MULTIPLE CHOICE
Chapter 1: Health Promotion and Disease Prevention
1. The nurse explains that the belief advancing the idea that disease is a result of an organically caused disorder is the
   a. biomedical model.
   b. biopsychosocial theory.
   c. Dunn’s high-level wellness model.
   d. Travis’ health model.
2. The nurse explains that the client’s ability to cope with stress dynamically will play a significant role in the client attaining maximum potential. This approach is most consistent with the model of
   a. King.
   b. Leninger.
   c. Levine.
   d. Neuman.
3. When the nurse encourages a Native American to seek health counsel from the tribe’s shaman, the nurse is following the tenets of
   a. King.
   b. Leninger.
   c. Pender.
   d. Rogers.
4. The nurse using the World Health Organization (WHO) description of health bases care on the premise that health is
   a. a gift from a higher being.
   b. any disease-free condition.
   c. complete mental, physical, and social well-being.
   d. high-level functioning despite illness.
5. The nurse planning a health promotion program with clients in the community will focus least on
   a. assisting the clients to make informed decisions.
   b. organizing methods to achieve optimal mental health.
   c. providing information and skills to maintain lifestyle changes.
   d. reducing genetic risk factors for illness.
6. A holistic belief system by the nurse would be most evident if the nurse
   a. accepts death as an outcome of life.
   b. encourages behavior modification programs.
   c. incorporates client perceptions of health when planning care.
d. supports goal-directed learning to improve health.
7. The nurse understands that the document he/she can use to plan community teaching projects addressing the federal population-based health objectives is
   a. Healthy People 2010.
   b. Nursing’s Agenda for Healthcare.
   c. the federal Medicare/Medicaid Acts.
   d. the Goldmark Report.
8. The nurse recognizes the activity that reflects primary prevention is
   a. a self-initiated walking regimen.
   b. collaboration with a physical therapist.
   c. physician-prescribed exercise after a heart attack.
   d. tuberculosis screening.
9. The nurse is planning a community STD (sexually transmitted disease) screening fair. This activity would be considered
   a. epidemiologic prevention.
   b. primary prevention.
   c. secondary prevention.
   d. tertiary prevention.
10. The nurse is developing a teaching plan for a 60-year-old man who experienced a cerebrovascular accident (CVA). The nurse works with the client to prevent aspiration when eating. This is an example of
   a. epidemiologic prevention.
   b. primary prevention.
   c. secondary prevention.
   d. tertiary prevention.

Chapter 2: Health Assessment
1. A nurse is collecting a health history from a client and feels the client is not reliable. One recommended way to verify some of the client data is to
   a. ask the client the same questions but in a different manner.
   b. confront the client with your suspicions.
   c. find and question a secondary source.
   d. have another nurse try to get data from the client.
2. The nurse is collecting a health history on a middle-aged African American male. The nurse asks about past blood pressure screening because the incidence of hypertension is higher in this ethnic group than in others. This is an example of
   a. a generalization based on the nurse’s limited experience with African Americans.
   b. bias, and the nurse should not question the client about blood pressure screening.
   c. stereotyping the client based on the client’s ethnic/racial group.
   d. using valid research data to focus questions on the client’s specific risks.
3. A client had surgery yesterday and is complaining of pain. The best action by the nurse is to
   a. ask the patient which pain medication she/he took last.
   b. do a complete assessment of the pain.
   c. prepare to administer the ordered pain medication.
   d. record the client’s complaints thoroughly and get the pain medication.
4. A client is being admitted to the hospital and the nurse has the client’s electronic record, including past medical history. What should the nurse do with this information?
a. Copy the information from the electronic database to the admission database.
b. Not use it because it is preferred to ask clients about past history at each encounter.
c. Save time and skip this part of the history-taking because the record is electronic.
d. Verify with the client that the list is current, complete, and correct.

5. To assess precipitating factors, the nurse interviewer would ask
a. “Do you remember the first time you had this problem?”
b. “How many times has the problem been related to activity?”
c. “What measures relieve this problem for you?”
d. “What were you doing when you first noticed the problem?”

6. Because the psychosocial assessment includes many more personal aspects of the client’s history, the most significant variable that may affect the quality and usefulness of the collected data is the
a. nurse’s ability to establish a therapeutic relationship.
b. nurse’s difficulty in differentiating normal from abnormal.
c. reluctance of most clients to share information with health care providers.
d. value the client places on the health interview.

7. In the preparation of a nursing care plan relative to the client’s mental status, the least helpful data would be those resulting from
a. client’s overall response to the interview.
b. formal psychological tests.
c. notation of appropriateness of affect.
d. observation of nonverbal behavior.

Chapter 3: Critical Thinking

1. The process by which a nurse uses purposeful thinking, informed reasoning, reflections, and thinking about thinking in clinical situations is called
a. clinical judgment.
b. critical thinking.
c. decision making.
d. problem solving.

2. It is crucial for the nurse to be able to make sound decisions using critical thinking because
a. it is the most efficient use of the nurse’s time and resources.
b. it uses previously learned knowledge in predictable situations.
c. most clients have problems for which there are no textbook answers.
d. nurses can recognize problems rapidly and provide speedy responses to situations.

3. A nurse with 6 year’s labor and delivery experience is floated to the intensive care unit. In this situation, the nurse would most likely function at the level of
a. advanced beginner.
b. competent.
c. novice.
d. proficient.

4. A nurse is working in the intensive care unit. When assessing the clients, the nurse notes one of them, who was scheduled to transfer to a step-down unit as soon as a bed becomes available, has a respiratory rate change from 18 to 20 breaths/min and an oxygen saturation (O2 sat) of 92%, when earlier it was 93%. The client denies complaints. The nurse calls the physician and requests a chest x-ray and arterial blood gases (ABGs). This nurse is working at which Benner Level of Competency in Nurses?
a. Advanced beginner
b. Competent
c. Expert
d. Proficient
5. A nurse is confused about the best way to confirm placement of a small flexible feeding tube before giving a bolus feeding. Colleagues on the unit suggest several different methods. The best process by which to determine a policy outlining the appropriate course of action is
a. critical reasoning.
b. evidence-based practice.
c. problem solving.
d. professional judgment.
6. A nurse who is alert to changes, confident, open-minded, proactive, and questioning is displaying which characteristics?
a. Alfaro’s Attitudes and Characteristics of a Critical Thinker
b. Benner’s Five Levels of Competency in Nurses
c. Hawk’s Model of Critical Thinking in Registered Nurses
d. Universal Intellectual Standards
7. A nurse brings a client a medication that is scheduled once daily with food. The medication administration record lists it as being due at 9:00 AM. The client refuses the medication, asking to take it later. The nurse replies “That’s OK. I can give it to you with your lunch if you like.” Which statement about the nurse is correct? The nurse
a. is being flexible and logical.
b. just made a medication error.
c. needs to call the doctor.
d. should tell the patient to take the medication now.

