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QUESTION 1

In cleansing the perineal area around the site of catheter insertion, the nurse would:

A. Wipe the catheter toward the urinary meatus

B. Wipe the catheter away from the urinary meatus

C. Apply a small amount of talcum powder after drying the perineal area

D. Gently insert the catheter another 12 inch after cleansing to prevent irritation from the balloon

Correct Answer: B

(A) Wiping toward the urinary meatus would transport microorganisms from the external tubing to the urethra, thereby increasing the risk of bladder infection. (B) Wiping away from the urinary meatus would remove microorganisms from the point of insertion of the catheter, thereby decreasing the risk of bladder infection. (C) Talcum powder should not be applied following catheter care, because powders contribute to moisture retention and infection likelihood. (D) The catheter should never be inserted further into the urethra, because this would serve no useful purpose and would increase the risk of infection.

QUESTION 2

A 6-month-old infant who was diagnosed at 4 weeks of age with a ventricular septal defect, was admitted today with a diagnosis of failure to thrive. His mother stated that he had not been eating well for the past month. A cardiac catheterization reveals congestive heart failure. All of the following nursing diagnoses are appropriate. Which nursing diagnosis should have priority?

A. Altered nutrition: less than body requirements related to inability to take in adequate calories

B. Altered growth and development related to decreased intake of food

C. Activity intolerance related to imbalance between oxygen supply and demand

D. Decreased cardiac output related to ineffective pumping action of the heart

Correct Answer: D

(A) Altered nutrition occurs owing to the fatigue from decreased cardiac output associated with congestive heart failure. (B) The decreased intake occurs due to fatigue from the altered cardiac output. (C) Fatigue occurs due to the decreased cardiac output. (D) The ineffective action of the myocardium leads to inadequate O2 to the tissues, which produces activity intolerance, altered nutrition, and altered growth and development.

QUESTION 3

A client was admitted to the hospital after falling in her home. At the time of admission, her blood alcohol level was 0.27 mg%. Her family indicates that she has been drinking a fifth of vodka a day for the past 9 months. She had her last drink 30 minutes prior to admission. Alcohol withdrawal symptoms would most likely be exhibited by her:

A. Two to 4 hours after the last drink

B. Six to 8 hours after the last drink

C. Immediately on admission D. Twenty-four hours after the last drink

Correct Answer: B

(A) This answer is incorrect. Alcohol withdrawal usually begins approximately 6? hours after the last drink. (B) This answer is correct. It takes approximately 6? hours for metabolism of alcohol. (C) This answer is incorrect. The alcohol is still in the system, as indicated by the high blood alcohol level. (D) This answer is incorrect. Symptoms of alcohol withdrawal usually begin within 6? hours of the last drink.

QUESTION 4

A 70-year-old client is almost finished receiving her second unit of packed red blood cells. The client, who weighs 80 lb, has started complaining of being short of breath and now has crackles in the bases of her lungs. After slowing or stopping the transfusion, the most appropriate initial nursing action would be to:

A. Raise the client\\'s head and place her feet in a dependent position

B. Notify the physician

C. Place the client on 2 liters of O2 via nasal cannula

D. Administer furosemide (Lasix) 20 mg IV push

Correct Answer: A

(A)

Raising the client\\'s head and placing her feet in a dependent position is an independent nursing action that can be taken to decrease venous return and to reduce pulmonary congestion. (B) Notifying the physician is an appropriate action that should be taken after the client is positioned to maximize her respiratory status. (C) Placing the client on O2may be done with a physician\\'s order or according to an institution\\'s standing orders; however, other actions should be taken first.

(D)

Furosemide 20 mg IV push is an appropriate medication for the client, but it must be ordered by her physician.

QUESTION 5

A client diagnosed with severe anemia is to receive 2 U of packed red blood cells. Prior to starting the blood transfusion, the nurse must:

A. Take a baseline set of vital signs

B. Hang Ringer\\'s lactate as the companion fluid

C. Use microdrip tubing for the blood administration

D. Have the registered nurse in charge assume responsibility for verifying the client and blood product information

Correct Answer: A

(A) A baseline set of vital signs is necessary to determine if any transfusion reactions occur as the blood product is being administered. (B) The only companion fluid to be used during a blood transfusion is normal saline. The calcium in Ringer\\'s lactate can cause clotting. (C) Only a blood administration set should be used. A microdrip tube would cause lysis of the red blood cells. (D) Proper identification of the recipient and the blood product must be validated by at least two people.