Answers to Practice Questions

1. 5,3,4,2,1,6...Use the strategy of priority setting, ABC, other physiological (Pain first of those), safety and security, love and belonging; Actual vs Risk; and considering timing when comparing options such as in this scenario where a community health nurse needs to drive to get to clients, as well as what are the RN responsibilities vs other providers in the community...The first client would be the person with DM who needs a fasting blood glucose as this is time sensitive esp with RN starting visits at 0900. Then the nurse should do the first dressing change when it is order bid as it is the RN responsibility to do a first dressing change and assessment. Then visit the client who has a home health aide appointment to see and assess client without interrupting scheduled event. Next the RN should observe the client who requires supervision for a dressing change so that if ordered for another change same day, the nurse would have ensured that the client is doing it correctly. Next would be the client who needs to be admitted as not time sensitive but needs to be done on nurse’s shift. And last would be the patient who needs a second dressing change as there is no time associated with it so there is less priority than all of the other clients.

2. First....again use priority setting as mentioned above, thus option 4 is the ABC and the priority.

3. The client’s labs indicate that the client is hyperkalemic and as such the EKG would indicated peaked T waves or option D. The T wave is sensitive to potassium level changes (if hypokalemia then inverted) as well as ischemic changes (also inverted T wave). Hyperkalemia would also potentially lead to a flat P wave, an increased PR interval, and a wide QRS complex, thus none of the other options.

4. Remember when doing SATA, think broad and wide, including risk for...With phlebitis (key is the itis), the physician needs to be notified, the catheter needs to be removed from IV site, warm compresses should be placed at the site for pain and edema, and the event and actions should be documented, thus A,B,C,E. D is wrong as the nurse should not start a new line is the same vein that is inflamed and/or infected. And while Tylenol may be appropriate for pain and fever, the phlebitis is not normal, thus F is wrong.

5. Anthrax is transmitted via inhalation of bacterial spores, through a cut or abrasion in the skin, and through ingestion of contaminated undercooked meat. Ticks or deer flies are more common in transmitting Lyme disease. D and E are too similar thus eliminate both as direct contact is not the way anthrax is transmitted.

6. The question is asking if you have on hand 900mg/6mL, how many mL are in 0.3 grams, which is equivalent to 300mg. Thus do med calc as you are familiar with and when you do you should get 2mL. For me 900/6=300/X...Cross multiply and you get 1800/900 or 2mL

7. Formula to use here is Volume X drip factor/time in minutes. Thus 250 X 10/240 minutes (4 hours). Calculation comes out to 10.4 gtts and when rounded to nearest whole number correct answer is 10gtts/minute.

8. This client is experiencing a wound evisceration where a part of the internal organs comes though an incision. This is considered a medical emergency, thus contact the physician. Prepare the client for wound closure, usually in OR. Document event and actions. So the correct answers are A, C, D. B is wrong coughing cold make the situation worse so the client should not be
encouraged to cough. Ice packs should not be used as they will cause vasoconstriction and could lead to necrosis of bowel. And clients should be in low fowlers position not flat.

9. Probable signs is key wording....Ballottement, Chadwick’s sign, Uterine enlargement, and Braxton Hicks contractions are the probable signs. Ballottement is the rebounding of the fetus again the nurse’s fingers on palpation, thus probable. Chadwick’s sign is the violet discoloration of the cervical mucous membranes, a probable sign. Uterine enlargement is a probable sign. Braxton Hicks contractions are known as false labor, but a probable sign They all indicate that the woman probably has a fetus, but are not positive. Positive signs include fetal heart rate and outline of fetus on ultrasound.

10. Magnesium sulfate is used because of its actions of depressing the CNS, thus minimizing the risk of seizures when hypertensive, and relaxing smooth muscle which will bring down the blood pressure. Think about those mechanisms of action when considering adverse effects. Flushing, Depressed respirations and extreme muscle weakness are the adverse reactions, A, D, E. Think these through. The other adverse reactions that might be present include depressed deep tendon reflexes, decreased urine output, increased pulmonary edema (as not voiding in normal amounts) and increased magnesium levels. If you are unsure when you are taking boards and get similar question, look for options where assessments indicate a decrease as most of the time magnesium will decrease findings not increase findings, except as seen in my explanation about pulmonary edema as a result of oliguria.

11. When assessing a client with symptoms of cold, cough and congestion, the nurse should include B, C, D, auscultate lung sounds, assess respirations, assess temperature. These assessments would provide objective data that might support client’s subjective data. Whether a family member has a history of any illness/disease is not relevant here. The key was any as that is not specific to respiratory disorders. Peripheral pulses would not be relevant here as no symptoms/assessment of hemodynamics or circulatory issues. Musculoskeletal and neurological exams would not be relevant here.