Chapter 4: Complementary and Alternative Therapies
1. According to the National Center for Complementary and Alternative Medicine, complementary medicine is
a. prescribed and overseen by a medical physician.
b. treatment of a physical illness by a spiritual intervention.
c. used in place of conventional medicine.
d. used together with conventional medicine.
2. Of the many complementary and alternative medicine (CAM) modalities available in the United States, the most rapidly growing area is
a. acupressure.
b. acupuncture.
c. dietary supplementation.
d. meditation.
3. A nurse taking the history of a client with rheumatoid arthritis might be alerted to the client’s use of CAM when the client says
a. “A bunch of nuts believe that putting nice smells in the air cures arthritis.”
b. “Doctors don’t know everything, you know.”
c. “I’ve heard something about alternative medicine. What is that?”
d. “What do you think about biofeedback?”
4. When the client asks the nurse about the use of therapeutic herbs, the nurse’s most instructional response would be
a. “Herbs are not regulated and may pose health risks if used with prescribed drugs.”
b. “Herbs have many qualities; some effects are good, and some are not.”

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c. “I have heard many people have used some herbal remedies and had good results.”
d. “If you are getting relief from some herbal remedy, there is probably no harm in it.”
5. The nurse reminds a client that the Dietary Supplement and Health Act of 1994 prevented manufacturers of dietary supplements from
a. making specific therapeutic claims for the product on their labels.
b. manufacturing products that are not tested or proven.
c. offering products for sale except through pharmacies.
d. publishing outrageous claims for the product on promotional materials.
6. When the client asks the nurse what “placebo effect” means, the nurse includes in the response that the placebo effect describes a
a. deterioration of the product to the point that it renders the product incapable of offering any therapeutic benefit.
b. phenomenon of a person taking the placebo and claiming positive effects because of psychological factors unrelated to the product.
c. practice of manufacturers to make hugely inflated claims to induce the potential user to believe in the worth of the product.
d. product that, although producing therapeutic effects for many users, has no effect on others.
7. A nurse understands that many conventional drugs are derived from plants, such as
a. meperidine (Demerol).
b. penicillin.
c. quinine.
d. steroids.
8. The nurse cautions that, when consumed in large quantities, antioxidants can become pro-oxidants, which
a. absorb large quantities of free radicals.
b. can produce free radicals.
c. create a free radical “shield.”
d. enhance the immune system.
9. A young Hispanic woman tells the nurse that she is going to have a healing ritual to center her spirit after the recent death of her husband. The nurse recognizes the alternative medicine system of
a. Ayurveda.
b. Curanderismo.
c. Reiki.
d. Tai Chi.
10. An elderly Chinese woman tells the nurse that she must improve the flow of her Qi. The nurse asks the client how long she has been using
a. acupuncture.
b. Ayurveda.
c. Tai Chi.
d. yoga.

**Chapter 5: Ambulatory Health Care**
1. Ambulatory care nursing is an emerging field of nursing practice in which the nurse
a. deals with clients who are ambulatory and able to walk into the clinic.
b. is part of an interdisciplinary team offering primary, secondary, and tertiary care.
c. offers an integrated system of care to persons within walking distance of the clinic.
d. works only with clients who are not acutely ill.

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2. Ambulatory care centers include
   a. care available 24 hours a day, 7 days a week.
   b. care for short-term medical-surgical procedures.
   c. services for those unable to provide self-care after a procedure.
   d. sleeping accommodations for a family member.
3. The nurse manager of an ambulatory care center assesses the center for environmental hazards to comply with guidelines of both the local state health department and the
   a. Ambulatory Care Nursing Administration and Practice.
   b. American Nurse’s Credentialing Center.
   d. Occupational Safety and Health Administration.
4. The facility that could best represent an ambulatory care center is a
   a. home health care agency.
   b. hospital with less than 50 beds.
   c. rehabilitation center.
   d. student health center.
5. In comparing the ambulatory care setting to an inpatient hospital setting, the nurse instructor is correct in stating that the ambulatory care setting
   a. has had so many cost increases that a visit is just as costly as the hospital.
   b. is already in decline and offers limited employment opportunities.
   c. may create a feeling of greater stress to the client than a hospital setting.
   d. provides an environment where the client is less at risk for nosocomial infection.
6. A nurse working in an ambulatory care setting would provide secondary prevention activities such as
   a. carrying out hypertension screening.
   b. giving instructions after minor surgery.
   c. providing cardiac rehabilitation.
   d. teaching young adults the benefits of good nutrition.
7. The nurse instructor describes an integrated delivery system and cites the example of
   a. a hospital’s alignment with several physician groups to increase hospital referral.
   b. an outpatient clinic in the hospital.
   c. enrollees of the system being “locked” into the system of care for services.
   d. providers concerned about generating revenue.
8. A health care service that provides a defined population with a stated range of services through prepayment of an annual or monthly capitation fee is a(n)
   a. health maintenance organization (HMO).
   b. nurse-managed ambulatory center.
   c. outpatient service of a community hospital.
   d. preferred provider organization (PPO).
9. The facility least suited to the provision of primary health care is a(n)
   a. ambulatory care center.
   b. emergency department.
   c. HMO.
   d. hospital outpatient clinic.
10. The nurse-manager explains to a new nurse at the ambulatory clinic that the service for which the telephone nursing practice is not feasible is
    a. assessing a client’s needs based on the nurse’s perception.

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b. developing a collaborative plan of care with a client.
c. evaluating outcomes of practice and care.
d. prioritizing the urgency of a client’s needs.

Chapter 6: Acute Health Care

1. The prepayment plan developed in 1929 is
   a. Blue Cross Health Insurance.
   b. Medicare Insurance.
   c. Medicaid Insurance.
   d. Health Maintenance Organization.

2. A hospital staff nurse is collaborating with a nurse case manager in planning the care of a client with a below-the-knee amputation. The primary role of the case manager is
   a. client education on specialized care.
   b. coordination of care for the client.
   c. direct care of the client’s medical problems.
   d. education of the staff nurse.

3. A registered nurse (RN) seeking work in a voluntary health agency would choose a
   a. church-affiliated hospital.
   b. proprietary hospital.
   c. state university hospital.
   d. veterans administration (VA) hospital.

4. A client experiences chest pain with electrocardiographic changes during an appointment with the primary care physician, and the physician orders hospital admission for cardiac monitoring. This type of admission is a(n)
   a. elective admission.
   b. emergency admission.
   c. direct admission.
   d. scheduled admission.

5. A client for whom the nurse would provide post–acute care is the
   a. 38-year-old following cesarean birth.
   b. 40-year-old recovering from kidney stone removal.
   c. 60-year-old receiving a regulated regimen of anti-hypertensive medication.
   d. 76-year-old needing rehabilitation after cardiac surgery.

