the inhaler, inhale deeply and quickly, place the mouthpiece in the mouth, exhale completely, and depress the canister.

Answer: A) Shake the inhaler, exhale completely, place the mouthpiece in the mouth, depress the canister, and inhale slowly and deeply.

Rational: This is the correct sequence for using an MDI effectively, ensuring the medication reaches the lungs.

96. A client with a history of unstable angina is admitted to the cardiac care unit. What is the priority nursing intervention?

A) Administer oxygen via nasal cannula.

B) Obtain a 12-lead ECG.

C) Obtain vital signs and assess chest pain.

D) Insert an intravenous (IV) catheter.

Answer: C) Obtain vital signs and assess chest pain

Rational: It is important to rapidly assess the patient's current status, including chest pain, vital signs, and oxygen saturation.

97. The nurse is reviewing the laboratory results of a patient with suspected kidney failure. Which of the following findings would the nurse expect to see?

A) Decreased serum creatinine

B) Elevated BUN

C) Decreased potassium

D) Decreased urine specific gravity

Answer: B) Elevated BUN

Rational: Kidney failure often leads to an increase in blood urea nitrogen (BUN) because the kidneys cannot filter waste products effectively.

98. A patient is receiving warfarin (Coumadin). Which of the following lab values is most important for the nurse to monitor?

A) Hemoglobin

B) Platelet count

C) Prothrombin time (PT) and INR

D) White blood cell count

Answer: C) Prothrombin time (PT) and INR

Rational: PT/INR are used to monitor the effectiveness and safety of warfarin therapy.

99. The nurse is caring for a patient with a new colostomy. What is the most important nursing intervention for the first few days post-operatively?

A) Instruct the patient on the procedure for changing the ostomy pouch.

B) Assess the stoma for color and viability.

C) Encourage the patient to eat a high-fiber diet.

D) Provide emotional support.

Answer: B) Assess the stoma for color and viability.

Rational: Assessing the stoma for color and viability (pink or red and moist) is crucial to assess for adequate blood supply and healing.

100. A patient with a diagnosis of pulmonary embolism (PE) is receiving intravenous heparin. The patient suddenly complains of flank pain and has a drop in blood pressure. What is the nurse's priority action?

A) Administer the antidote for heparin, protamine sulfate.

B) Assess for signs of bleeding.

C) Notify the Rapid Response Team/physician immediately.

D) Increase the heparin infusion rate.

Answer: C) Notify the Rapid Response Team/physician immediately.

Rational: The sudden flank pain and drop in blood pressure could indicate a retroperitoneal bleed, a serious complication of heparin therapy. Prompt notification of the rapid response team or physician is required for quick intervention.

Okay, here are 100 NCLEX-style questions for Section 5: Pharmacology and Lab Values, along with the answers and rational explanations:

Section 5: Pharmacology and Lab Values(100 questions)

1. A patient is prescribed Lisinopril. What is the primary action of this medication?

A) Beta-blocker

B) ACE inhibitor

C) Calcium channel blocker

D) Diuretic

Answer: B) ACE inhibitor

Rational: Lisinopril is an ACE (angiotensin-converting enzyme) inhibitor. ACE inhibitors lower blood pressure by preventing the conversion of angiotensin I to angiotensin II. Angiotensin II is a potent vasoconstrictor.

2. The nurse is administering an intramuscular (IM) injection of morphine to a patient. Which of the following is the most important assessment before administration?

A) Blood pressure

B) Respiratory rate

C) Temperature

D) Pulse oximetry

Answer: B) Respiratory rate

Rational: Morphine is an opioid analgesic that can cause respiratory depression. The nurse must assess the respiratory rate before administration to ensure it is within a safe range (typically above 12 breaths per minute).

3. A patient is taking warfarin (Coumadin). What is the therapeutic range for the International Normalized Ratio (INR)?

A) 0.5-1.0

B) 1.0-2.0

C) 2.0-3.0

D) 3.0-4.0

Answer: C) 2.0-3.0

Rational: The therapeutic INR range for patients on warfarin is typically 2.0-3.0, although this may vary based on the indication (e.g., mechanical heart valve). Warfarin thins the blood and the INR measures how quickly the blood clots.

4. A patient is prescribed furosemide (Lasix). The nurse should monitor the patient for which electrolyte imbalance?

A) Hyperkalemia

B) Hypokalemia

C) Hypernatremia

D) Hypercalcemia

Answer: B) Hypokalemia

Rational: Furosemide is a loop diuretic that can cause the loss of potassium through increased urinary excretion, leading to hypokalemia (low potassium).

5. A patient is taking digoxin. Which of the following signs and symptoms would indicate digoxin toxicity?

A) Bradycardia and yellow halos around lights

B) Tachycardia and muscle weakness

C) Hypertension and headache

D) Diarrhea and increased appetite

Answer: A) Bradycardia and yellow halos around lights

Rational: Digoxin toxicity can cause bradycardia (slow heart rate), as well as visual disturbances such as seeing yellow halos around lights. Other signs include nausea, vomiting, and cardiac arrhythmias.

6. A patient is taking an aminoglycoside antibiotic. What is a potential serious side effect that the nurse must monitor for?

A) Ototoxicity

B) Hepatotoxicity

C) Nephrotoxicity

D) All of the above

Answer: D) All of the above

Rational: Aminoglycoside antibiotics (e.g., gentamicin, tobramycin) can cause ototoxicity (damage to the inner ear), nephrotoxicity (kidney damage), and hepatotoxicity (liver damage). The nurse should monitor renal function (BUN, creatinine), hearing, and liver function tests.

7. A patient is receiving intravenous potassium chloride (KCl). What is the most important nursing action?

A) Infuse the KCl rapidly.

B) Monitor the patient's urine output.

C) Assess the IV site for infiltration.

D) Administer the KCl via IV push.

Answer: C) Assess the IV site for infiltration.

Rational: Potassium chloride (KCl) is a vesicant and can cause severe tissue damage if it infiltrates. The IV site must be assessed frequently for signs of infiltration (pain, swelling, redness). KCl must never be given via IV push or rapidly.

8. A patient is prescribed metoprolol. What is the primary action of this medication?

A) Beta-blocker

B) ACE inhibitor

C) Calcium channel blocker

D) Diuretic

Answer: A) Beta-blocker

Rational: Metoprolol is a beta-blocker, which lowers blood pressure and heart rate by blocking the effects of epinephrine and norepinephrine on the heart.

9. The nurse is preparing to administer a medication via the subcutaneous (SC) route. What is the appropriate angle of injection?

A) 15 degrees

B) 30 degrees

C) 45 degrees

D) 90 degrees

Answer: C) 45 degrees

Rational: The appropriate angle for a subcutaneous injection is usually 45 degrees, although this may vary based on the patient's body fat. A 90-degree angle is often used for muscular (IM) injections and only done if the patient has a lot of subcutaneous tissue.

10. A patient with a history of asthma is prescribed a beta-blocker. What is the nurse's primary concern?

A) Increased risk of bleeding

B) Worsening of asthma symptoms

C) Risk of hypoglycemia

D) Development of heart failure

Answer: B) Worsening of asthma symptoms

Rational: Beta-blockers can cause bronchoconstriction, which can worsen asthma symptoms. Beta-blockers should be used cautiously, if at all, in patients with asthma.

11. A patient is taking insulin. What is a sign and symptom of hypoglycemia?

A) Polyuria

B) Polydipsia

C) Tachycardia and tremors

D) Blurred vision

Answer: C) Tachycardia and tremors

Rational: Hypoglycemia (low blood sugar) can cause symptoms such as tachycardia (rapid heart rate), tremors, sweating, and confusion.

12. A patient is taking theophylline. The nurse should monitor the patient for which of the following side effects?

A) Constipation

B) Tachycardia and nervousness

C) Hypotension

D) Hypoglycemia

Answer: B) Tachycardia and nervousness

Rational: Theophylline is a bronchodilator. Common side effects include tachycardia (rapid heart rate), nervousness, and insomnia.

13. A patient is receiving an intravenous antibiotic. The nurse observes the patient developing hives, itching, and difficulty breathing. What is the priority nursing action?

A) Stop the infusion immediately.

B) Administer the next dose as scheduled.

C) Slow the infusion rate.

D) Assess vital signs and document the findings.

Answer: A) Stop the infusion immediately.

Rational: The patient is exhibiting signs of an allergic reaction, potentially anaphylaxis, which is a life-threatening emergency. The infusion must be stopped immediately.

14. A patient is prescribed a statin medication. What is a key teaching point for this medication?

A) Take the medication with food.

B) Monitor blood glucose levels regularly.

C) Report any muscle pain to the healthcare provider.

D) Avoid grapefruit juice.

Answer: C) Report any muscle pain to the healthcare provider.

Rational: Statins can cause muscle pain and weakness (myopathy), which can progress to rhabdomyolysis, a serious condition. Patients should report any muscle pain to their healthcare provider.

15. A patient is taking an oral hypoglycemic medication. The nurse is educating the patient about the medication. What is a key teaching point?

A) Take the medication at bedtime.

B) Monitor blood glucose levels as prescribed.

C) Avoid alcohol.

D) All of the above

Answer: D) All of the above

Rational: Patients taking oral hypoglycemic medications should be taught to take the medication as prescribed, monitor blood glucose levels, and avoid alcohol, as it can affect blood sugar control.

