NORFOLK STATE UNIVERSITY
DEPARTMENT OF NURSING
NUR 362 SUMMER 2005

TEST # 3
UNIT III

DIRECTIONS: PLEASE WRITE YOUR NAME, THE DATE AND SIGN
YOUR NAME BELOW. CHECK YOUR BOOKLET TO
MAKE SURE THAT YOU HAVE 50 MULTIPLE CHOICE
QUESTIONS. PLEASE DOCUMENT ALL ANSWERS ON
THE SCANTRON SHEET THAT WAS PROVIDED.
YOU HAVE 75 MINUTES TO FINISH THIS TEST.

HONOR CODE STATEMENT

On my honor as a Norfolk State University Nursing Student, I have given nor
received aid on this examination and I pledge to report any breach in the honor
code.

NAME ____________________________ DATE ____________________

SIGNATURE ________________________
MULTIPLE CHOICE

Identify the letter of the choice that best completes the statement or answers the question.

1. A recommended intervention for a lifestyle stress indicator and reduction in the incidence of heart disease is:
   a. Regular physical exercise.
   b. Attendance at a support group.
   c. Self-awareness skill development.
   d. Time management.

2. The nurse is involved in crisis intervention with a family in which the father has just lost his job and is experiencing periods of depression. The mother has a chronic debilitating illness that has put added responsibilities on the adolescent child, who is having behavioral problems. The nurse intervenes specifically to focus the family on their feelings by:
   a. Pointing out the connection between the situation and their responses
   b. Encouraging the use of the family’s usual coping skills
   c. Working on time-management skills
   d. Discussing past experiences

3. A child and his mother have gone to the playroom on the pediatric unit. His mother tells him he cannot have a toy another child is playing with. The child cries, throws a block, and runs over to kick the door. This child is using a mechanism known as:
   a. Displacement
   b. Compensation
   c. Conversion
   d. Denial

4. Clients undergoing stress may undergo periods of regression. The nurse assesses this regressive behavior in the situation in which:
   a. An adult client exercises to the point of fatigue
   b. An 8-year-old child sucks his thumb and wets the bed
   c. An adult client avoids speaking about health concerns
   d. An 11-year-old child experiences stomach cramps and headaches

5. During the end-of-shift report the nurse notes that a client had been very nervous and preoccupied during the evening and that no family visited. To determine the amount of anxiety that the client is experiencing, the nurse should respond:
   a. “Would you like for me to call a family member to come support you?”
   b. “Would you like to go down the hall and talk with another client who had the same surgery?”
   c. “How serious do you think your illness is?”
   d. “You seem worried about something. Would it help to talk about it?”
6. A 23-year-old who recently had a head injury from a motor vehicle accident (MVA) is in a state of unconsciousness. Which of the following physiological adaptations is primarily responsible for his level of consciousness?
   a. Medulla oblongata
   b. Reticular formation
   c. Pituitary gland
   d. External stress response

7. A 72-year-old client is in a long-term care facility after having had a cerebrovascular accident. The client is noncommunicative, enteral feedings are not being absorbed, and respirations are becoming labored and the family have been notified of the client’s distress. Which of the stages of the GAS is the client experiencing?
   a. Resistance stage
   b. Exhaustion stage
   c. Reflex pain response
   d. Alarm reaction

8. The client is to receive a medication via the buccal route. The nurse plans to implement the following action:
   a. Place the medication inside the cheek
   b. Crush the medication before administration
   c. Offer the client a glass of orange juice after administration
   d. Use sterile technique to administer the medication

9. The nurse is documenting administration of a medication that is given at 10:00 AM, 2:00 PM, and 6:00 PM. The medication that the nurse is documenting is:
   a. Morphine sulfate, 10 mg q4h pm
   b. Propranolol (Inderal), 10 mg po bid
   c. Diazepam, 5 mg po tid
   d. Cephalexin (Keflex), 500 mg po q8h

