Sample of Questions

1. A client with a hemothorax has a chest tube in the fourth intercostal space connected to suction at 20 cm H2O pressure. Four hours after insertion, which client outcome should the nurse consider to be within normal limits for this client?
2. No bubbling in the suction chamber of the Pleuravac
3. Serous fluid in the drainage chamber of the Pleurovac
4. **Fluctuation with respiration in the water-seal chamber of the Pleuravac**
5. The dry gauze dressing over the insertion site is clean and intact
6. A client has started long-term maintenance therapy with a cardiotonic-“Toxic” medication that has a narrow therapeutic index. Teaching the client the signs/symptoms of which adverse effect is most important?
7. Displacement
8. **Toxicity**
9. Dependence
10. Tolerance
11. In caring for a client who is receiving peritoneal dialysis, the nurse should be alert for that what complications?
12. Clear dialysate drainage and burning on urination
13. An occluded vascular access device and flank pain
14. **Abdominal pain, tenderness, and rigidity (peritonitis)**
15. Increased serum albumin level, decreased BUN, and increase hematocrit
16. A high fluid intake is prescribed for a client with urolithiasis. The client wishes to know the chief purpose for this intervention. What should the nurse tell the client about this prescription?(esto ocurre en renal calciu)(stone—piedres)
17. This action is designed to decrease the uric acid in the urine
18. **The purpose is to increase the hydrostatic pressure behind the stone to assist in its downward passage( ayudar a la piedra salir con precion)**
19. The intent is to increase the specific gravity of the urine, thereby increasing the probability of passing the stone
20. The fluids will increase bilirubin excretion, thereby assisting to resolve jaundice associated with stone formation
21. Normal saline 0.9% is prescribed for a client with fluid volume deficit at a rate of 100 ml/hour. Before starting the infusion, the nurse observes that the client’s urine is dark amber in color. What action should the nurse take?
22. Start the IV at a keep-open rate until the assessment finding is reported o the healthcare provider
23. Insert a saline lock, but do not start any IV fluid until contacting the healthcare provider
24. Review the list of PRN medications to see if a diuretic can be administered
25. **Administer the normal saline at the prescribed rate of 100 ml/hour**
26. Which explanation of autonomic cardiac regulation mediated by sympathetic innervations is correct?
27. Sympathetic activation boosts K+ efflux and increases the inotropic effect
28. **Increased Ca+ influx with sympathetic stimulation raises the heart rate ( increased Na + tambien)**
29. Sympathetic activation decreases dromotrophy by lowering conduction speed
30. Increased Na+ influx with sympathetic stimulation reduces pacemaker firing
31. The nurse learns that a newly admitted adult client has a six month history of recurring somatic pain. During the admission interview, it is most important for the nurse to question the client about what problem ?problema cronico
32. Periods of restlessness
33. Episodes of tremors
34. **Feelings of depression**
35. Nausea and vomiting
36. A pregnant client begins to cry when the UAP tries to assist her in donning a hospital gown, and she refuses to remove an undergarment that is worn in her culture to preserve modesty. What should the charge nurse do first?
37. Incorporate individualized cultural care into the nursing plan of care
38. Discuss the importance of respecting cultural beliefs with the UAP
39. **Determine if continued wearing of the garment will compromise care**
40. Talk with the client to determine alternate means to preserve modesty
41. The nurse is preparing to insert an IV in an adult male client. Which client’s lab value is most important for the nurse to consider prior to inserting the (IV? para evitar prolongado sangramiento)
42. Serum sodium of 130 mEq/L
43. WBC of 12,000/mm
44. Hemoglobin of 12 g/dl
45. **Platelet count of 60,000/mm**
46. A 12-year-old boy who is 54 inches tall is scheduled for x-rays of his hands and wrist to determine growth patterns. The mother asks the nurse why these x-rays are being taken. What explanation is best for the nurse to provide this mother?(en el Rx se ve la epiphysis del hueso que es la covectura de cartilage que cubre la cabeza del hueso)
47. If the growth areas of the bone are closed, then growth hormone therapy can open them
48. **Hormonal influences on the bone at this age can be determined by x-ray**
49. Wrist and hand fractures are common among children of small stature
50. X-ray therapy is helpful in promoting the effectiveness of growth hormone therapy
51. The nurse is reviewing laboratory results for a client with adrenal insufficiency. Which finding should the nurse report to the healthcare provider?