12. Infants with acyanotic heart defects have a left to right shunt and thus no unoxygenated blood is going out to body. There are some common assessments you will see with most, but not all, acyanotic defects due to the shunting taking place. If blood is shunted through an opening or hole in heart from left to right (higher pressure to lower pressure), there is increased blood flow on right side of heart, leading to right sided hypertrophy as right ventricle and atria have to pump harder with more blood to pump to lungs; there is an increased incidence of respiratory infections due to more blood going to lungs, thus more stasis, thus more infection; There is the presence of a heart murmur as the blood is shunted across the opening or hole in heart; and there is decreased cardiac output (oliguria, decreased or weak peripheral pulses, weak cry, poor suck reflex, fatigue, feeding difficulties, poor weight gain) as some of the blood which would normally go out to body is being shunted back to right side of heart. Thus the correct answers are B, D, F.

13. When client develops pulmonary edema, in order of priority the nurse should, 3,2,6,4,8,1,7,5. In other words, the first priority is to place client in high fowlers position to assist with breathing (ABC); next would be administer oxygenation; then assess lung sounds; then get IV access; prepare to administer a diuretic (usually Lasix) and morphine sulfate; then insert a foley since the meds should be pulling fluid from body and the nurse needs accurate data as to output; then prepare for intubation and vent if needed, and last would be to document.
14. If you are unfamiliar with this medication, then use common sense and some of my strategies we discussed...with most meds the nurse would not want to restrict fluids as you would want client to be able absorb the medication as it is intended to be, thus A is not correct. The nurse, as with most medications, would instruct the client to avoid alcohol, so B is correct. The nurse would monitor liver function studies as many antifungal drugs are hepatotoxic so C is correct. The nurse should not administer most medications with antacids as they can decrease or inhibit absorption, thus D is not correct. The nurse should teach the client to avoid exposure to the sun, as again, many antifungals cause the client to have sensitivity to the sun, so E is correct. And most medications can be taken with food thus F is incorrect. So the correct answers are B, C, E.

15. Whenever depressed clients suddenly are more energetic and upbeat saying nothing is wrong or that they are fine, that is a clue to them possibly being suicidal thus option C is the correct response. This is like children/adolescents who start to give away their toys or belongings. The other options are not appropriate for this client.

16. A hyphema is the collection of blood in the anterior chamber of the eye, but even if you did not know that, you should still have been able to choose the correct answer, which is B, semi-fowlers on bedrest. If a client hits their head on a steering wheel, you would want them elevated to some degree to ensure that there are no changes in ICP, thus even if you didn’t know the condition of this client, your best educated guess would be option B and you still would have been correct. Lateral and flat are inappropriate positions.

17. A common complication of cancer is the development of SIADH. Remember that this is the disorder where there is too much ADH or antidiuretic hormone thus the client will have water intoxication or too much volume. In order to best manage this complication the nurse should anticipate that the physician would order radiation therapy and chemotherapy to manage the lung cancer, serum sodium levels due to risk of hyponatremia (sodium is diluted from large volume of water), and medication that is antagonistic to ADH so that antidiuretic hormone is blocked from holding the volume in the body, thus the systemic circulation. Thus the correct answers are A,B,D,E. The nurse should not increase fluids as the client is not voiding and already has too much volume so C is incorrect. The nurse would not anticipate the order of decreased oral sodium level as the serum sodium is diluted out and as such they client would need normal or even increased intake of sodium.

18. When teaching a parent to care of a child with AIDS at home, it is important to emphasize to monitor the child’s weight daily as they have a risk for weight loss due to immune disorder and anorexia; ensure that the child is not exposed to other illnesses due to the child have a weakened immune system; ensuring frequent handwashing to prevent or reduce the risk of infection; and clean up body spills with a 10:1 ratio of water to bleach to prevent the spread of infections. So B, C, D, E are correct. A is incorrect as the symptoms listed while may being expected DO require special interventions. F is incorrect as unless the immunization schedule does not need to be altered....the only change would be not to give live vaccines and replace them with versions that are not live.

19. The mafenide acetate can suppress renal excretion of acid, thus leading to acidosis. The body would compensate by blowing off CO2 to keep the body in acid-base balance, thus hyperventilation or option D is the correct response. If you did not know that, look at all of the options and look for systemic effects....option A is localized so wrong; When left with B, C, and
D, choose the worst option as you are essentially looking for the adverse effect and you would have either chosen B or D and taken your best educated guess.

20. When administering live vaccines, the contraindications to be aware of are if the child has had a previous anaphylactic reaction to the vaccine and if the child’s immune system is severely deficient, thus options B and E. The other options do not pose a risk when administering a live vaccine.