10. The nurse administers the intramuscular medication of iron by the Z-track method. The medication was administered by this method to:
    a. Provide faster absorption of the medication into the subcutaneous tissue
    b. Reduce discomfort from the small gauge needle
    c. Provide more even absorption of the drug throughout the GI system
    d. Prevent the drug from irritating sensitive tissue

11. The client is ordered to have eye drops administered daily to both eyes. Eye drops should be instilled on the:
    a. Cornea
    b. Outer canthus
    c. Lower conjunctival sac
    d. Opening of the lacrimal duct

12. After administration of ear drops to the left ear, the client should be positioned:
    a. Prone
    b. Upright
    c. Right lateral
    d. Dorsal recumbent with hyperextension of the neck.
13. The order is for eye medication, 6 gtt s OD. The nurse administers:
   a. 2 ml to the right eye
   b. 2 drops to the left eye
   c. 2 drops to the right eye
   d. 2 drops to both eyes

14. The client is to receive a Mantoux test for tuberculosis. This test is administered via an intradermal injection. The nurse recognizes that the angle of injection that is used for an intradermal injection is:
   a. 15 degrees
   b. 30 degrees
   c. 45 degrees
   d. 90 degrees

15. The nurse is evaluating the integrity of the ventrogluteal injection site. The nurse finds the site by locating the:
   a. Middle third of the lateral thigh
   b. Greater trochanter, anterior iliac spine, and iliac crest
   c. Anterior aspect of the upper thigh
   d. Acromion process and axilla

16. The client is to receive heparin by injection. The nurse prepares to inject this medication in the client’s:
   a. Scapular region
   b. Vastus lateralis
   c. Posterior gluteal
   d. Abdomen

17. The nurse is administering an injection at the ventrogluteal site. Upon aspiration, the nurse notices that there is blood in the syringe. The nurse should:
   a. Inject the medication
   b. Pull the needle back slightly and inject the medication
   c. Move the skin to the side and inject the medication slowly
   d. Discontinue the injection and prepare the medication again

18. The nurse is assessing the body alignment of an alert client that is ambulating in the hallway. The first action that the nurse should take is to:
   a. Observe gait
   b. Put the client in the bed and ask the client to perform leg lifts
   c. Determine activity tolerance
   d. Determine range of joint motion

19. While ambulating in the hallway of a hospital, the client complains of extreme dizziness. The nurse, alert to a syncopeal episode, should first:
   a. Support the client and walk quickly back to the room
   b. Lean the client against the wall until the episode passes
   c. Lower the client gently to the floor using a wide base of support
   d. Leave the client and go for help
20. Nurses must implement appropriate body mechanics to prevent injury to themselves and clients. Which principle of body mechanics should the nurse incorporate into client care?
   a. Flex the knees, and keep the feet wide apart
   b. Assume a position far enough away from the client
   c. Twist the body in the direction of movement
   d. Use the strong back muscles for lifting or moving

21. A 79-year-old resident in a long-term care facility is known to "wander at night" and has fallen in the past. Which of the following is the most appropriate nursing intervention?
   a. An abdominal restraint should be placed on the client during sleeping hours
   b. The client should be checked frequently during the night
   c. A radio should be left playing at the bedside to assist in reality orientation
   d. The client should be placed in a room away from the activity of the nursing station

22. A visiting nurse completes an assessment of the ambulatory client in the home and determines the nursing diagnosis of Risk for injury related to decreased vision. Based on this assessment, the client will benefit the most from:
   a. Installing blue fluorescent lighting throughout the house
   b. Becoming oriented to the position of the furniture and stairways
   c. Maintaining complete bed rest in a hospital bed with side rails
   d. Applying physical restraints

23. The process of oxygenation includes ventilation, perfusion, and:
   a. diffusion
   b. respiratory cycling
   c. respiratory condition
   d. junctional arrhythmias