52. **Calcium 12 mg/dl (esta alto)**
53. Sodium 138 mEq/L
54. Glucose 110 mg/dl
55. Potassium 4.0 mEq/L
56. At 0700 the nurse receives report for a client with chronic intractable pain “who needs morphine every 4 hours during the day shift to control pain.” After reviewing the client’s record, what action should the nurse implement?
57. **Request a change in the prescribed dose of fentanyl (Duragesic) transdermal patch**
58. Scheduled the PRN doses of morphine and codeine at the same time every 4 hours
59. Correct the shift summary to be consistent with the medication administration record
60. Administer a PRN dose of morphine immediately at the IV rate of 1 mg/minute
61. After a client experiences spontaneous rupture of the membranes during labor, the nurse notes a visible prolapse of the umbilical cord. What intervention should the nurse implement immediately?
62. **Push the presenting part off the cord**
63. Turn the client to a supine position
64. Administer oxygen by face mask at 6L/min
65. Prepare the client for a cesarean delivery
66. The nurse is preparing a teaching plan for a client receiving magnesium-based antacids for treatment of gastro-esophageal reflux disease (GERD). Which instruction should the nurse plan to include?
67. “Increase fiber and fluids in your diet to prevent constipation”
68. **“Avoid taking any other drugs 1 to 2 hours before and after taking the antacid”**
69. “Swallow the antacid with a glass of low-fat milk to help coat the stomach lining”
70. “Take the antacids on an as-needed basis whenever you feel bloating or heartburn”
71. The nurse is caring for a young adult male client with facial injuries resulting from a motor vehicle collision. Which client statement indicative of the highest priority for nursing intervention?
72. “I am not taking any more medications because they make my mouth dry”
73. “I don’t want my family and friends to see me looking like this”
74. “My biggest fear is that this injury will cause me to lose my job”
75. **“I can’t sleep through the night because I awaken with pain when I move”**
76. What is the most important primary preventative measure the nurse can emphasize as a means of reducing the risk of developing acute glomerulonephritis in the general population?
77. Teach all females to seek medical attention for urinary tract infections
78. Encourage all persons to have a yearly physical with a urinalysis
79. **Use good hand washing techniques to prevent throat and skin infections**
80. Eat a low salt diet and monitor the blood pressure frequently
81. The mother of a child with cerebral palsy (CP) asks the nurse if her child’s impaired movements will worsen as the child grows. Which response provides the best explanation?
82. The outcome depends on the continued development of the brain lesion
83. **The course of CP is variable but the brain damage is not progressive**
84. The most common permanent physical disability of childhood is CP
85. The classification of CP determines the severity of motor dysfunction
86. Three days postoperative, a client’s wound drainage changes in appearance from sanguineous to serous. Based on this finding, what nursing intervention should the nurse implement?
87. Monitor the client’s vital signs
88. Apply pressure to the wound
89. **Continue to monitor the wound…..serous “good” (clear liquid)**
90. Obtain a wound culture
91. Following the administration of total parenteral nutrition (TPN) via a central line to a client diagnosed with inflammatory bowel disease (IBD), the nurse should expect what outcome?
92. A negative nitrogen balance during TPN administration
93. A weight loss of 6 pounds within two weeks
94. **Afebrile with no purulent drainage from catheter site**
95. Hydration as evidenced by tented skin turgor
96. Based on the principles of asepsis, the nurse should consider which circumstance to be sterile?
97. **An open sterile Foley catheter kit set up on a table at the nurse’s waist level**
98. A sterile glove the nurse thinks might have touched her hair
99. A one-inch border around the edges of a sterile field set up in the operating room
100. A wrapped, unopened sterile 4x4 gauze pad placed on a damp table top
101. The nurse is preparing to administer medications to a client who was admitted to the hospital with a diagnosis of deep vein thrombosis (DVT). Which action should the nurse implement?