6. While administering an antibiotic to a client with an infection, the nurse explains the importance of completing the full course of antibiotic therapy. This is an example of
   a. formal education.
   b. giving advice.
   c. informal education.
   d. setting an example.

7. When unit staffing includes unlicensed assistive personnel, the nurse is aware that
   a. delegating tasks to unlicensed assistive personnel is not in the scope of RN practice.
   b. licensed personnel are accountable for the tasks delegated to the unlicensed personnel.
   c. unlicensed assistive personnel do not have clinical duties on a client care unit.
   d. unlicensed assistive personnel have formal training and function independently.

8. When a nurse is able to work effectively in more than one care area (e.g., general medical-surgical, and cardiac care unit), the nurse is said to be
   a. cross-trained.
b. flexibly assigned.
c. nursing intense.
d. skill mixed.
9. An applicant was denied employment with a health care agency because she is a recovering alcoholic. This action by the agency violates the
b. Americans with Disabilities Act.
c. Civil Rights Act.
d. Occupational Safety and Health Act.
10. A planned program of loss prevention and liability control best defines
a. client satisfaction.
b. clinical pathway.
c. quality assurance.
d. risk management.
Chapter 7: Critical Care
1. The population that is increasingly using critical care units and needing specialized nursing care is the population of
a. elderly.
b. middle-age adults.
c. underserved pregnant women.
d. uninsured.
2. The ICU nurse planning care for a critically ill client tries to arrange care to minimize the most disruptive stressor for the client, which is
a. alteration in sleep.
b. fear of the unknown.
c. persistent pain.
d. sense of isolation.
3. Critical care units (CCUs) have been developed in almost all hospitals because such units
a. allow for concentration of expert personnel.
b. can offer special services to the family.
c. contain costs.
d. separate the seriously ill from the other clients.
4. The nurse admitting clients to the critical care unit understands that priority clients for this area are those who need
a. a cleaner environment to prevent nosocomial infections.
b. continuous physiologic monitoring.
c. frequent vital sign checks.
d. private rooms conducive to rest and sleep.
5. The nurse admitting clients to an intensive care unit understands that research demonstrates best client outcomes when clients
a. are in an area that allows liberal family visitation.
b. have consistent nurses caring for them.
c. have state of the art physiologic monitoring.
d. receive multidisciplinary care led by an intensivist.
6. A nurse who is acting in a manner that respects and supports the client’s and family’s basic rights, values, and beliefs is functioning in which professional role?

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a. Advocate  
b. Caregiver  
c. Critical thinker  
d. Manager  

7. A nurse working in critical care would plan interactions with clients’ families based on the understanding that families most need  
a. knowledge.  
b. respect.  
c. sleep.  
d. spiritual support.  

8. A nurse working in the critical care unit would assess the client’s complexity by asking questions related to  
a. ability of the client and family to make sound decisions.  
b. effect of family, stress, and environmental factors on the client.  
c. interplay of multiple medical problems on the current condition.  
d. the client’s ability to use compensatory coping mechanisms.  

9. The essential nurse competency that the critical care nurse uses when providing best care practices is  
a. advocacy.  
b. clinical inquiry.  
c. clinical judgment.  
d. systems thinking.  

Chapter 8: Home Health Care  

1. The nurse explains to a client that the person who would be most likely to receive home health care is the client who is  
a. 65-years-old with a wrist fracture.  
b. 68-years-old with a cataract in one eye.  
c. 72-years-old with diabetes mellitus.  
d. 74-years-old with a hearing impairment.  

2. The Henry Street Settlement in New York City, which offered public health nursing to clients with chronic health problems, was established by  
a. Clara Barton.  
b. Dorothea Dix and Sojourner Truth.  
c. Frances Root.  
d. Lillian Wald and Mary Brewster.  

3. The program that had the greatest influence on the number of agencies providing community health care is  
a. ADC.  
b. Medicaid.  
c. Medicare.  
d. Social Security.  

4. A home health nurse has a client with permanent left-sided weakness after a stroke; the client is cared for by his wife and daughter. The nurse will design the plan of care to  
a. help the wife manage the home.  
b. limit input from the wife and daughter.  
c. reduce the impact of the client’s health care beliefs.  
d. stimulate the client to become independent.  

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5. The home health nurse uses the Omaha System for planning care and is able to evaluate the client’s health status with the portion of that tool known as
a. Assessment and Analysis.
b. Intervention Scheme.
c. Problem Classification.
d. Problem Rating Scale.
6. The service requested and needed by an applicant to home health that would not be eligible for coverage under Medicare is
a. home health aide.
b. housekeeping services.
c. physical therapy.
d. speech therapy.
7. A home health nurse explains to a client that the Omaha System was designed to facilitate
a. client understanding of the overall health care plan.
b. documentation of unusual events and associated malpractice risks.
c. nursing practice, documentation, and data management.
d. the nurse’s ability to visit more clients during the workday.
8. The component that is not part of the Omaha System is
a. Intervention Scheme.
b. Problem Classification Scheme.
c. Problem Rating Scale for Outcomes.
d. Rating Scale for Client Satisfaction.
9. The domain of the Omaha System that the nurse would reference in making her assessment relative to caretaking/parenting is
a. Environment.
b. Health-Related Behaviors.
c. Physiological.
d. Psychosocial.
10. The home health nurse explains that her philosophy is based on the belief that clients should
a. adhere to the care plan generated by the nurse.
b. alter cultural practices to meet health needs.
c. be knowledgeable about their health care.
d. feel no responsibility for their health care.

Chapter 9: Long-Term Care
1. Historically, European countries in the 1700s housed older persons in institutions with
a. farmers, who could use them as labor.
b. mentally ill persons.
c. older people of the same gender.
d. those of the same socioeconomic class.
2. The enactment of Social Security in 1935 afforded older adults the ability to
a. enter a city-sponsored nursing home.
b. purchase care privately.
c. receive care by a physician in the home.
d. stay in hospitals until completely well.
3. The Hill-Burton Hospital Survey and Construction Act of 1946 provided building funds and resulted in nursing homes that

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1. The rehabilitation nurse stresses that the major focus in a rehabilitation setting is

a. allowed for flexible visiting hours.
b. resembled hospitals.
c. were located only in rural settings.
d. were to have at least 100 beds.

4. In 1965 the enactment of Medicare and Medicaid provided older adults and poor persons with the assurance of
a. a minimal level of health care.
b. a reasonable standard of living.
c. guaranteed housing.
d. increased food allowance funding.

5. The Omnibus Budget Reconciliation Act of 1987 (OBRA) affected nursing homes by
a. allowing residents more choice in the selection of a nursing home.
b. mandating that each resident have a private room and bath.
c. producing profound reforms in nursing home care.
d. providing for better funding to meet the needs of the residents.