16. A patient has a serum potassium level of 6.8 mEq/L. What is the priority nursing action?

A) Administer potassium chloride IV.

B) Place the patient on a cardiac monitor.

C) Encourage the patient to drink plenty of fluids.

D) Monitor the patient's blood pressure.

Answer: B) Place the patient on a cardiac monitor.

Rational: A potassium level of 6.8 mEq/L is dangerously high (hyperkalemia), and can cause cardiac arrhythmias, including life-threatening ones. The patient should be placed on a cardiac monitor.

17. A patient is taking aspirin. What is a potential side effect of this medication?

A) Hypercalcemia

B) Gastric irritation

C) Constipation

D) Tachycardia

Answer: B) Gastric irritation

Rational: Aspirin is an NSAID (nonsteroidal anti-inflammatory drug) that can cause gastric irritation and increase the risk of peptic ulcers.

18. A patient has a serum sodium level of 125 mEq/L. What is this condition called?

A) Hypernatremia

B) Hyponatremia

C) Hyperkalemia

D) Hypokalemia

Answer: B) Hyponatremia

Rational: Hyponatremia is a low serum sodium level.

19. A patient is prescribed enoxaparin (Lovenox). The nurse should monitor the patient for which of the following?

A) Increased risk of bleeding

B) Development of hypertension

C) Risk of hypoglycemia

D) All of the above

Answer: A) Increased risk of bleeding

Rational: Enoxaparin is an anticoagulant that increases the risk of bleeding. The nurse should monitor for signs of bleeding (e.g., bruising, hematuria, bleeding gums).

20. A patient is taking an antidepressant medication. The nurse is teaching the patient about the medication. What is a key teaching point?

A) Expect immediate relief of symptoms.

B) Avoid alcohol.

C) Discontinue the medication if side effects occur.

D) Do not change the dose without consulting the physician.

Answer: B) Avoid alcohol.

Rational: Most antidepressants should not be taken with alcohol due to the risk of increased sedation and other interactions. Do not stop the medication abruptly.

21. The nurse is reviewing a patient's lab results. The patient's creatinine level is 2.8 mg/dL. What is the nurse's primary concern?

A) Elevated blood glucose

B) Kidney function

C) Liver function

D) Electrolyte imbalance

Answer: B) Kidney function

Rational: Creatinine is a waste product of muscle metabolism that is filtered by the kidneys. An elevated creatinine level indicates decreased kidney function.

22. A patient is prescribed a medication that is known to be nephrotoxic. The nurse should monitor which of the following laboratory tests?

A) Complete blood count (CBC)

B) Liver function tests (LFTs)

C) Serum creatinine and BUN

D) Prothrombin time (PT) and INR

Answer: C) Serum creatinine and BUN

Rational: Serum creatinine and BUN (blood urea nitrogen) are indicators of kidney function. Nephrotoxic medications can damage the kidneys, so these tests are important to monitor.

23. A patient is receiving an intravenous infusion of packed red blood cells (PRBCs). What is the priority nursing action during the first 15 minutes of the infusion?

A) Monitor the patient's temperature.

B) Stay with the patient and observe for a reaction.

C) Increase the infusion rate.

D) Administer a diuretic.

Answer: B) Stay with the patient and observe for a reaction.

Rational: During the first 15 minutes of a blood transfusion, the nurse should stay with the patient to observe for signs of a transfusion reaction (e.g., fever, chills, rash, difficulty breathing).

24. A patient is prescribed levothyroxine (Synthroid). What is the purpose of this medication?

A) Treatment of hyperthyroidism

B) Treatment of hypothyroidism

C) Control of blood sugar

D) Relief of pain

Answer: B) Treatment of hypothyroidism

Rational: Levothyroxine is a synthetic thyroid hormone used to treat hypothyroidism (low thyroid function).

25. A patient is taking an anticholinergic medication. The nurse should monitor the patient for which of the following side effects?

A) Diarrhea

B) Urinary retention

C) Excessive salivation

D) Bradycardia

Answer: B) Urinary retention

Rational: Anticholinergic medications block the action of acetylcholine. Anticholinergic effects include dry mouth, blurred vision, constipation, and urinary retention.

26. A patient's platelet count is 75,000/mm3. What is the nurse's primary concern?

A) Increased risk of infection

B) Increased risk of bleeding

C) Kidney failure

D) Liver failure

Answer: B) Increased risk of bleeding

Rational: A platelet count of 75,000/mm3 is below the normal range (150,000-450,000/mm3), increasing the risk of bleeding.

27. A patient is prescribed albuterol. What is the primary action of this medication?

A) Beta-blocker

B) Diuretic

C) Bronchodilator

D) ACE inhibitor

Answer: C) Bronchodilator

Rational: Albuterol is a beta-agonist bronchodilator used to treat asthma and other respiratory conditions by opening the airways.

28. A patient is taking a calcium channel blocker. The nurse should monitor the patient for which of the following side effects?

A) Tachycardia

B) Constipation

C) Increased blood sugar

D) Diarrhea

Answer: B) Constipation

Rational: Calcium channel blockers can cause constipation.

29. A patient is prescribed an opioid analgesic medication. The nurse is teaching the patient about the medication. What is a key teaching point?

A) The medication can cause constipation.

B) The medication can cause hyperglycemia.

C) The medication can cause hypotension.

D) The medication can cause insomnia.

Answer: A) The medication can cause constipation

Rational: Opioid analgesics can cause constipation.

30. A patient has a hemoglobin level of 8 g/dL. What is the nurse's primary concern?

A) Increased risk of infection

B) Anemia

C) Liver failure

D) Kidney failure

Answer: B) Anemia

Rational: A hemoglobin level of 8 g/dL is below the normal range and indicates anemia (low red blood cell count).

31. A patient is prescribed omeprazole (Prilosec). What is the purpose of this medication?

A) Antibiotic

B) Antidiabetic

C) Proton pump inhibitor

D) Anticoagulant

Answer: C) Proton pump inhibitor

Rational: Omeprazole is a proton pump inhibitor (PPI) used to reduce stomach acid production and treat conditions such as GERD and peptic ulcers.

32. A patient is taking an oral corticosteroid medication. What is a key teaching point for this medication?

A) Take the medication on an empty stomach.

B) Avoid sudden discontinuation of the medication.

C) Limit fluid intake.

D) Increase potassium intake.

Answer: B) Avoid sudden discontinuation of the medication.

Rational: Oral corticosteroids should not be stopped abruptly, as this can lead to adrenal insufficiency. The dose must be gradually tapered.

33. A patient is prescribed digoxin. The nurse is reviewing the patient's medication list. Which of the following medications, if also being taken by the patient, would increase the risk of digoxin toxicity?

A) Furosemide

B) Lisinopril

C) Metoprolol

D) Aspirin

Answer: A) Furosemide

Rational: Furosemide can cause potassium loss. Hypokalemia increases the risk of digoxin toxicity.

34. A patient has a blood glucose level of 350 mg/dL. The patient is exhibiting which of the following signs and symptoms?

A) Tachycardia

B) Hypoglycemia

C) Hyperglycemia

D) Tremors

Answer: C) Hyperglycemia

Rational: A blood glucose level of 350 mg/dL is elevated and indicates hyperglycemia (high blood sugar).

35. A patient is receiving a continuous intravenous infusion. The nurse observes that the IV site is red, warm, and swollen. What is the nurse's primary concern?

A) Air embolism

B) Infiltration

C) Phlebitis

D) Infection

Answer: C) Phlebitis

Rational: The signs and symptoms described indicate phlebitis, which is inflammation of the vein.

**36. A patient is prescribed a medication that can cause orthostatic hypotension. The nurse should teach the patient to: **

A) Take the medication with food.

B) Change positions slowly.

C) Avoid alcohol.

D) Monitor blood glucose levels.

Answer: B) Change positions slowly.

Rational: Orthostatic hypotension is a drop in blood pressure when changing positions. Changing positions slowly helps to prevent dizziness and falls.

37. A patient is receiving a blood transfusion. The patient develops a fever, chills, and back pain. What is the nurse's priority action?

A) Stop the transfusion immediately.

B) Administer acetaminophen.

C) Slow the infusion rate.

D) Assess vital signs and continue the transfusion.

Answer: A) Stop the transfusion immediately.

Rational: The patient is showing signs of a febrile transfusion reaction. The transfusion must be stopped immediately.

38. A patient's white blood cell (WBC) count is 20,000/mm3. What is the nurse's primary concern?

A) Anemia

B) Infection

C) Increased risk of bleeding

D) Kidney failure

Answer: B) Infection

Rational: A WBC count of 20,000/mm3 is elevated and indicates leukocytosis, which is often associated with infection.

39. A patient is prescribed a potassium-sparing diuretic. The nurse should monitor the patient for which electrolyte imbalance?

A) Hypokalemia

B) Hyperkalemia

C) Hyponatremia

D) Hypocalcemia

Answer: B) Hyperkalemia

Rational: Potassium-sparing diuretics (e.g., spironolactone) can cause hyperkalemia (high potassium) because they prevent the excretion of potassium.

40. A patient is taking an antibiotic medication. The nurse is teaching the patient about the medication. What is a key teaching point?

A) Take the medication until symptoms resolve.

B) Take the medication for the full prescribed course.

C) Skip doses if side effects occur.