24. A mother of a young child enters the kitchen and finds the child on the floor. A bottle of cleanser is next to the child, and particles of the substance are around the child's mouth. The parent's first action should be to:
   a. Call the Poison Control unit
   b. Provide ipecac syrup
   c. Check the child's airway and breathing
   d. Remove the particles of cleanser from the mouth

25. The nurse is checking the client's overall oxygenation. In assessment of the presence of central cyanosis, the nurse will inspect the client's:
   a. arms
   b. scalp
   c. Earlobes
   d. Tongue and soft palate of the mouth

26. The nurse is working on a pulmonary unit at the local hospital. The nurse is alert to one of the early signs of hypoxia in the clients which is:
   a. Cyanosis
   b. Restlessness
   c. A decreased respiratory rate
   d. A decreased blood pressure
27. It is suspected that the client’s oxygenation status is deteriorating. The nurse is aware that the abnormal assessment finding that represents the most serious indication of the client’s decreased oxygenation is:
   a. Poor skin turgor
   b. Clubbing of the nails
   c. Central cyanosis/hypoxemia
   d. Pursed-lip breathing

28. A client is suspected of having a fat-soluble vitamin deficiency. To assist the client with this deficiency, the nurse informs the client:
   a. “More exposure to sunlight and drinking more fortified milk could solve your nutritional problem.”
   b. “Eating more pork, fish, eggs, and poultry will increase your vitamin B complex intake.”
   c. “Increasing your protein intake will increase your negative nitrogen imbalance.”
   d. “Decreasing your triglyceride levels by eating less saturated fats would be a good health intervention for you.”

29. The client is diagnosed with malabsorption syndrome (celiac disease). In teaching about the gluten-free diet, the nurse informs the client to avoid:
   a. Citrus fruits
   b. Vegetables
   c. Red meats
   d. Wheat products

30. The client has had throat surgery and is now able to have oral intake. The nurse should offer the client which of the following foods first:
   a. Chicken noodle soup
   b. Ginger ale
   c. Oatmeal
   d. Hot tea with extra lemon

31. The nurse is discussing dietary intake with a client who is human immunodeficiency virus (HIV) positive. The nurse informs the client that the diet will include:
   a. Restriction of potassium, phosphate, and sodium
   b. Reduction in carbohydrate intake
   c. Decreased protein and increased folie acid intake
   d. Reduction in fat, with smaller, more frequent meals

32. A client is seen in the outpatient clinic for follow-up of a nutritional deficiency. In planning for the client’s dietary intake, the nurse includes a complete protein, such as:
   a. Eggs
   b. Oats
   c. Lentils
   d. Peanuts
33. According to the Food Guide, vegetables should be included in the average adult’s diet as:
   a. 1 serving per day
   b. 2 to 8 servings per day
   c. 3 to 5 servings per day
   d. 6 to 11 servings per day

34. After a surgical procedure, the client is advanced to a full liquid diet. The nurse is able to recommend which one of the following foods for this client?
   a. Custard
   b. Pureed meats
   c. Soft fresh fruit
   d. Canned vegetable soup

35. The nurse is speaking with parents of a child at a day-care center. The parents ask the nurse about the nutritional needs of their toddler. An appropriate finger food that is identified by the nurse is:
   a. Nuts
   b. Popcorn
   c. Cheerios
   d. Hot dogs

36. For the client who is receiving parenteral nutrition via a central venous catheter, the nurse recognizes that a priority is to:
   a. Use sterile technique during the administration of the feedings
   b. Maintain the initial infusion rate at no more than 40 to 60 ml per hour
   c. Complete the administration of the feedings within 12 hours
   d. Have radiographic confirmation of the placement of the catheter

37. A client has been on prolonged bed rest, and the nurse is observing for signs associated with immobility. In assessment of the client, the nurse is alert to a(n):
   a. Increased blood pressure
   b. Decreased heart rate
   c. Increased urinary output
   d. Decreased peristalsis