6. The nurse plans programming at a nursing home understanding that the defining impairment that affects almost all residents in a nursing home is
a. Alzheimer’s disease or other cognitive deficit.
b. impairment in ability to perform activities of daily living (ADL).
c. profound hearing loss or other unspecified sensory deficit.
d. severe, progressive visual deficit.

7. A nurse teaching a new resident and family about the Resident Rights outlined by OBRA would include which information? A resident has the right to
a. be informed of rights, rules, and responsibilities.
b. choose activities and care.
c. have clean, safe, home-like environment.
d. organize and participate in resident groups.

8. In regard to nursing services in a long-term care facility, OBRA regulations include
a. a director of nursing that holds at least a master’s degree in health administration.
b. availability of vocational nurses on each unit 24 hours a day, 7 days a week.
c. the presence of at least four direct caregivers on duty per unit for each shift, regardless of census.
d. the provision of nursing personnel consistent with the level of care and needs of residents.

9. The nurse admitting a new resident to a long-term care facility is mindful that after the resident is assessed, a care plan must be written within
a. 1 day.
b. 3 days.
c. 5 days.
d. 7 days.

10. After a long-term care facility nurse receives a phone order from the physician, the nurse must ensure that the order is countersigned in
a. 8 hours.
b. 12 hours.
c. 24 hours.
d. 48 hours.

Chapter 10: Rehabilitation
1. The rehabilitation nurse stresses that the major focus in a rehabilitation setting is
a. acquisition of services for the newly discharged client.
b. elimination of clinical manifestations.
c. prevention of disease progression.
d. skills’ instruction for independence.

2. The nurse clarifies that the Medicare criteria to qualify for rehabilitation services include that a client will
   a. communicate adequately to be understood.
   b. participate in 3 hours of therapy daily.
   c. require three or more therapeutic modalities.
   d. walk independently with crutches, cane, or walker.

3. The rehabilitation nurse reminds a client that according to the International Classification of Functioning, Disability and Health (ICF), the broad theoretical qualification criterion for rehabilitation services is that the client
   a. has impaired mobility in two limbs.
   b. has impairments that lead to reduced ability to engage in activities.
   c. is no longer capable of independent living.
   d. requires assistance in mobility, dressing, and toileting.

4. The rehabilitation nurse uses the Functional Independence Measures (FIM) tool to assess the client’s
   a. attitude.
   b. physical strength.
   c. rehabilitation goals.
   d. self-care capabilities.

5. The rehabilitation nurse explains that the transdisciplinary approach to rehabilitation provides the client with
   a. more efficient service at a greatly reduced cost.
   b. reduced number of personnel with whom to interact.
   c. reduced time spent on therapeutic modalities.
   d. shortened stay in the rehabilitation unit.

6. To set the stage for a successful rehabilitation experience, the rehabilitation nurse helps the client and the family conceptualize their definition of
   a. activity participation.
   b. independence.
   c. quality of life.
   d. wellness.

7. The nurse makes sure that the client and the family understand that in the transdisciplinary approach, the entire team
   a. estimates the time required for full functioning.
   b. identifies a primary therapist.
   c. limits what each discipline will offer.
   d. sets team goals during transdisciplinary meetings.

8. A rehabilitation nurse scores the client at “1” in a functional area on the FIM. This means the client has
   a. full independence in that area.
   b. independence in that area with use of an assistive device.
   c. partial dependence in need of significant assistance.
   d. total dependence.

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9. A nurse incorporating a client’s psychosocial reaction to a disabling illness into the plan of care would use a staging model because the model
a. allows the nurse to group the client with peers for socializing.
b. describes the process of adaptation as a standardized process.
c. explains some common reactions to the disabling condition.
d. predicts the experience of psychosocial adaptation.

Chapter 11: Clients with Fluid Imbalances

1. A client has a serum sodium level of 115 mEq/L. The nurse has initiated a slow IV infusion of hypertonic saline solution per IV pump in a large vein. Which other intervention should the nurse implement as a priority?
   a. Assess the client for dysphagia.
   b. Have on-hand a calcium-channel blocker in case of overdose.
   c. Initiate seizure and safety precautions.
   d. Start a second IV in case the first one infiltrates.

2. A nurse is caring for four clients who are at risk for or who have an actual fluid volume deficit. Which client should the nurse assess first? The nurse should first assess the client who
   a. is confused and spits out oral foods/fluids.
   b. is on a tube-feeding running at 85 ml/hour.
   c. was admitted with polyuria.
   d. has diarrhea and now is restless.

3. A client with severe malnutrition has pedal edema and ascites. The nurse notes that the weight is unchanged for the last 2 days. The most appropriate action by the nurse is to
   a. ask the assistive personnel to re-weigh the client.
   b. assess vital signs, level of consciousness, and urine output.
   c. call the physician to request IV diuretics.
   d. have biomedical engineering check the scale.

4. The nurse notes that a client with renal disease has a plasma osmolality of 200 mOsm/kg and a plasma sodium level of 122 mEq/L. The nurse would further assess the client for other manifestations of
   a. extracellular fluid volume excess.
   b. hyperosmolar fluid volume deficit.
   c. intracellular fluid volume excess.
   d. iso-osmolar fluid volume deficit.

5. A client who regularly exercises vigorously is being discharged from the emergency department after suffering from dehydration that was corrected. The nurse would realize that the client needs additional instructions when the client says
   a. “Drinking water too fast just goes through the kidneys and doesn’t help.”
   b. “I will try to avoid exercising outside in high humidity.”
   c. “OK, I’ll stop trying to lose weight by wearing sweats all summer long.”
   d. “When I get thirsty, I know to stop and drink something then.”

6. A client with dehydration is being weighed on a standing scale next to the bed. The most important action by the nurse is to
   a. assist the client to prevent falls.
   b. calibrate the scale per manufacturer’s directions.
   c. document the weight and compare it with prior ones.
   d. explain to the client what is going to happen.

7. The nurse has a client who received large amounts of IV fluids during and following surgery, yet the
client’s urinary output is low and the client is agitated. The nurse realizes the IV fluid that most likely has caused this problem is
a. D5W.
b. 0.45% NS.
c. 0.9% NS.
d. 3% saline.
8. The nurse who is caring for a client prescribed diuretics and fluid restriction to control edema can most easily evaluate the effectiveness of the medical protocol by
a. calculating plasma osmolality.
b. careful weight assessment.
c. checking the lab report on serum sodium level.
d. measuring the ankle circumference.
9. The nurse makes the evaluation that the intake of one of the adult clients in her care is adequate when she measures the total daily intake as
a. 750 ml.
b. 900 ml.
c. 1000 ml.
d. 2000 ml.
10. The nurse anticipates that an order for an isotonic intravenous (IV) solution will read
a. 0.45% sodium chloride.
b. 0.9% sodium chloride.
c. 3% sodium chloride.
d. 5% dextrose in water.