D) Store the medication in a warm place.

Answer: B) Take the medication for the full prescribed course.

Rational: Antibiotics should be taken for the full prescribed course, even if the patient feels better, to ensure the infection is eradicated and to prevent antibiotic resistance.

41. A patient is prescribed a medication that can cause photosensitivity. The nurse should teach the patient to:

A) Avoid sunlight and use sunscreen.

B) Increase fluid intake.

C) Take the medication with food.

D) Avoid alcohol.

Answer: A) Avoid sunlight and use sunscreen.

Rational: Photosensitivity is increased sensitivity to sunlight. Patients taking medications that cause photosensitivity should be taught to avoid sunlight and use sunscreen.

42. A patient has a prothrombin time (PT) of 30 seconds. What is the nurse's primary concern?

A) Increased risk of bleeding

B) Increased risk of infection

C) Kidney failure

D) Liver failure

Answer: A) Increased risk of bleeding

Rational: A prolonged PT indicates that the blood is clotting more slowly than normal, which can increase the risk of bleeding.

43. A patient is prescribed a bronchodilator. The nurse should teach the patient to:

A) Take the medication at bedtime.

B) Monitor blood glucose levels regularly.

C) Avoid caffeine.

D) Increase sodium intake.

Answer: C) Avoid caffeine

Rational: Bronchodilators can cause nervousness and tachycardia; caffeine can worsen these side effects.

44. A patient is receiving intravenous fluids. The nurse assesses the patient and notes crackles in the lungs, and a bounding pulse. The nurse suspects:

A) Dehydration

B) Hypervolemia

C) Hypovolemia

D) Pneumonia

Answer: B) Hypervolemia

Rational: Crackles in the lungs and a bounding pulse are indicative of fluid overload or hypervolemia.

45. A patient has a hematocrit level of 30%. What is the nurse's primary concern?

A) Infection

B) Anemia

C) Thrombocytosis

D) Kidney failure

Answer: B) Anemia

Rational: A hematocrit of 30% is below the normal range and indicates anemia.

46. A patient is taking an anticoagulant medication. The nurse should teach the patient to:

A) Increase intake of Vitamin K rich foods

B) Use a soft toothbrush.

C) Discontinue the medication if experiencing a headache.

D) All of the above.

Answer: B) Use a soft toothbrush.

Rational: Anticoagulants increase the risk of bleeding.

47. A patient is taking a medication that can cause hepatotoxicity. The nurse should monitor the patient's:

A) PT/INR

B) LFTs (Liver Function Tests)

C) Creatinine

D) Potassium

Answer: B) LFTs (Liver Function Tests)

Rational: LFTs assess liver function.

48. A patient's serum glucose is 55 mg/dL. The patient is likely experiencing:

A) Hyperglycemia

B) Diabetic Ketoacidosis

C) Hypoglycemia

D) Hyperkalemia

Answer: C) Hypoglycemia

Rational: A blood glucose level of 55 mg/dL is low and indicates hypoglycemia.

49. The nurse is administering a medication via the intradermal route. What is the appropriate angle of injection?

A) 15 degrees

B) 30 degrees

C) 45 degrees

D) 90 degrees

Answer: A) 15 degrees

Rational: The appropriate angle for an intradermal injection is 15 degrees.

50. A patient is prescribed pantoprazole. This medication is used to:

A) Lower blood glucose

B) Reduce stomach acid

C) Thin the blood

D) Decrease blood pressure

Answer: B) Reduce stomach acid

Rational: Pantoprazole is a proton pump inhibitor and reduces stomach acid.

51. A patient with heart failure is prescribed Digoxin. Which of the following would the nurse monitor for?

A) Peripheral Edema

B) Shortness of Breath

C) Yellow-green halos around lights

D) All of the above

Answer: D) All of the above

Rational: Digoxin is a medication used to treat heart failure. All the above are signs and symptoms of Digoxin toxicity.

52. The patient with a history of hypertension is prescribed a new medication. The nurse reviews the lab values. Which lab result would indicate the medication is effective?

A) Increased Potassium

B) Decreased Blood Pressure

C) Increased Blood Glucose

D) Decreased Urine Output

Answer: B) Decreased Blood Pressure

Rational: The most effective way to see if the medication is effective is to monitor the patient's blood pressure.

53. A patient is receiving a blood transfusion and begins to experience a fever. What is the nurse's priority action?

A) Slow the rate of the infusion

B) Stop the infusion

C) Administer Tylenol

D) Document the findings

Answer: B) Stop the infusion

Rational: If a patient begins experiencing a fever during a blood transfusion, the nurse should stop the infusion immediately.

54. The patient is prescribed a potassium-sparing diuretic. Which of the following should the nurse teach the patient to avoid?

A) Vitamin K rich foods

B) Potassium-rich foods

C) Sodium-rich foods

D) Calcium-rich foods

Answer: B) Potassium-rich foods

Rational: Potassium-sparing diuretics cause the body to retain potassium. The patient should avoid eating potassium-rich foods.

55. A patient is prescribed an IV antibiotic. What is the most important thing to assess before administration?

A) Allergies

B) Vital signs

C) Site of insertion

D) Pain level

Answer: A) Allergies

Rational: It is crucial to assess for allergies before administering an IV antibiotic.

56. The nurse is reviewing a patient's lab results. Which of the following values is most important to report immediately?

A) Potassium 6.0 mEq/L

B) Sodium 135 mEq/L

C) Glucose 100 mg/dL

D) Calcium 9.0 mg/dL

Answer: A) Potassium 6.0 mEq/L

Rational: Potassium of 6.0 is life threatening and should be reported immediately.

**57. A patient taking an ACE inhibitor should be monitored for: **

A) Cough

B) Weight gain

C) Edema

D) Hyperglycemia

Answer: A) Cough

Rational: The most common side effect of ACE inhibitors is a dry cough.

58. What is the therapeutic range for aPTT for a patient on Heparin?

A) 1.0-2.0 times the normal

B) 2.0-3.0 times the normal

C) 1.5-2.5 times the normal

D) 2.5-3.5 times the normal

Answer: C) 1.5-2.5 times the normal

Rational: The therapeutic range for aPTT on Heparin is 1.5-2.5 times the normal value.

59. The nurse is educating a patient about how to self-administer an EpiPen. What is the most important step?

A) Inject the medication into the muscle

B) Hold the pen in place for 10 seconds after administration

C) Call 911 after administering

D) All of the above.

Answer: D) All of the above

Rational: All are crucial steps. Inject in the muscle, hold the pen in place for 10 seconds after administration, and call 911 after administering.

**60. The nurse is caring for a patient with heart failure. The patient's BNP level is elevated. The nurse understands that the BNP level: **

A) Indicates liver damage

B) Indicates cardiac workload and stretching of the ventricles

C) Indicates kidney damage

D) Indicates infection

Answer: B) Indicates cardiac workload and stretching of the ventricles

Rational: BNP levels are elevated in heart failure because the heart is working harder.

61. A patient is prescribed prednisone. Which of the following should the patient avoid?

A) Aspirin

B) NSAIDs

C) Alcohol

D) All of the above

Answer: D) All of the above

Rational: A patient taking prednisone should avoid alcohol, aspirin and NSAIDs.

62. The nurse is administering a medication via the rectal route. What is the correct position for the patient?

A) Supine

B) Prone

C) Left lateral

D) Right lateral

Answer: C) Left lateral

Rational: The left lateral position promotes the medication to stay where it needs to stay.

63. The nurse is caring for a patient prescribed a loop diuretic. Which of the following lab values would the nurse monitor for?

A) Decreased Potassium

B) Increased Potassium

C) Decreased Sodium

D) Increased Sodium

Answer: A) Decreased Potassium

Rational: Loop diuretics decrease the potassium in the blood stream.

64. What is the antidote for opioids?

A) Naloxone

B) Flumazenil

C) Protamine Sulfate

D) Vitamin K

Answer: A) Naloxone

Rational: Naloxone is the antidote for opioids.

65. The patient is being discharged with an opioid prescription. What is the most important teaching the nurse should provide?

A) The medication may cause drowsiness

B) The medication is not addictive

C) The medication will always work

D) The medication will make you nauseous

Answer: A) The medication may cause drowsiness

Rational: Opioid medication may cause drowsiness.

66. Which lab result is most important to monitor for a patient on Heparin?

A) INR

B) aPTT

C) Platelets

D) BUN and Creatinine

Answer: B) aPTT

Rational: aPTT is used to monitor Heparin.

67. The nurse is administering an ophthalmic medication. What is the correct administration technique?

A) Place medication in the corner of the eye

B) Place medication directly on the cornea

C) Place medication in the conjunctival sac

D) Place medication on the eyelid

Answer: C) Place medication in the conjunctival sac

Rational: Ophthalmic medication is placed in the conjunctival sac.

68. What is the antidote for Warfarin?

A) Naloxone

B) Flumazenil

C) Protamine Sulfate

D) Vitamin K

Answer: D) Vitamin K

Rational: Vitamin K is the antidote for Warfarin.

69. The patient is prescribed antibiotics. What is the most important teaching the nurse should provide?

A) Stop the medication when you feel better

B) Take the full course of the medication

C) Skip doses if you feel better

D) Change the dose if needed

Answer: B) Take the full course of the medication

Rational: The patient should take the full course of antibiotics.