38. A client is leaving for surgery, and because of preoperative sedation, needs complete assistance to transfer from the bed to the stretcher. Which of the following should the nurse do first?
   a. Elevate the head of the bed
   b. Explain the procedure to the client
   c. Place the client in the prone position
   d. Assess the situation for any potentially unsafe complications

39. An immobilized client is suspected as having atelectasis (collapsed lungs). This is assessed by the nurse on auscultation, as:
   a. Harsh crackles
   b. Wheezing on inspiration
   c. Diminished breath sounds
   d. Bronchovesicular whooshing
40. The best approach for the nurse to use to assess the presence of thrombosis in an immobilized client is to:
   a. Check for symmetry of lower extremities by measuring the calf and thigh diameters
   b. Always elicit Homan’s sign
   c. Palpate the temperature of the feet
   d. Observe for a loss of taut and skin turgor in the lower legs

41. A client is getting up for the first time after a long period of bed rest. The nurse should assess a orthostatic blood pressure by first:
   a. Assess respiratory function
   b. Obtain a baseline blood pressure in a supine position
   c. Assist the client to sit at the edge of the bed
   d. Ask the client if he or she feels lightheaded

42. Antiembolitic stockings (TEDs) are ordered for the client on bed rest after surgery. The nurse explains to the client that the primary purpose for the elastic stockings is to:
   a. Keep the skin warm and dry
   b. Prevent abnormal joint flexion
   c. Apply external pressure to promote venous return
   d. Prevent bleeding

43. To reduce the chance of external hip rotation in a client on prolonged bed rest, the nurse should implement the use of a:
   a. Footboard
   b. Trochanter roll
   c. Trapeze bar
   d. Bed board

44. With advancing age, which of the following normal physiological changes in sensory function occur?
   a. Decreased sensitivity to glare
   b. Increased number of taste buds
   c. Difficulty discriminating vowel sounds
   d. Decreased sensitivity to pain

45. The nurse is working with a client with a slight hearing impairment. To promote communication with this client, the nurse should:
   a. Speak at the client
   b. Use visual aids such as the hands and eyes when speaking
   c. Approach a client quietly from behind before speaking
   d. Select a public area to have a conversation
46. The client was working in the kitchen and was splashed in the face with a caustic cleaning agent. His eyes were affected, and he was brought to the hospital for treatment. After cleansing and evaluation, his eyes were bandaged. When assisting this client who has temporary visual loss to eat, the nurse should:
   a. Feed the client the entire meal
   b. Allow the client to experiment with foods
   c. Orient the client to the location of the foods on the plate
   d. Encourage the family to feed the client

47. The nurse completes a safety assessment during a home visit to an older adult client. Of the following observations made by the nurse, the one that is of greatest concern for this client who has evidence of sensory impairment is:
   a. Low-pile carpeting throughout the home
   b. A handrail on the stairs that extends the full length
   c. Adequate lighting in all the rooms
   d. The gray/black faded settings on the gas stove control gauge

48. During a home safety assessment, the nurse identifies a number of hazards. Of the following hazards that are noted by the nurse, which one represents the greatest risk for this client with diabetic peripheral neuropathy (tactile sensation deficit)?
   a. Improper water heater settings
   b. Absence of smoke detectors
   c. Cluttered walkways
   d. Lack of bathroom grab bars

49. A home safety measure specific for a client with diminished olfaction is the use of:
   a. Smoke detectors on all levels
   b. Extra lighting in hallways
   c. Amplified telephone receivers
   d. Mild water heater temperatures

50. The nurse has completed the admission assessment for a client admitted to the hospital’s subacute care unit. Of the following nursing diagnoses identified by the nurse, the one that takes the highest priority is:
   a. Potential for social isolation
   b. Injury, risk for
   c. Adjustment, impaired
   d. Communication, impaired verbal

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