Chapter 12: Clients with Electrolyte Imbalances
1. Physical assessment of a client with cardiac dysrhythmia reveals hypoactive bowel sounds, muscle weakness, dizziness, postural hypotension, shallow respirations, increased fatigue, and decreased tendon reflexes. The laboratory result consistent with these findings is
a. serum calcium level of 4.3 mEq/L.
b. serum magnesium level of 1.3 mEq/L.
c. serum phosphorus level of 1.1 mEq/L.
d. serum potassium level of 3.0 mEq/L.
2. A client is being discharged from the hospital and will be taking oral potassium chloride. The nurse should teach the client to take this medication
a. at bedtime.
b. between meals.
c. on an empty stomach.
d. with a glass of juice.
3. For a client in renal failure with an abnormally elevated serum potassium level, the priority assessment by the nurse would be the client’s
a. electrocardiogram (ECG) strips.
b. level of consciousness.
c. serial BUN and creatinine levels.
d. urine output.
4. A client has a low serum calcium level. During a bath the nurse cleans the client’s face with a cloth, and the lips, nose, and side of the face contract. The nurse documents the presence of
a. Bell’s palsy.
b. Chvostek’s sign.
c. tic douloureux.
d. Trousseau’s sign.
5. A client has been admitted with hypokalemia but all treatments have failed to raise the potassium level suitably. The nurse would assess the client further and report findings of
a. chronic insomnia.
b. estrogen use.
c. laxative abuse.
d. recent leg fracture.
6. The nurse caring for a client taking thiazide diuretics should be sure to observe for
a. decreased urine output.
b. increased peristalsis.
c. neurologic depression.
d. neuromuscular irritability.
7. Self-care teaching for a client with hypercalcemia should include
a. administering antidiarrheal medications.
b. decreasing sodium and calcium intake.
c. encouraging foods that increase urine acidity.
d. restricting fluid intake to less than 1 liter a day.
8. A client has a magnesium deficit in addition to congestive heart failure (CHF). The most appropriate nursing diagnosis is
a. Altered Comfort.
b. High Risk for Injury.
c. Impaired Skin Integrity.
d. Risk for Decreased Cardiac Output.
9. A client has been admitted in a hypercalcemic crisis and the family is distraught. One family member grabs the nurse’s hand and states “I just don’t know what I’ll do if he/she dies!” The best response by the nurse is
a. “Don’t worry. We see this and treat it all the time in clients just like this.”
b. “I know that you are upset, but I have to take care of the client first.”
c. “What has your loved one been eating and drinking during the last week?”
d. “Yes, this is serious but I can come back and answer some questions for you.”
10. The factor in the client’s history that the nurse assesses as a risk for the development of hypermagnesemia is
a. Addison’s disease.
b. gastrointestinal disease.
c. vomiting.
d. water intoxication.

Chapter 13: Acid-Base Balance

1. When an individual’s serum pH begins to fall below 7.35, the mechanism that responds instantaneously to return the serum pH to normal level is
a. ammonia gas combining with H+.
b. excretion of acid by the lungs.
c. plasma bicarbonate buffering the acid.
d. secretion of hydrogen ions (H+) by the kidneys.
2. A client in diabetic ketoacidosis has an elevated serum potassium ion (K+) level. The nurse explains
to the client that this is caused by
a. bicarbonate loss in the urine instead of K+ loss.
b. binding of H+ to blood proteins.
c. increased reabsorption of K+ in the distal tubule of the nephron.
d. secretion by the kidneys of H+ and retention of K+.
3. The nurse teaching a 32-year-old man with renal failure about the pathophysiologic mechanism of acid-base balance recognizes that the instructions have been understood when the client says
a. “Acidic foods must be eliminated from my diet.”
b. “I lose too much acid through my kidneys.”
c. “My breathing increases to correct imbalances.”
d. “My urine output will increase when my pH falls.”
4. The nurse explains to a concerned family member of a client who has developed respiratory acidosis that the kidneys
a. achieve optimal compensation immediately.
b. are unable to compensate.
c. can achieve optimal compensation in about 3 days.
d. will compensate within 24 hours.
5. In an assessment of current clients, the nurse recognizes that the client most likely to develop respiratory acidosis has
a. chronic obstructive pulmonary disease.
b. hypokalemia.
c. salicylate overdose.
d. pulmonary fibrosis.
6. The nurse is caring for a client who has developed metabolic acidosis and has an anion gap of 12 mEq/L. The nurse informs a family member that this finding indicates that the client’s acidosis is caused by
a. accelerated lipid metabolism.
b. an increase of fixed acid.
c. increases in carbonic acid.
d. loss of bicarbonate.
7. A client is admitted to the hospital with severe vomiting and is diagnosed with metabolic alkalosis. The nurse anticipates that the laboratory value that would support this diagnosis is
a. arterial carbon dioxide tension (PaCO2) of 30 mm Hg.
b. arterial pH of 7.30.
c. serum calcium level of 9.0 mEq/L.
d. serum potassium level of 3.0 mEq/L.
8. The nurse assesses that the client admitted in respiratory acidosis has compensated when the arterial blood gas (ABG) readings are
a. carbon dioxide level of 50 mm Hg and bicarbonate level of 30 mEq/L.
b. carbon dioxide level of 50 mm Hg and bicarbonate level of 20 mEq/L.
c. carbon dioxide level of 30 mm Hg and bicarbonate level of 30 mEq/L.
d. carbon dioxide level of 30 mm Hg and bicarbonate level of 24 mEq/L.
9. For a 34-year-old client in renal failure who develops acidosis, the nurse would assess for
a. drowsiness.
b. hypoventilation.
c. muscle hyperactivity.
10. To prevent error in sampling arterial blood gases (ABGs), the nurse will
   a. place the sample immediately in ice water.
   b. shake the sample to mix in heparin.
   c. transfer the sample from syringe to air-tight glass test tube.
   d. use a large beveled needle to withdraw the sample.

**Chapter 14: Clients Having Surgery**

1. The nurse explains to a client that because of alterations in liver function caused by cirrhosis, the client is predisposed to postoperative fluid shifts and wound infection related to
   a. elevated creatinine phosphokinase levels.
   b. elevated lactic dehydrogenase levels.
   c. low albumin levels.
   d. low blood urea nitrogen levels.

2. A client who is extremely overweight has been advised to lose weight before surgery. To encourage the client, the nurse knows that the most appropriate statement is
   a. “It will decrease the operating room time by half if you lose weight.”
   b. “Surgery requires more anesthesia if you are overweight.”
   c. “With the weight loss, you decrease the chance of complications after surgery.”
   d. “You’ll feel better after surgery if you lose the weight before.”