70. The nurse is caring for a patient with hypothyroidism and administering levothyroxine. What is the most important lab value to monitor?

A) TSH

B) Potassium

C) Sodium

D) BUN

Answer: A) TSH

Rational: TSH is the most important lab value to monitor.

71. A patient is receiving a blood transfusion and develops a fever and chills. What is the first action the nurse should take?

A) Administer acetaminophen

B) Slow the rate of infusion

C) Stop the infusion

D) Assess the patient's lung sounds

Answer: C) Stop the infusion

Rational: Fever and chills during a blood transfusion can be signs of a reaction, so the infusion must be stopped.

72. The nurse is teaching a patient about taking digoxin. What is the most important information to include?

A) Monitor for signs of low blood pressure

B) Take the medication with meals

C) Monitor for signs of digoxin toxicity

D) Avoid foods high in potassium

Answer: C) Monitor for signs of digoxin toxicity

Rational: Signs of digoxin toxicity are crucial to understand.

73. A patient has a potassium level of 3.0 mEq/L. What is the primary concern?

A) Hyperkalemia

B) Risk for cardiac arrhythmias

C) Fluid overload

D) Risk for bleeding

Answer: B) Risk for cardiac arrhythmias

Rational: Low potassium can cause cardiac arrhythmias.

74. The nurse is administering an intramuscular (IM) injection. What is the correct angle of injection?

A) 15 degrees

B) 45 degrees

C) 90 degrees

D) 30 degrees

Answer: C) 90 degrees

Rational: IM injections are given at a 90-degree angle to reach the muscle.

75. What is the therapeutic INR range for a patient on warfarin (Coumadin)?

A) 0.5-1.0

B) 1.0-2.0

C) 2.0-3.0

D) 3.0-4.0

Answer: C) 2.0-3.0

Rational: This is the standard therapeutic range.

76. Which of the following foods should a patient taking warfarin (Coumadin) limit?

A) Foods high in potassium

B) Green leafy vegetables

C) Citrus fruits

D) Dairy products

Answer: B) Green leafy vegetables

Rational: Green leafy vegetables are high in vitamin K, which can decrease the effectiveness of warfarin.

77. A patient is receiving IV potassium chloride (KCl). Which of the following is a priority nursing action?

A) Administer KCl rapidly

B) Monitor the patient's urine output

C) Assess the IV site for infiltration

D) Encourage the patient to ambulate

Answer: C) Assess the IV site for infiltration

Rational: KCl is irritating and can cause tissue damage if it infiltrates.

78. A patient is prescribed furosemide (Lasix). Which electrolyte imbalance is a major concern?

A) Hyperkalemia

B) Hypokalemia

C) Hypernatremia

D) Hypocalcemia

Answer: B) Hypokalemia

Rational: Furosemide is a loop diuretic that can cause potassium loss.

79. A patient is taking a statin medication. What is a key teaching point?

A) Report any muscle pain to the healthcare provider

B) Avoid grapefruit juice

C) Take the medication with food

D) Monitor blood glucose levels

Answer: A) Report any muscle pain to the healthcare provider

Rational: Muscle pain can indicate a serious side effect.

80. A patient with diabetes is prescribed insulin. What is a sign of hypoglycemia?

A) Polyuria

B) Polydipsia

C) Tachycardia and tremors

D) Blurred vision

Answer: C) Tachycardia and tremors

Rational: These are common signs.

81. The nurse is reviewing lab results. Which result is most concerning and should be reported immediately?

A) Potassium 3.0 mEq/L

B) Sodium 140 mEq/L

C) Glucose 90 mg/dL

D) Platelets 200,000/mm3

Answer: A) Potassium 3.0 mEq/L

Rational: Severe Hypokalemia can cause cardiac issues.

82. A patient with a suspected myocardial infarction (MI) is admitted to the hospital. Which laboratory test is most important to monitor?

A) Complete blood count (CBC)

B) Creatine kinase-MB (CK-MB)

C) Complete metabolic panel (CMP)

D) Prothrombin time (PT) and INR

Answer: B) Creatine kinase-MB (CK-MB)

Rational: CK-MB is a cardiac enzyme that is elevated after an MI.

83. A patient is prescribed an opioid analgesic. The nurse should monitor for which common side effect?

A) Diarrhea

B) Constipation

C) Tachycardia

D) Hypertension

Answer: B) Constipation

Rational: Opioids can slow the digestive system.

84. A patient is prescribed lisinopril. The nurse should monitor the patient for which side effect?

A) Dry cough

B) Tachycardia

C) Fluid retention

D) Hyperglycemia

Answer: A) Dry cough

Rational: This is a common ACE inhibitor side effect.

85. A patient is receiving an IV antibiotic. The patient reports itching and develops a rash. What is the priority nursing action?

A) Continue the infusion

B) Administer an antihistamine

C) Stop the infusion immediately

D) Slow the rate of infusion

Answer: C) Stop the infusion immediately

Rational: This could indicate an allergic reaction.

86. A patient with a history of asthma is prescribed a beta-blocker. The nurse is most concerned about which potential complication?

A) Development of heart failure

B) Worsening of asthma symptoms

C) Increased risk of bleeding

D) Risk of hypoglycemia

Answer: B) Worsening of asthma symptoms

Rational: Beta-blockers can cause bronchoconstriction.

87. The nurse is teaching a patient about taking an oral hypoglycemic medication. Which instruction is most important?

A) Take the medication at bedtime

B) Monitor blood glucose levels as prescribed

C) Avoid alcohol

D) All of the above

Answer: D) All of the above

Rational: These are all important.

88. A patient's blood pressure is 160/90 mmHg. Which medication would likely be prescribed?

A) Insulin

B) Antibiotic

C) Antihypertensive

D) Antidepressant

Answer: C) Antihypertensive

Rational: This is a high blood pressure reading.

89. A patient is prescribed albuterol. What is the primary purpose of this medication?

A) Reduce blood pressure

B) Open the airways

C) Lower blood sugar

D) Prevent blood clots

Answer: B) Open the airways

Rational: Albuterol is a bronchodilator.

90. What is the correct order for administering medication?

A) Give the patient the medication, assess the patient, document

B) Assess the patient, give the patient the medication, document

C) Give the patient the medication, document, assess the patient

D) Document, assess, give medication

Answer: B) Assess the patient, give the patient the medication, document

Rational: This is the most important order.

91. What does the BUN test tell you?

A) Liver function

B) Kidney function

C) Platelet function

D) Blood Clotting function

Answer: B) Kidney function

Rational: BUN (Blood Urea Nitrogen) is a measure of how well your kidneys are working. It reflects the amount of urea nitrogen in your blood, a waste product that the kidneys filter out.

92. The nurse is reviewing a client's laboratory results. The client has a serum creatinine level of 3.0 mg/dL. Which of the following is the nurse's priority concern?

A) Increased risk of infection

B) Risk for bleeding

C) Decreased kidney function

D) Decreased liver function

Answer: C) Decreased kidney function

Rational: Serum creatinine is a waste product removed by the kidneys. An elevated level indicates that the kidneys are not filtering waste products effectively.

93. The nurse is caring for a client with a deep vein thrombosis (DVT) who is receiving heparin. Which of the following laboratory tests is most important for the nurse to monitor?

A) International Normalized Ratio (INR)

B) Activated partial thromboplastin time (aPTT)

C) Platelet count

D) Blood urea nitrogen (BUN)

Answer: B) Activated partial thromboplastin time (aPTT)

Rational: aPTT is used to monitor the effectiveness of heparin therapy.

94. The client is taking warfarin. What is the primary action of this medication?

A) Prevents the formation of blood clots

B) Dissolves existing blood clots

C) Reduces blood pressure

D) Lowers blood glucose

Answer: A) Prevents the formation of blood clots

Rational: Warfarin is an anticoagulant that prevents the formation of blood clots.

95. The client with diabetes is prescribed metformin. The nurse understands that metformin works by:

A) Increasing insulin production

B) Decreasing insulin resistance

C) Preventing the breakdown of carbohydrates

D) Slowing gastric emptying

Answer: B) Decreasing insulin resistance

Rational: Metformin works primarily by decreasing insulin resistance and reducing glucose production by the liver.

96. The client is prescribed an anticholinergic medication. The nurse should monitor for which of the following side effects?

A) Diarrhea

B) Urinary retention

C) Increased salivation

D) Bradycardia

Answer: B) Urinary retention

Rational: Anticholinergic medications block the action of acetylcholine and can cause urinary retention, dry mouth, blurred vision, and constipation.

97. The client is prescribed an antidepressant medication. Which of the following is most important for the nurse to assess?

A) Liver function

B) Risk for falls

C) Suicidal ideation

D) Appetite

Answer: C) Suicidal ideation

Rational: Antidepressants can increase the risk of suicidal thoughts, especially in the early stages of treatment, so this is a critical assessment.

98. The nurse is administering an intravenous (IV) push medication. Which of the following is the most important step?

A) Flush the IV line before and after medication administration

B) Administer the medication slowly over the prescribed time

C) Check the patient's vital signs before administration

D) All of the above

Answer: D) All of the above

Rational: All these steps are critical for safe IV push medication administration.

99. The nurse is caring for a client with a sodium level of 120 mEq/L. What does the nurse understand about this client's condition?

A) Hypernatremia

B) Hypokalemia

C) Hyponatremia

D) Hypocalcemia

Answer: C) Hyponatremia

Rational: Hyponatremia is a low sodium level.

