

# TruMerit **NQE** Practice Questions

For nurses preparing for the  
Nurse Qualifying Exam (NQE)

150 Q&As | [TruMerit.org/NQE](https://www.TruMerit.org/NQE)



This set of 150 practice questions has been created for nurses preparing to sit for the TruMerit Nurse Qualifying Exam. While these questions are not directly aligned to the official NQE blueprint, you may still find them helpful in providing you with practice in applying your knowledge, sharpening your decision-making skills, and building the confidence you need to succeed.

Each of the practice questions reflects realistic nursing practice. Together, they cover a broad spectrum of scenarios you may encounter in clinical settings. Importantly, this collection includes questions from all eight domains and their subdomains within the NQE framework, ensuring that each area is thoughtfully represented.

This resource is ideal for:

- Reviewing essential nursing content.
- Practicing critical thinking.
- Reinforcing nursing concepts.
- Identifying areas for further review.

Whether you are testing your readiness or reinforcing core nursing principles, this supplemental resource offers a supportive way to prepare for the NQE.

You have worked hard to get here. Let's take the next step together, one question at a time.



## NQE Practice Questions

1. A patient is admitted to the hospital after sustaining a fractured hip. The nurse should expect to observe that the affected extremity appears to be
  - A. abducted.
  - B. internally rotated.
  - C. shortened.
  - D. hyperextended.
2. Which measure should be included in the care plan of a patient after removal of a suprapubic tube?
  - A. Change abdominal dressing as necessary.
  - B. Check the specific gravity of urine twice daily.
  - C. Instruct to lie on abdomen several times a day.
  - D. Encourage to drink fruit juices high in potassium.
3. Which nursing intervention should take priority in the care of a patient immediately after excision of a pituitary tumor?
  - A. monitoring vital signs every 4 hours
  - B. encouraging coughing and deep breathing
  - C. maintaining accurate intake and output records
  - D. maintaining NPO/NBM dietary status
4. A nurse is monitoring a patient who is in labor. The nurse should recognize which fetal heart finding as an early indicator of maternal sepsis?
  - A. tachycardia
  - B. variable decelerations
  - C. audible murmur
  - D. irregular rate
5. When working with a group of clients who are depressed, what is the best action a nurse could take?
  - A. Limit the duration of the nurse–client relationships.
  - B. Promote achievable goals with the clients.
  - C. Restrict social involvement among the clients.
  - D. Conduct daily motivational sessions with the clients.
6. A primary healthcare provider orders an enteric–coated medication for a patient who is fed through a percutaneous endoscopic gastrostomy (PEG) tube. The nurse should
  - A. request the pharmacist supply a different medication.
  - B. crush the tablet and administer the medication.
  - C. dissolve the tablet and administer the medication.
  - D. withhold the medication and call the primary provider.
7. A nurse should monitor a child with attention deficit hyperactivity disorder (ADHD) who is taking methylphenidate for a change in
  - A. bladder function.
  - B. bowel pattern.
  - C. child’s appetite.
  - D. visual acuity.



8. Which measure should the nurse include in the care plan of an adolescent female recently diagnosed with genital herpes?
  - A. Administer sitz baths several times throughout the day.
  - B. Apply talcum powder to the perineum after bathing.
  - C. Encourage adolescent female to wear silk underwear.
  - D. Observe for side effects of anthelmintic medications.
  
9. Which intervention should the nurse plan to use when caring for a patient with thrombophlebitis of the right lower extremity?
  - A. Keep the patient in a high-Fowler position.
  - B. Apply cold moist compresses to reduce edema.
  - C. Assess the patient for signs and symptoms of pulmonary embolus.
  - D. Exercise the patient's right lower extremity to decrease muscle spasms.
  
10. A teenager seeks contraceptive counseling without informing her parents. This is permitted by local law. Which nursing action is most appropriate?
  - A. Contact the parents to involve them in the discussion.
  - B. Provide the service confidentially and assess for safety.
  - C. Encourage the patient to wait until a parent is present.
  - D. Discuss with the teenager the benefits of abstinence.
  
11. A nurse overhears the patient's visitor asking the patient about their private medical history. The patient appears uncomfortable but does not object. What is the nurse's priority?
  - A. Leave the room to allow the private conversation to continue.
  - B. Ask the visitor to step out, then confirm if patient wants privacy.
  - C. Assume patient's consent and continue with tasks that are assigned.
  - D. Immediately remove the visitor without asking for patient input.
  