3. Preoperative assessment data that should be reported to the surgeon include
   a. complaining of mild anxiety.
   b. having a sore throat.
   c. potassium level within normal range.
   d. using acetaminophen for headaches.

4. The preoperative assessment finding that the nurse would report to the surgeon for preoperative treatment is
   a. hemoglobin concentration of 13.5 mg/dl.
   b. partial thromboplastin time of 25 seconds.
   c. potassium level of 3.0 mEq/L.
   d. sodium level of 140 mEq/L.

5. During the preoperative interview, the client’s statement that would alert the nurse to an increased risk during surgery is “I
   a. am a reformed smoker; I haven’t had a cigarette in 10 years.”
   b. rarely eat red meat; it usually makes me feel bloated.”
   c. take a couple of aspirin every day for my headaches.”
   d. take a large assortment of vitamins daily.”

6. A client scheduled for a dilation and evacuation following a miscarriage is visibly upset and states that she is frightened and does not know what to expect. The perioperative nurse best demonstrates understanding of the situation by saying
   a. “I’ll give you something to help you relax.”
   b. “Let me explain what is going to happen.”
   c. “This is a simple procedure; it will be over in no time.”
   d. “You’re still young, and you can have more children.”

7. The methodology likely to be most effective in meeting a client’s teaching/learning needs preoperatively is
   a. teaching only the client.

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b. teaching the client and family.
c. using brief verbal instructions.
d. using only written instructions.

8. The nurse explains to a preoperative class of six clients awaiting surgery that studies indicate the primary benefit of the class is to
a. distribute information to the most individuals in a short time.
b. explain legal responsibilities.
c. promote a less complicated postoperative course.
d. provide uniform information.

9. The nurse will plan preoperative teaching about how to cough and deep-breathe for
a. 1 week before the procedure.
b. immediately postoperatively.
c. the afternoon before surgery.
d. the nurse’s first discussion about the surgery.

10. When teaching the proper method of coughing, the nurse should instruct the client to
a. breathe in and out through the nose.
b. deep-breathe after coughing.
c. relax the abdominal muscles.
d. splint the incision.

Chapter 15: Perspectives in Genetics

1. The Human Genome Project (HGP) was begun in 1990 to
a. alter the course of inherited disorders.
b. clone an animal, then a human.
c. determine the location of genes on chromosomes.
d. replicate the structure of deoxyribonucleic acid (DNA).

2. Autosomes are the chromosomes that
a. are common to males and females.
b. are inherited from the paternal side.
c. determine gender.
d. exist in paired forms.

3. The nurse explains to a client that the condition of a sperm or egg having an irregular number of chromosomes is called
a. aneuploidy.
b. genotype.
c. phenotype.
d. polypeptide.

4. A nurse counseling a couple about genetic disorders explains that Tay-Sachs disease is a genetically linked disorder seen in 7% of the
a. African-American ethnic group.
b. Ashkenazi Jewish ethnic group.
c. Hispanic ethnic group.
d. Northern European ethnic group.

5. The nurse counseling a couple that wish to obtain genetic testing before starting a family explains that the purpose of such screening is to
a. allow genetic-defect-free individuals to obtain insurance discounts.
b. identify individuals who are healthy but carry a disease-carrying gene.

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c. prevent genetically-based diseases from being transmitted.
d. provide genetic analysis to anyone who desires it.

6. A nurse educating clients in a genetic screening clinic explains that recessive genes on autosomal chromosomes can be passed on
   a. to children of either gender.
   b. only to males.
   c. only to females.
   d. to females after skipping a generation.

7. A nurse explains to a family that if a man has a recessive gene on his X chromosome, that characteristic can be passed on to
   a. any child of either gender.
   b. his daughters.
   c. his sons.
   d. no child as it is a random mutation.

8. A nurse providing genetic counseling explains that when one parent has an autosomal dominant gene for an inherited disease, the chances of the child being affected are
   a. 10%.
   b. 25%.
   c. 50%.
   d. 100%.

Chapter 16: Perspectives in Oncology

1. In planning programs for cancer prevention, the nurse should provide information about cancer as the _____ leading cause of death
   a. major
   b. second
   c. third
   d. fourth

2. After discussing the difference between benign and malignant tumors with a client, the nurse would know that the client understood the discussion when the client says
   a. “A benign tumor does not invade other tissue.”
   b. “Malignant tissue is not found far from the original site of the tumor.”
   c. “Malignant tumors do not respond well to chemotherapy.”
   d. “The control of growth is impaired only in malignant tissue.”

3. The number of new cancer cases diagnosed has increased steadily since 1900. The nurse explains to a client that one of the reasons for this increase is that
   a. cancer is related to most birth defects.
   b. many false-positive cancer results are reported.
   c. people who live longer are less prone to cancer.
   d. statistical analysis and reporting are more accurate.

4. A nurse is conducting a smoking cessation clinic. What information about smoking does the nurse include in the teaching component of the program?
   a. A pack-year history is the length of time, in years, a person has smoked.
   b. Smokeless tobacco is harmless because the carcinogens have been removed.
   c. Smoking causes more cancer in the United States than do all other causes combined.
   d. The risk of cancer for someone who stops smoking does not improve.

5. A client is considering having genetic testing for cancer that “runs in the family.” Vital information

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for the nurse to include in the teaching plan before the client has the testing includes telling the client that
a. Genetic testing is simple and inexpensive and the client does not need to seek out a specialist to interpret the results.
b. If a genetic test comes back positive for a gene related to cancer, the client will develop the cancer.
c. There are so many genetically-based cancers that even genetic testing cannot possibly cover them all.
d. There are specific state and federal laws to protect people who undergo genetic testing from insurance and job discrimination.
6. The nurse reviewing a research report recognizes that a discussion of oncogenes will address
a. a chemotherapeutic agent that eradicates viruses that cause cancer.
b. factors in the immune system protecting the client from malignant growths.
c. risk factors in cancer development.
d. segments of DNA that transform normal cells into malignant cells.
7. A nurse is conducting a wellness seminar in which the cancer-fighting actions of diet and physical activity are presented. A woman in the audience says, “I thought diet and exercise were related to heart disease.” The best response by the nurse is
a. “In people who don’t smoke, diet and activity are the most important risk factors.”
b. “They are important for both, but the diet to prevent cancer is totally different.”
c. “They are important for heart disease too, but cancer is a bigger killer.”
d. “You’re right; diet and activity are more important to prevent heart disease.”
8. A client has worked for 2 years installing insulation containing asbestos. The nurse will determine further assessment questions based on the understanding that occupational exposure to carcinogens represents ____% of all human cancers.
a. <2 b. 2-8 c. 10-12 d. >12
9. A nurse is administering IV chemotherapy. What personal protective equipment (PPE) should the nurse use when doing this task?
a. A gown and gloves
b. Gloves and a mask
c. No special PPE is needed
d. Only gloves
10. After explaining how malignant cells differ from normal cells to a client with breast cancer, the nurse knows the client understands the characteristics of malignant cells when the client says “Malignant cells
a. are larger than normal cells and have designated purposes.”
b. cannot grow if inflammation is present.”
c. develop chromosomal abnormalities as they mature.”
d. develop the same antigens as normal cells do.”