100. Which of the following lab results would be expected in a client with Chronic Kidney Disease?

A) Decreased Creatinine

B) Decreased BUN

C) Increased GFR

D) Increased Creatinine

Answer: D) Increased Creatinine

Rational: In chronic kidney disease, the kidneys' ability to filter waste products is diminished, leading to an elevated level of creatinine, a waste product, in the blood.

Okay, here are 100 NCLEX-style pediatric nursing questions with answers and rationales, each in three phrases:

Section 6: Pediatric Nursing (100 Questions)

1. **Question:** A nurse is assessing a 6-month-old infant. Which finding requires the most immediate intervention?

* A) Babinski reflex present.
* B) Posterior fontanel open.
* C) Lethargy and poor feeding.
* D) Grasping reflex present.
* **Answer: C**
* **Rationale:** Lethargy and poor feeding suggest illness; these signs indicate potential serious complications. Prompt assessment and intervention are crucial.

2. **Question:** A child with asthma is prescribed albuterol. What does the nurse teach the parents about this medication?

* A) Give the medication once daily.
* B) This is a long-term controller medication.
* C) Monitor for increased heart rate.
* D) Administer only during a severe exacerbation.
* **Answer: C**
* **Rationale:** Albuterol is a beta-agonist; it can cause tachycardia. The nurse teaches parents to monitor the child's heart rate.

3. **Question:** What is a priority nursing intervention for a child admitted with bacterial meningitis?

* A) Initiating seizure precautions.
* B) Administering oral antibiotics.
* C) Encouraging fluid intake.
* D) Restricting visitors.

* **Answer: A**

* **Rationale:** Bacterial meningitis can cause seizures; protect the child. Initiate seizure precautions immediately upon admission.

4. **Question:** The nurse is caring for a child post-tonsillectomy. Which assessment finding warrants immediate intervention?

* A) Slightly elevated temperature.

* B) Frequent swallowing.

* C) Refusal to drink fluids.

* D) Mild sore throat.

* **Answer: B**

* **Rationale:** Frequent swallowing suggests bleeding; assess the child. Post-tonsillectomy bleeding is a serious complication.

5. **Question:** A child with cystic fibrosis requires chest physiotherapy. What is the primary goal of this therapy?

* A) Improve lung expansion.

* B) Mobilize and clear secretions.

* C) Prevent respiratory infections.

* D) Decrease the work of breathing.

* **Answer: B**

* **Rationale:** Chest physiotherapy mobilizes secretions; it allows their clearance. This prevents airway obstruction.

6. **Question:** When assessing a child with suspected appendicitis, what is a classic finding?

* A) Pain in the left lower quadrant.

* B) Rebound tenderness in the right lower quadrant.

* C) Diffuse abdominal pain.

* D) Pain relieved by lying still.

* **Answer: B**

* **Rationale:** Rebound tenderness indicates inflammation; it is a sign of appendicitis. Assess the child's abdomen for this finding.

7. **Question:** A child is receiving intravenous fluids. What is the most important assessment?

* A) Urine output.

* B) Capillary refill.

* C) Skin turgor.

* D) Blood pressure.

* **Answer: A**

* **Rationale:** Urine output reflects hydration; it indicates kidney function. Monitor urine output to assess fluid balance.

8. **Question:** The nurse is teaching the parents of a child with a seizure disorder. Which statement indicates a need for further teaching?

* A) "I will give the medication as prescribed."

* B) "I will never leave my child unattended during a seizure."

* C) "I will put something in my child's mouth during a seizure."

* D) "I will call the doctor if the seizure lasts longer than 5 minutes."

* **Answer: C**

* **Rationale:** Never put anything in the mouth; it could cause injury. This statement indicates incorrect understanding and requires correction.

9. **Question:** A newborn has a high bilirubin level. What is the priority nursing intervention?

* A) Encouraging frequent feedings.

* B) Administering phototherapy as prescribed.

* C) Monitoring bowel movements.

* D) Assessing the infant's temperature.

* **Answer: B**

* **Rationale:** Phototherapy lowers bilirubin; it prevents complications. Administer phototherapy according to the prescription.

10. **Question:** A child with chickenpox is admitted to the hospital. What is the primary nursing intervention?

* A) Administering antibiotics.
* B) Implementing droplet precautions.
* C) Providing comfort measures for itching.
* D) Monitoring for signs of dehydration.
* **Answer: C**
* **Rationale:** Chickenpox causes severe itching; this is a priority symptom. Provide comfort measures to relieve the child.

11. **Question:** When administering an intramuscular injection to a toddler, what is the preferred site?

* A) Deltoid muscle.
* B) Vastus lateralis muscle.
* C) Dorsogluteal muscle.
* D) Ventrogluteal muscle.
* **Answer: B**
* **Rationale:** Vastus lateralis is preferred; it's a safe muscle site. This site has good muscle mass.

12. **Question:** The nurse is assessing a child with heart failure. Which assessment finding is the priority?

* A) Peripheral edema.
* B) Increased heart rate.
* C) Difficulty breathing.
* D) Poor feeding.
* **Answer: C**
* **Rationale:** Difficulty breathing indicates distress; it requires immediate action. Assess respiratory status frequently.

13. **Question:** What is the most appropriate action for a nurse to take when caring for a child with a suspected head injury?

* A) Administering pain medication.
* B) Assessing level of consciousness.
* C) Encouraging oral fluids.
* D) Elevating the head of the bed.
* **Answer: B**
* **Rationale:** Level of consciousness indicates severity; it should be assessed. Monitor the child's neurological status.

14. **Question:** A school-aged child is diagnosed with strep throat. Which nursing intervention is most important?

* A) Administering antibiotics as prescribed.
* B) Encouraging the child to rest.
* C) Teaching the child about handwashing.
* D) Providing cool liquids to drink.
* **Answer: A**
* **Rationale:** Antibiotics treat strep throat; it prevents complications. Administer antibiotics as prescribed for the child.

15. **Question:** A child with a fractured femur is in skeletal traction. What is the priority nursing assessment?

* A) Neurovascular status.
* B) Skin integrity.
* C) Pain level.
* D) Pin site infection.
* **Answer: A**
* **Rationale:** Neurovascular compromise is a priority; assess frequently. Assess for circulation, sensation, and movement.

16. **Question:** The nurse is assessing a child with Kawasaki disease. What is a hallmark sign of this condition?

* A) High fever.
* B) Joint pain.
* C) Skin rash.
* D) Strawberry tongue.
* **Answer: D**
* **Rationale:** Strawberry tongue is characteristic; it is a key sign. Assess for this unique finding.

17. **Question:** A child with diabetes is experiencing hypoglycemia. What is the priority nursing intervention?

* A) Administering insulin.
* B) Providing a quick-acting carbohydrate.
* C) Checking blood glucose.
* D) Encouraging the child to rest.
* **Answer: B**
* **Rationale:** Provide a quick-acting carbohydrate; it raises blood sugar. This intervention manages hypoglycemia immediately.

18. **Question:** A child with bronchiolitis is admitted to the hospital. What is the priority nursing intervention?

* A) Administering antibiotics.
* B) Providing oxygen as prescribed.
* C) Encouraging oral fluids.
* D) Administering bronchodilators.
* **Answer: B**
* **Rationale:** Oxygenation is essential; provide this support. Administer oxygen as prescribed for the child.

19. **Question:** A child is diagnosed with iron-deficiency anemia. What dietary instruction should the nurse provide to the parents?

* A) Limit milk intake.
* B) Increase intake of processed foods.
* C) Encourage intake of citrus fruits.
* D) Avoid iron-rich foods.
* **Answer: A**
* **Rationale:** Milk can interfere with iron absorption. Limit the child's milk intake.

20. **Question:** The nurse is assessing a child with suspected intussusception. What is a classic symptom of this condition?

* A) Projectile vomiting.
* B) Currant jelly stools.
* C) Diarrhea.
* D) Constipation.
* **Answer: B**
* **Rationale:** Currant jelly stools are a classic sign; this indicates bleeding. Assess the child's stool.

21. **Question:** A child is prescribed digoxin. What is the most important nursing action before administering the medication?

* A) Check the child's temperature.
* B) Assess the child's heart rate.
* C) Check the child's blood pressure.
* D) Ask the child about chest pain.
* **Answer: B**
* **Rationale:** Digoxin slows heart rate; assess before giving the medication. Hold the medication if heart rate is too low.

22. **Question:** A child is admitted with suspected pyloric stenosis. What is a classic symptom?

* A) Bilious vomiting.

* B) Non-projectile vomiting.

* C) Projectile vomiting.

* D) Diarrhea.

* **Answer: C**

* **Rationale:** Projectile vomiting is a classic sign; it's forceful. Assess for this symptom in the child.

23. **Question:** The nurse is caring for a child with cerebral palsy. What is a priority goal of care?

* A) Preventing skin breakdown.

* B) Promoting mobility and independence.

* C) Administering medications.

* D) Ensuring adequate nutrition.

* **Answer: B**

* **Rationale:** Mobility and independence is important; it improves life. Support the child's functional abilities.

24. **Question:** When teaching parents about preventing SIDS, what should the nurse emphasize?

* A) Place the baby on their stomach to sleep.

* B) Keep the baby's room very warm.

* C) Avoid soft bedding and pillows.

* D) Smoke around the baby is okay.

* **Answer: C**

* **Rationale:** Soft bedding increases SIDS risk; ensure a safe sleep environment. Educate parents about safe sleep.

25. **Question:** The nurse is teaching a preschool-aged child about a procedure. What is the most effective teaching method?

* A) Providing detailed written instructions.

* B) Using dolls or puppets to demonstrate.

* C) Explaining the procedure in scientific terms.

* D) Ignoring the child's questions.

* **Answer: B**

* **Rationale:** Use dolls or puppets; these methods are effective. This teaching method is age-appropriate.

26. **Question:** The nurse is caring for a child with Wilms' tumor. What is a crucial nursing action?

* A) Palpating the abdomen frequently.

* B) Avoiding palpation of the abdomen.

* C) Administering enemas.

* D) Encouraging high fluid intake.

* **Answer: B**

* **Rationale:** Avoid palpating the abdomen; it can cause spread. Protect the tumor from disruption.

27. **Question:** A child is receiving chemotherapy. What is a priority nursing intervention?

* A) Monitoring for signs of infection.

* B) Encouraging a high-protein diet.

* C) Administering pain medication as needed.

* D) Providing emotional support.

* **Answer: A**

* **Rationale:** Chemotherapy suppresses the immune system; prevent infection. Monitor for signs of infection closely.

28. **Question:** A child is diagnosed with lead poisoning. What is a priority nursing intervention?

* A) Administering antibiotics.

* B) Providing chelation therapy.

* C) Encouraging increased fluid intake.

* D) Teaching the child to wash hands.

* **Answer: B**

* **Rationale:** Chelation therapy removes lead; this is the main treatment. Administer chelation as prescribed.

29. **Question:** The nurse is caring for a child with a tracheostomy. What is a priority nursing intervention?

* A) Suctioning the airway as needed.

* B) Changing the tracheostomy tube every day.

* C) Providing a high-calorie diet.

* D) Restricting fluids.

* **Answer: A**

* **Rationale:** Suction as needed; this ensures airway patency. Observe the child's respiratory status.

30. **Question:** A child is admitted with severe dehydration. What is the priority nursing intervention?

* A) Administering intravenous fluids.

* B) Monitoring intake and output.

* C) Providing oral rehydration solution.

* D) Assessing vital signs frequently.

* **Answer: A**

* **Rationale:** Intravenous fluids rehydrate rapidly; this is immediate. Administer fluids as prescribed.

31. **Question:** The nurse is caring for a child with rheumatic fever. What is a key nursing intervention?

* A) Administering antibiotics.

* B) Encouraging bed rest.

* C) Monitoring for carditis.

* D) Providing a high-sodium diet.

* **Answer: C**

* **Rationale:** Carditis is a major complication; monitor for this. Observe the child for heart involvement.

32. **Question:** A child is experiencing an anaphylactic reaction. What is the priority nursing intervention?

* A) Administering epinephrine.

* B) Administering oxygen.

* C) Monitoring vital signs.

* D) Calling the rapid response team.

* **Answer: A**

* **Rationale:** Epinephrine reverses the reaction; it's the primary drug. Administer epinephrine immediately.

33. **Question:** A child is experiencing a tonic-clonic seizure. What is the priority nursing intervention?

* A) Restraining the child's limbs.

* B) Inserting an oral airway.

* C) Protecting the child from injury.

* D) Administering anti-seizure medication.

* **Answer: C**

* **Rationale:** Protect the child from injury; this is most important. Ensure the child's safety.

34. **Question:** A child is being discharged home after a tonsillectomy. What is the most important discharge instruction?

* A) Encourage the child to drink through a straw.

* B) Offer only clear liquids for 24 hours.

* C) Monitor for signs of bleeding.

* D) Encourage the child to eat solid foods.

* **Answer: C**

* **Rationale:** Monitor for bleeding; this is a serious complication. Instruct the parents to watch for bleeding.

35. **Question:** The nurse is caring for a child with osteomyelitis. What is a key nursing intervention?

* A) Administering oral antibiotics.
* B) Immobilizing the affected limb.
* C) Encouraging ambulation.
* D) Applying heat to the affected area.
* **Answer: B**
* **Rationale:** Immobilize the limb; it decreases pain and promotes healing. Provide comfort and support the child.

36. **Question:** The nurse is caring for a child who has undergone a cardiac catheterization. What is a crucial post-procedure assessment?

* A) Checking the puncture site for bleeding.
* B) Monitoring the child's blood pressure.
* C) Assessing the child's distal pulses.
* D) All of the above.
* **Answer: D**
* **Rationale:** Assess the child completely; monitor for complications. Evaluate vital signs and site assessment.

37. **Question:** A child with a history of seizures is admitted to the hospital. What is the most important nursing action?

* A) Maintain seizure precautions.
* B) Administer anti-seizure medications.
* C) Encourage the child to rest.
* D) Restrict visitors.
* **Answer: A**

* **Rationale:** Seizure precautions is the priority; be prepared. Implement these precautions immediately.

38. **Question:** A child is experiencing a vaso-occlusive crisis related to sickle cell anemia. What is the priority nursing intervention?

* A) Administering oxygen.
* B) Providing pain relief.
* C) Encouraging fluid intake.
* D) Administering blood transfusions.
* **Answer: B**
* **Rationale:** Pain is a major symptom; provide analgesia. Administer pain medication as prescribed.

39. **Question:** The nurse is teaching parents about the administration of oral medications to a child. What is the most important instruction?

* A) Mix the medication with a large amount of food.
* B) Use a measuring spoon for accuracy.
* C) Administer the medication in front of siblings.
* D) Crush tablets that are difficult to swallow.
* **Answer: B**
* **Rationale:** Use a measuring device; accuracy is essential. Use an appropriate oral syringe.

40. **Question:** A child is undergoing a lumbar puncture. What is a priority nursing intervention?

* A) Positioning the child in a side-lying position.
* B) Monitoring the child's vital signs.
* C) Applying a pressure dressing to the puncture site.
* D) All of the above.
* **Answer: D**
* **Rationale:** Perform all interventions; these are standard practices. Ensure a safe procedure.

41. **Question:** A nurse is caring for a child with a suspected foreign body aspiration. What is the priority action?

* A) Assess the child's respiratory status.
* B) Administer oxygen.
* C) Encourage the child to cough.
* D) Prepare for a chest X-ray.
* **Answer: A**
* **Rationale:** Respiratory status is critical; assess first. Observe for signs of distress.

42. **Question:** A child is receiving intravenous fluids. What should the nurse monitor to prevent fluid overload?

* A) Urine output.
* B) Blood pressure.
* C) Lung sounds.
* D) All of the above.
* **Answer: D**
* **Rationale:** Monitor all components; it assesses fluid status. Closely observe the child.

43. **Question:** The nurse is preparing to administer a medication to a child. What is the most important step?

* A) Verify the medication order.
* B) Check the child's allergies.
* C) Calculate the correct dosage.
* D) All of the above.
* **Answer: D**
* **Rationale:** All are important actions; follow all steps. Ensure safe medication administration.

44. **Question:** A child with a history of asthma is experiencing an acute exacerbation. What is the priority medication to administer?

* A) Oral steroids.
* B) Albuterol via nebulizer.
* C) Antibiotics.
* D) Leukotriene modifiers.
* **Answer: B**
* **Rationale:** Albuterol opens airways; administer quickly. This is a quick relief medication.

45. **Question:** The nurse is assessing a newborn. Which finding requires further investigation?

* A) Heart rate of 130 bpm.
* B) Respiratory rate of 40 breaths per minute.
* C) Acrocyanosis.
* D) Grunting respirations.
* **Answer: D**
* **Rationale:** Grunting indicates distress; requires intervention. Assess the newborn further.

46. **Question:** A child is diagnosed with a urinary tract infection (UTI). What is an important nursing intervention?

* A) Administering antibiotics.
* B) Encouraging fluid intake.
* C) Monitoring urine output.
* D) All of the above.
* **Answer: D**
* **Rationale:** All are important interventions; provide complete care. Manage and monitor the UTI.

47. **Question:** The nurse is caring for a child with a burn injury. What is a priority assessment?

* A) Pain level.
* B) Fluid balance.

* C) Wound appearance.
* D) All of the above.
* **Answer: D**
* **Rationale:** Assess all areas; they identify needs. Monitor the child for complications.

48. **Question:** A child is diagnosed with leukemia. What is a priority nursing intervention?
* A) Preventing infection.
* B) Managing pain.
* C) Providing emotional support.
* D) All of the above.
* **Answer: D**
* **Rationale:** All nursing actions are important; provide complete care. The child requires intensive care.

49. **Question:** When educating parents about giving medications to children, what is a crucial teaching point?
* A) Never refer to medication as "candy".
* B) Mix medications with food to ensure compliance.
* C) Administer medication when the child is sleeping.
* D) Stop medications when symptoms improve.
* **Answer: A**
* **Rationale:** Avoid using candy terms; it reduces dangers. Ensure medication safety.

50. **Question:** The nurse is teaching a child about a procedure. Which approach is most appropriate for a preschooler?
* A) Detailed explanations using medical terminology.
* B) Allowing the child to handle equipment.
* C) Explaining the procedure the day of.
* D) Ignoring the child's questions.
* **Answer: B**

* **Rationale:** Hands-on experiences reduce anxiety; they increase learning. Engage the child in preparation.