**Chapter 17: Clients with Cancer**
1. The nurse is reviewing the American Cancer Society (ACS) recommendations for breast cancer screening with a 50-year-old female client. The nurse should emphasize the recommendation for
a. breast examination by a health care professional semi-annually.
b. breast self-examination (BSE) monthly.
c. chest x-ray study yearly when the client is over age 40.
d. mammography when a lump is detected.
2. The recommendation the nurse should share with a 22-year-old sexually active client who is seeking information on the prevention of cervical cancer is that a Pap smear
a. is needed annually by all women over age 18.
b. should be done annually until two tests are negative, then once every 2-3 years, in women over 30.
c. should be done biannually for clients who have been sexually active for 3 years but not later than age 21.
d. should be performed twice a year for all sexually active women over age 18.

3. After a client has a series of diagnostic tests, the studies confirm the presence of rectal cancer. The nurse’s primary intervention should be to
   a. assess the meaning and effect of cancer as perceived by the client.
   b. determine if the client is emotionally ready to deal with the diagnosis of cancer.
   c. reassure the client that many treatment modalities are available.
   d. support the physician when the client is informed of the diagnosis.

4. The nurse caring for a client with cancer of the thyroid gland has a tumor classified as T2, N1, M0. The nurse explains that the “T” in this classification schema represents
   a. number of years the tumor has been present.
   b. site of the tumor.
   c. size of the tumor.
   d. virulence of malignancy.

5. A 32-year-old client who has a history of familial polyposis but no manifestations still wants to explore the possibility of preventive surgery. The most appropriate response the nurse can make is
   a. “Cancer is not always hereditary, and you should change risk factors in your life.”
   b. “It is an overreaction to seek radical treatment before you develop symptoms.”
   c. “Monthly rectal smears may allay your anxiety without surgery.”
   d. “Subtotal colectomy is a procedure you might seek further information about.”

6. Yesterday a 28-year-old client was diagnosed with rectal cancer. The nurse has made the nursing diagnosis of Anxiety Related to Fear of the Unknown, as manifested by anger. The best approach for the nurse to take in relation to the client’s need for information is to
   a. offer suggestions to modify the client’s expressions of anger.
   b. provide the client with a detailed plan for future interventions.
   c. provide the client with simple explanations of proposed treatments.
   d. specifically discuss the scientific facts related to rectal cancer.

7. The nurse is administering medication in phase III trials to a client with lung cancer. Assessments made in this phase of the drug investigation involve
   a. determination of the maximum tolerated dose.
   b. evaluation of the drug’s general effectiveness.
   c. explanation of how the drug compares with standard treatments.
   d. description of the type and severity of side effects.

8. The client is receiving a drug in a phase I clinical trial. Regarding the type of malignancy for which the client is being treated, the nurse makes the assumption that the cancer
   a. and its treatment are not covered by the client’s insurance.
   b. is limited in size and virulence.
   c. is not following the expected disease course.
   d. will not respond to other known treatments for cancer.

9. The nurse caring for a client who has an implanted radiation source should reduce self-exposure by incorporating the strategy of
   a. limiting the time spent close to the client to 30 minutes per 8-hour shift.
   b. remaining 6 feet away from the client except for essential care.

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c. wearing a lead-shielded apron whenever entering the client’s room.
d. wearing a radiation meter or film badge to measure exposure.
10. The nursing action that has the highest priority for a 32-year-old client with an implanted radiation source should focus on
   a. assessing the client’s reaction to the diagnosis and treatment.
   b. preventing skin problems related to radiation.
   c. promoting regular activity while confined to the room.
   d. safeguarding the client and others from unnecessary radiation exposure.

**Chapter 18: Clients with Wounds**

1. The nurse predicts that the wound capable of becoming “ideally healed” is a(n)
   a. abdominal incision.
   b. burn scar on the leg.
   c. cancerous lesion on the inside of the cheek.
   d. severe acne on the face.
2. A client has a chronic, nonhealing ulcer on the lower leg. The nurse thinks the client could benefit from negative-pressure wound therapy. The most appropriate action by the nurse would be to
   a. ask the charge nurse to discuss the matter with the physician.
   b. call the physician and request an order for a negative pressure machine.
   c. keep track of supplies used currently to estimate the cost of continuing the present regimen.
   d. request the physician write an order to consult the wound care nurse.
3. A nurse is changing a dressing over a client’s abdominal surgical incision. Which action by the nurse is most important?
   a. Apply dressings using aseptic or sterile technique.
   b. Irrigate the wound with copious amounts of solution.
   c. Use strict sterile technique, including sterile gloves.
   d. Wash the suture line carefully to remove debris.
4. The edges of a client’s appendectomy incision are approximated, and no drainage is noted. The nurse documents on the client’s wound record that the incision appears to be healing by
   a. granulation.
   b. primary intention.
   c. secondary intention.
   d. tertiary intention.
5. The nurse who is using an enzymatic debridement ointment will
   a. apply the ointment liberally over large areas.
   b. keep the area moist after application.
   c. medicate the client before applying ointment to viable tissue.
   d. use the ointment cautiously on neoplastic ulcers.
6. A frail client with multiple chronic medical conditions has a chronic, infected, malodorous wound. The client begins to cry when the nurse tries to explain to the client an aggressive approach to wound care. The nurse should revise the plan to focus on
   a. better pain control so the client can tolerate the aggressive therapy.
   b. palliative care and quality of life.
   c. the client’s emotional barrier to the recommended treatment.
   d. the possibility of eventual amputation.
7. A client must do dressing changes at home on a clean, but open, surgical wound. The nurse determines that goals for discharge instructions have been met when the client says:
a. “I will be sure to keep the skin surrounding the wound dry.”
b. “I will sit under a heat lamp for 30 minutes a day to help dry up the drainage.”
c. “If I run out of saline, I can irrigate the wound with half strength peroxide.”
d. “Pulling out the dried up dressings will help clean the wound out.”
8. A client with an open wound develops a temperature of 99.8° F. The most appropriate action by the nurse is to
   a. administer an antipyretic.
   b. continue to monitor the client’s temperature.
   c. cool the client’s environment.
   d. keep the client warm.
9. A nurse is caring for a client with a chronic lower leg wound caused by venous insufficiency. Which action by the nurse is most appropriate?
   a. Apply ice to the surrounding tissue.
   b. Elevate the leg and apply compression stockings.
   c. Keep the leg in one position to avoid further injury.
   d. Position the leg flat with heels elevated off the bed.
10. On removing a dressing from a client on the third postoperative day, the nurse notes thin, pink-colored drainage and documents this as
    a. serous.
    b. sanguineous.
    c. serosanguineous.
    d. purulent.