51. **Question:** A child with a head injury is experiencing a decreased level of consciousness. What is the priority nursing action?

* A) Administering pain medication.
* B) Assessing the child's pupils.
* C) Encouraging oral fluids.
* D) Repositioning the child.
* **Answer: B**
* **Rationale:** Pupil assessment indicates brain function; assess frequently. This monitors for complications.

52. **Question:** A child with diabetes mellitus is admitted with ketoacidosis. What is the priority nursing intervention?

* A) Administering insulin.
* B) Administering intravenous fluids.
* C) Monitoring blood glucose levels.
* D) All of the above.
* **Answer: D**
* **Rationale:** All interventions are necessary; they are all essential. Manage the DKA.

53. **Question:** The nurse is caring for a child with bacterial pneumonia. What is the priority nursing intervention?

* A) Administering antibiotics.
* B) Encouraging deep breathing exercises.
* C) Monitoring the child's respiratory status.
* D) All of the above.
* **Answer: D**
* **Rationale:** All are critical actions for treatment; it supports recovery. Provide comprehensive care for the child.

54. **Question:** A child is post-operative following an appendectomy. What is a priority nursing assessment?

* A) Assessing bowel sounds.
* B) Monitoring the incision site.
* C) Managing pain.
* D) All of the above.
* **Answer: D**
* **Rationale:** All are vital for post-op care; ensure these assessments. Provide thorough post-op support.

55. **Question:** A child is receiving chemotherapy and develops neutropenia. What is a key nursing intervention?

* A) Implementing strict hand hygiene.
* B) Monitoring the child's temperature.
* C) Avoiding invasive procedures.
* D) All of the above.
* **Answer: D**
* **Rationale:** All are essential actions; take appropriate precautions. Prevent and monitor for infection.

56. **Question:** The nurse is caring for a child with Tetralogy of Fallot. What is a common symptom?

* A) Cyanosis.
* B) Bounding pulses.
* C) A heart murmur.
* D) All of the above.
* **Answer: D**
* **Rationale:** All are common findings; understand this condition. The child will likely have multiple symptoms.

57. **Question:** A child is suspected of having a concussion after a fall. What is a critical piece of advice for the parents?

* A) Let the child sleep as much as possible.
* B) Monitor the child for changes in behavior.
* C) Encourage the child to resume normal activities.
* D) Give the child ibuprofen for headaches.
* **Answer: B**
* **Rationale:** Observe for changes; this monitors for complications. Provide clear follow-up advice.

58. **Question:** The nurse is caring for a child with suspected Kawasaki disease. Which diagnostic test is often ordered?

* A) Electrocardiogram (ECG).
* B) Complete blood count (CBC).
* C) Echocardiogram.
* D) Urinalysis.
* **Answer: C**
* **Rationale:** Echocardiogram monitors heart; this is a key test. Assess the child's cardiac status.

59. **Question:** A child is prescribed an antiemetic medication. When should the nurse administer this medication?

* A) When the child begins to vomit.
* B) Before the child eats meals.
* C) Before the child experiences nausea.
* D) After the child has vomited several times.
* **Answer: C**
* **Rationale:** Administer before nausea; prevent vomiting. Follow medication protocols.

60. **Question:** A child is diagnosed with pertussis (whooping cough). What is the primary mode of transmission?

* A) Airborne.

* B) Droplet.

* C) Contact.

* D) Vector-borne.

* **Answer: B**

* **Rationale:** Pertussis is spread by droplets; use droplet precautions. Protect the child and others.

61. **Question:** A 2-year-old child is admitted with suspected iron deficiency anemia. What is the most appropriate food for the nurse to encourage the parents to offer the child?

* A) Whole milk.

* B) Orange juice.

* C) Cooked spinach.

* D) Apple sauce.

* **Answer: C**

* **Rationale:** Spinach is high in iron; encourage foods rich in it. Dietary changes support treatment.

62. **Question:** When teaching the parents of a child with a new diagnosis of type 1 diabetes mellitus about insulin administration, what is the most important information to include?

* A) Rotate injection sites to prevent lipohypertrophy.

* B) Mix different types of insulin in the same syringe.

* C) Administer insulin intravenously during times of illness.

* D) Store insulin at room temperature for up to a month.

* **Answer: A**

* **Rationale:** Site rotation prevents issues; teach parents about injection sites. Prevent and minimize problems.

63. **Question:** The nurse is assessing an infant with a suspected congenital heart defect. Which finding is of greatest concern?

* A) A heart murmur.

* B) Poor feeding.

* C) Tachypnea.

* D) Cyanosis at rest.

* **Answer: D**

* **Rationale:** Cyanosis at rest is critical; assess the child immediately. This requires immediate attention.

64. **Question:** What is an important consideration for a child receiving IV antibiotics?

* A) Administer the medication slowly via IV push.

* B) Monitor for signs of allergic reaction.

* C) Discontinue the medication if the child develops a fever.

* D) Administer the medication with food to prevent nausea.

* **Answer: B**

* **Rationale:** Allergic reactions are possible; carefully monitor the child. Observe for any adverse events.

65. **Question:** The nurse is caring for a child with a seizure disorder. What is the priority nursing action during a seizure?

* A) Insert a tongue blade into the child's mouth.

* B) Restrain the child to prevent injury.

* C) Protect the child from injury.

* D) Administer anti-seizure medication.

* **Answer: C**

* **Rationale:** Protecting the child is critical; focus on this priority. Ensure the child's safety.

66. **Question:** A child with acute glomerulonephritis has edema and hypertension. What is an appropriate nursing intervention?

* A) Encourage high sodium intake.

* B) Administer intravenous fluids.

* C) Restrict fluid intake.

* D) Increase activity level.
* **Answer: C**
* **Rationale:** Restrict fluids; this manages the edema. This is a critical part of care.

67. **Question:** The nurse is providing education to the parents of a child with sickle cell anemia. What is the most important instruction to prevent a vaso-occlusive crisis?

* A) Avoid strenuous exercise.
* B) Maintain adequate hydration.
* C) Administer daily iron supplements.
* D) Avoid exposure to sunlight.
* **Answer: B**
* **Rationale:** Hydration is very important; it prevents the crisis. Encourage this often.

68. **Question:** The nurse is caring for a child with bacterial meningitis. Which assessment finding is the most indicative of this condition?

* A) Lethargy.
* B) Headache.
* C) Nuchal rigidity.
* D) Fever.
* **Answer: C**
* **Rationale:** Nuchal rigidity is common; this is a key sign. Assess for this finding.

69. **Question:** A child is being discharged home following a pyloromyotomy. What should the nurse teach the parents about feeding the infant?

* A) Start with full-strength formula right away.
* B) Offer small, frequent feedings of clear liquids.
* C) Avoid handling the baby after feeding.
* D) Increase feedings as tolerated, gradually.
* **Answer: D**

* **Rationale:** Gradually increase feeds; it prevents vomiting. This will support the child's recovery.

70. **Question:** The nurse is assessing a child with suspected gastroenteritis. What is the priority nursing action?

* A) Obtain a stool specimen.
* B) Assess the child's hydration status.
* C) Administer antiemetics.
* D) Encourage the child to eat.
* **Answer: B**
* **Rationale:** Assess hydration first; this is most critical. Dehydration is a major risk.

71. **Question:** When assessing a child who has experienced a burn, which finding is most concerning?

* A) Pain at the burn site.
* B) Blisters on the skin.
* C) Edema at the burn site.
* D) Difficulty breathing.
* **Answer: D**
* **Rationale:** Difficulty breathing is critical; it needs prompt action. This is an emergency sign.

72. **Question:** The nurse is preparing to administer an intramuscular injection to an infant. What is the preferred injection site?

* A) Deltoid.
* B) Vastus lateralis.
* C) Dorsogluteal.
* D) Ventrogluteal.
* **Answer: B**
* **Rationale:** Vastus lateralis is preferred; this is the safest. Ensure accurate injection.

73. **Question:** A 4-year-old child is being seen for a routine check-up. Which developmental milestone should the nurse expect to assess?

* A) Hop on one foot.
* B) Tie shoelaces.
* C) Write their name.
* D) Ride a bike without training wheels.
* **Answer: A**
* **Rationale:** Hopping on one foot is typical for a 4-year-old's gross motor skills development.

74. **Question:** A nurse is teaching a parent about the importance of handwashing to prevent infections in children. What should the nurse emphasize?

* A) Handwashing is only necessary when visibly dirty.
* B) Handwashing should be done for at least 20 seconds.
* C) Alcohol-based hand sanitizers are as effective as soap and water.
* D) It is important to wash hands only before meals.
* **Answer: B**
* **Rationale:** Handwashing for at least 20 seconds effectively removes germs.

75. **Question:** The nurse is caring for a child with asthma. Which action should be a priority during an asthma attack?

* A) Administer a bronchodilator.
* B) Offer the child fluids.
* C) Provide a calm environment.
* D) Encourage the child to use breathing exercises.
* **Answer: A**
* **Rationale:** Administering a bronchodilator is critical to relieve bronchospasm immediately.

76. **Question:** Which sign should the nurse recognize as an indicator of possible child abuse?

* A) Unexplained bruises in various stages of healing.
* B) Frequent minor injuries from playing.

* C) Child frequently missing school.

* D) Sudden changes in behavior.

* **Answer: A**

* **Rationale:** Unexplained bruises in different stages of healing are concerning for potential abuse.

77. **Question:** A nurse is educating parents about the signs and symptoms of otitis media. Which symptom should the nurse include?

* A) Frequent sneezing.

* B) Persistent cough.

* C) Pulling at the ear.

* D) Watery eyes.

* **Answer: C**

* **Rationale:** Pulling at the ear is a common sign of ear discomfort, often related to otitis media.

78. **Question:** During a well-child visit, which immunizations should a nurse ensure are up to date for a child at 12 months of age?

* A) MMR (measles, mumps, rubella).

* B) Flu vaccine.

* C) DTaP (diphtheria, tetanus, pertussis).

* D) Varicella (chickenpox).

* **Answer: A**

* **Rationale:** The MMR vaccine is recommended between 12-15 months of age.

79. **Question:** A child presents with a high fever and a rash that began on the face and spread downwards. What condition should the nurse suspect?

* A) Measles.

* B) Chickenpox.

* C) Rubella.

* D) Fifth disease.

* **Answer: A**

* **Rationale:** Measles typically presents with a high fever and a rash that starts on the face.

80. **Question:** In assessing a child for suspected developmental delays, which of the following should the nurse prioritize for screening?

* A) Language skills.

* B) Social skills.

* C) Gross motor skills.

* D) Fine motor skills.

* **Answer: A**

* **Rationale:** Language skills are crucial for communication and can significantly impact overall development.

81. **Question:** The nurse is providing discharge instructions for a child with a new diagnosis of diabetes mellitus. Which statement by the parent indicates a need for further teaching?

* A) "I will check my child's blood sugar levels daily."

* B) "I can give my child juice if they feel low."

* C) "I don't need to worry if my child skips a meal."

* D) "I should carry snacks with me for my child."

* **Answer: C**

* **Rationale:** Skipping meals can lead to hypoglycemia in children with diabetes and should be addressed.

82. **Question:** A nurse is explaining to a parent how to prevent dental caries in children. Which recommendation is important to include?

* A) Offer sugary drinks between meals.

* B) Brush teeth at least twice a day.

* C) Avoid using fluoride toothpaste until age 3.

* D) Allow prolonged bottle-feeding at night.

* **Answer: B**

* **Rationale:** Regular brushing helps prevent dental caries.

83. **Question:** A child with a history of cystic fibrosis is experiencing frequent cough and respiratory distress. What is the priority nursing action?

* A) Administer prescribed antibiotics.

* B) Encourage oral hydration.

* C) Perform chest physiotherapy.

* D) Assess the child's oxygen saturation.

* **Answer: D**

* **Rationale:** Assessing oxygen saturation is crucial to determine the severity of respiratory distress.

84. **Question:** The nurse is teaching parents about appropriate toys for a toddler. Which toy is best suited for this age group?

* A) Small building blocks.

* B) A toy kitchen set with small items.

* C) A large, colorful ball.

* D) A model train set.

* **Answer: C**

* **Rationale:** A large, colorful ball encourages physical activity and gross motor skills, which are best for toddlers.

85. **Question:** A nurse is caring for an infant with a suspected allergic reaction. Which assessment finding would be most concerning?

* A) Rash on the abdomen.

* B) Swelling of the lips and difficulty swallowing.

* C) Sneezing and runny nose.

* D) Mild irritability.

* **Answer: B**

* **Rationale:** Swelling of the lips and difficulty swallowing indicates a serious allergic reaction (anaphylaxis).

86. **Question:** In caring for an adolescent with anorexia nervosa, which of the following interventions is essential?

* A) Encouraging weight gain at a rapid pace.

* B) Offering frequent small meals.

* C) Monitoring for binge-eating episodes.

* D) Allowing the adolescent to eat alone.

* **Answer: B**

* **Rationale:** Offering frequent small meals can help manage intake and minimize anxiety around eating.

87. **Question:** A nurse is monitoring a child who has received an epinephrine injection for anaphylaxis. What should be the priority observation?

* A) Level of consciousness.

* B) Heart rate and blood pressure.

* C) Skin color and temperature.

* D) Presence of wheezing or stridor.

* **Answer: B**

* **Rationale:** Monitoring heart rate and blood pressure is crucial following epinephrine administration due to potential cardiovascular effects.

88. **Question:** When teaching a parent about colic in infants, which statement is accurate?

* A) Colic is due to improper feeding techniques.

* B) Colic usually resolves by 6 months of age.

* C) Colic is a sign of a serious medical condition.

* D) Colic occurs in infants who are well-fed and content.

* **Answer: B**

* **Rationale:** Colic typically resolves by 3 to 6 months of age without causing harm.

89. **Question:** A nurse is assessing a child with suspected pneumonia. Which sign should the nurse look for?

* A) Bradycardia.
* B) Increased respiratory rate.
* C) Elevated blood pressure.
* D) Hyperglycemia.
* **Answer: B**
* **Rationale:** Increased respiratory rate is a common sign associated with pneumonia due to respiratory distress.

90. **Question:** For a child diagnosed with attention deficit hyperactivity disorder (ADHD), which intervention is crucial for the nurse to implement?

* A) Limit all physical activity to avoid distractions.
* B) Provide a consistent routine and structure.
* C) Encourage competitive games to improve focus.
* D) Increase sugary snacks to boost energy levels.
* **Answer: B**
* **Rationale:** A consistent routine and structure help children with ADHD better manage their symptoms.

91. **Question:** A 2-year-old is being seen for a fever and runny nose. What is the most appropriate nursing action?

* A) Recommend aspirin for fever.
* B) Assess for signs of dehydration.
* C) Advise the use of cold compresses.
* D) Encourage the child to take a warm bath.
* **Answer: B**
* **Rationale:** Assessing for signs of dehydration is crucial, as young children are more vulnerable.

92. **Question:** When caring for a child who is scheduled for a lumbar puncture, what is the nurse's priority action?

* A) Ensure the child is well-hydrated.
* B) Educate the child about the procedure.
* C) Position the child correctly for the procedure.
* D) Obtain informed consent from the parent.
* **Answer: D**
* **Rationale:** Obtaining informed consent from the parent is necessary prior to the procedure.

93. **Question:** Which dietary recommendation should the nurse make for an adolescent with acne?

* A) Increase dairy intake.
* B) Limit sugary and processed foods.
* C) Consume high amounts of carbohydrates.
* D) Avoid fruits and vegetables.
* **Answer: B**
* **Rationale:** Limiting sugary and processed foods may help manage acne.

94. **Question:** A parent asks the nurse when their child should start having annual sports physicals. What is the best response?

* A) At age 5.
* B) Before starting middle school.
* C) At the beginning of high school.
* D) Yearly starting at age 2.
* **Answer: C**
* **Rationale:** Sports physicals are generally recommended before high school sports participation.

95. **Question:** In caring for a child in a wheelchair, which nursing intervention is the priority?

* A) Encouraging the child to walk.

* B) Ensuring the wheelchair is properly locked.
* C) Offering the child snacks while seated.
* D) Promoting independence in self-care.
* **Answer: B**
* **Rationale:** Ensuring the wheelchair is locked is crucial for the child's safety.

96. **Question:** A child with a history of eczema is being discharged. What is the most important instruction for the parents to follow?

* A) Apply topical steroids only when the rash is severe.
* B) Use gentle soaps and moisturizers daily.
* C) Avoid all foods that may cause allergic reactions.
* D) Bathe the child with hot water for comfort.
* **Answer: B**
* **Rationale:** Daily use of gentle soaps and moisturizers helps manage eczema effectively.

97. **Question:** During a well-child visit, the nurse determines that a 3-year-old child is not meeting the expected developmental milestones. What should the nurse do next?

* A) Refer the child to a specialist.
* B) Wait until the next visit to reassess.
* C) Encourage more playtime to promote development.
* D) Document the findings and provide reassurance.
* **Answer: A**
* **Rationale:** Referring the child to a specialist for further evaluation is necessary for appropriate intervention.

98. **Question:** What should the nurse include when teaching about the proper administration of a nasal spray for a child?

* A) Use only when the child has a fever.
* B) Administer with the child lying flat.
* C) Shake the bottle before use.

* D) Instruct the child to hold their breath during administration.

* **Answer: C**

* **Rationale:** Shaking the bottle ensures homogeneity of the medication in the spray.

99. **Question:** A nurse is assessing a child with cystic fibrosis. Which finding is most closely associated with this condition?

* A) Frequent respiratory infections.

* B) Severe obesity.

* C) Normal sweat chloride levels.

* D) Diarrhea with no mucus.

* **Answer: A**

* **Rationale:** Frequent respiratory infections are common in cystic fibrosis due to thick mucous.

100. **Question:** The nurse is caring for a child who has just received a dose of the MMR vaccine. What should the nurse inform the parents about potential side effects?

* A) The child may develop a fever or mild rash.

* B) A severe allergic reaction is common.

* C) The vaccine will cause the child to contract measles.

* D) No side effects will occur.

* **Answer: A**

* **Rationale:** It is common for the child to develop a mild fever or rash after the MMR vaccine.

These questions cover a range of pediatric nursing topics, from developmental milestones to disease management.

I hope these questions and rationales are helpful for your NCLEX preparation. Best of luck!