Chapter 19: Perspectives on Infectious Disease and Bioterrorism

1. The nurse caring for a client who develops a urinary tract infection during hospitalization explains that the infection is likely a
   a. consequence of bacteremia.
   b. nidus formation.
   c. nosocomial infection.
   d. viral infection.
2. The nurse explaining an infection to a client with the flu would describe an infection as a/an
   a. defect in the immune system.
   b. hypersensitivity reaction between a human antigen and a biologic agent.
   c. inflammatory response to an irritant.
   d. parasitic relationship between an organism and host.
3. A client has been exposed to an infectious organism but has no clinical manifestations of disease. The nurse cautions the client that this period of time is the
   a. cell gap.
   b. immune response.
   c. infection curve.
   d. latent period.
4. The nurse caring for a client infected with methicillin-resistant Staphylococcus aureus(MRSA) should
   a. discourage transfer to a long-term care facility.
   b. encourage the client to increase fluid consumption.
   c. place the client in protective isolation.
   d. use standard precautions plus transmission-based precautions.
5. A notation on a client’s health record notes that she has a subclinical infection. The nurse assessing
this client would expect
a. clinical manifestations of the disease that are not as dramatic as usual.
b. fever with no elevation in the white blood cell count.
c. no systemic manifestations of disease.
d. reports of fatigue and lassitude after the infection.
6. For clients thought to be in the period of communicability for influenza, the community health nurse will focus the interventions on
a. ensuring that clients do not infect others.
b. evaluating clients’ response to the organism.
c. protecting clients from complications.
d. supporting clients’ immune systems.
7. A client is taking a 3-week diving vacation in a foreign country and will be staying at a local hotel known for its native food. The nurse cautions the client that a common traveler’s infection is giardiasis, and that the client should be cautious about
a. eating food and drinking beverages prepared in the foreign country.
b. flying on an airplane in close contact with other persons.
c. swimming in the coastal waters of the foreign country.
d. taking the necessary inoculations required to travel.
8. The infection control nurse explains to the staff that resistant organisms, like vancomycin-resistant Enterococcus (VRE), evolve by
a. colonizing a client who has had repeated nosocomial infections.
b. contact with the host’s weakened immune system.
c. infecting a client with a history of untreated infections.
d. mutation of the pathogen because of frequent exposure to antibiotics.
9. A nurse is concerned about caring for three postoperative clients and one client with an infectious disease. The nursing manager educates the nurse about the most effective way to prevent the spread of infectious diseases, which is to
a. care for the postoperative clients first, and then see the infected client.
b. place the infected client in the appropriate isolation.
c. practice appropriate hand-washing and sanitation.
d. transfer the infected client to a private room at the end of the hallway.
10. The nurse assesses a client’s systemic manifestations of fever and malaise as the line of defense known as
a. complete.
b. partial.
c. primary.
d. secondary.

Chapter 20: Clients with Pain
1. To provide the best care to a client having pain, the nurse must assess which information in addition to using a pain measuring scale?
   a. A record of any healing taking place in damaged tissue
   b. Objective measurements of the tissue damage
   c. The client’s perception of the pain
   d. The type of pain fibers conducting the pain
2. An elderly client has mild dementia and the nurse feels the client may be in pain. The best way for the nurse to assess this client for pain is by

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a. asking direct questions about pain.
b. changing the way the nurse phrases the questions.
c. having the client rate pain with a 1-10 scale.
d. using the FACES pain scale.

3. A client’s leg was pinned under a piece of heavy equipment in the workplace for several hours, during which he was in severe pain. The physiologic response that the occupational health nurse could have assessed in this situation is
   a. a wide pulse pressure.
   b. constricted pupils.
   c. dry, cold skin.
   d. tachycardia.

4. The nurse caring for a client with suspected appendicitis knows that the pain associated with appendicitis is
   a. cutaneous pain.
   b. somatic pain.
   c. superficial pain.
   d. visceral pain.

5. A client with end-stage cancer is on a continuous IV of morphine to control intractable pain. The family is concerned that the client has a decreasing level of consciousness and has shallow respirations. Which action by the nurse is most appropriate?
   a. Call the physician and report the family’s concerns.
   b. Prepare to administer naloxone (Narcan).
   c. Review the goals of end-of-life care with the family.
   d. Slow the rate of the IV infusion.

6. A client is in the hospital with an exacerbation of a chronic pain condition. Orders are for prn morphine IV push. When the primary nurse left for the weekend, the client’s pain was under control. When the nurse returns to work, the client is reporting wild swings in pain control, being oversedated at some times and having extreme pain at other times. Which action by the primary nurse would best get this client’s pain under control?
   a. Ask the physician to order the pain medication on a round-the-clock schedule.
   b. Observe the client for behaviors that might indicate possible addiction.
   c. Plan to administer the maximum amount of pain medication the next time it is due.
   d. Question the client about the pain to determine if he/she is exaggerating.

7. The most effective way for the nurse to administer pain medication to a client who is experiencing severe pain related to metastatic liver cancer is to
   a. administer medication only when other methods of pain relief are ineffective.
   b. dispense pain medications on a regular basis.
   c. give only intravenous pain medications.
   d. respond promptly to as-needed (prn) pain requests.

8. A client who has been dealing with chronic pain for the past 2 years would like to try biofeedback as a method of pain relief. The statement that indicates that the client understands this method of treatment is
   a. “I want to give my attention to something other than my pain.”
   b. “I work really well with groups. I think that support will be just what I need.”
   c. “I’m willing to try to control how blood flows to different parts of my body.”
   d. “It will be nice to try something that won’t cost me anything.”

9. A client who has been in chronic pain after an automobile accident successfully reduces his pain
through a combination of biofeedback and meditation. The conclusion the nurse may draw from his success is that the
a. pain was acute in nature.
b. pain was psychological in nature.
c. placebo effect occurred.
d. therapy caused physiologic changes.

10. A client has chronic back pain from an injury several years ago. The client is in the doctor’s office, complaining of insomnia with fatigue and dissatisfaction with the previous physician who “did nothing to help the pain.” The client has a blunt affect and relates no longer being able to do many things that once were enjoyable. The nurse working with an interdisciplinary team to manage this client’s pain understands the client
a. has adapted a sick role out of frustration with the situation and health care.
b. is probably malingering to get workers’ compensation.
c. might be addicted to drugs and should have a urine drug screen.
d. would not be so irritable after getting some sleep.

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