12. A client who is being treated for psychosis tells the nurse, "The doctor told me that my mother is doing the devil's work." Which interpretation of this remark is accurate? The client is
  - A. attempting to get validation of the doctor's statement.
  - B. showing distrust in the nurse's capability.
  - C. ineffectively controlling their disorganized thoughts.
  - D. trying to make the doctor look incompetent.
  
13. A patient with borderline personality disorder is in the psychiatric unit for treatment of an acute episode. The patient's condition has improved, and discharge planning is being done. Which behavior(s) by the patient would indicate to the nurse that the patient is ready for discharge? (Select all that apply.)
  - A. The patient directs the patient group activities for 2 weeks.
  - B. The patient invites her mother to stay with her after discharge.
  - C. The patient requests off-unit passes to visit friends at a restaurant.
  - D. The patient complies with a mutually agreed contract for 1 week.
  
14. The nurse should be most concerned about which laboratory result for a client who takes clozapine?
  - A. blood urea nitrogen level 12 mg/dL
  - B. serum potassium level 4.5 mEq/L
  - C. serum lithium level 1.3 mEq/L
  - D. white blood cell count 4,500/cu mm



15. Which finding(s) should a nurse typically observe when assessing a patient who has acute gout? (Select all that apply.)
  - A. mild discomfort of the spine
  - B. pain of a metatarsophalangeal joint
  - C. elevated serum uric acid
  - D. decreased erythrocyte sedimentation rate.
  
16. Which nursing action best demonstrates social responsibility in promoting equitable access to healthcare?
  - A. Focus outreach on private patients to ensure follow-up.
  - B. Organize mobile clinics targeting underserved populations.
  - C. Refer patients to emergency rooms for all urgent needs.
  - D. Encourage online booking only for most appointments.
  
17. A viral video is circulating with inaccurate claims about vaccine side effects. What should the nurse prioritize when addressing this with patients?
  - A. Debunk the video using scientific evidence and patient education.
  - B. Warn patients not to use social media for health advice.
  - C. Refer patients to the hospital's legal department for more help.
  - D. Avoid discussing the video to prevent controversy.
  
18. How can a nurse most effectively contribute to local healthcare policy development?
  - A. Attend policy meetings to listen but avoid direct engagement.
  - B. Collaborate with interdisciplinary teams and present clinical data.
  - C. Present the policy issue and ask for feedback from stakeholders.
  - D. Submit written concerns from staff to hospital administration.
  
19. Which action(s) by a nurse best supports environmental sustainability in a rural health setting? (Select all that apply.)
  - A. Refer all of the patients to in-person consultations.
  - B. Recommend reusable home equipment for chronic care.
  - C. Discourage use of digital health tools for elderly patients.
  - D. Allow unlimited telehealth access to rural patients.
  
20. A hospital implements a green initiative to reduce single-use plastics. What is the nurse's role in supporting this planetary health goal?
  - A. Educate staff on safe alternatives to single-use plastics.
  - B. Request additional single-use supplies for emergencies.
  - C. Focus only on patient outcomes, not environmental issues.
  - D. Avoid engaging in facility-level sustainability discussions.
  
21. A patient who has a diagnosis of acute stroke is conscious when admitted to the hospital. Which nursing action should be given priority?
  - A. Inserting an indwelling urinary catheter.
  - B. Applying antiembolic stockings to patient's legs.
  - C. Reporting the diagnosis to the physician.
  - D. Assessing neurological status of the patient.



22. The nurse is caring for a patient who had an abdominal–perineal resection earlier today. Which observation should be reported to the physician promptly?
- A. absence of the patient’s bowel sounds
  - B. blood in the urine of the patient
  - C. edema of the patient’s stoma
  - D. dressings’ serosanguineous drainage
23. The nurse administers a nitroglycerin tablet to a patient who has known stable angina. After 5 minutes, the nurse checks the patient’s blood pressure and finds that it is 80/50 mmHg. What is the priority nursing intervention?
- A. Start an intravenous (IV) line.
  - B. Obtain an electrocardiogram.
  - C. Provide emotional support to the patient.
  - D. Lay the patient flat, and call the physician.
24. Which statement about dressings used for venous access devices would be most important for guiding the nurse’s practice?
- A. Transparent polyurethane dressings have a greater risk for infection than gauze dressings.
  - B. If blood is oozing from the catheter insertion site, transparent polyurethane dressings should be used.
  - C. Both gauze and transparent polyurethane dressings should be sealed along the entire perimeter of the dressing.
  - D. Triple antibiotic ointment should be used with gauze dressings to thoroughly protect the catheter insertion site.
25. Which statement, if made by a person who is 12 weeks pregnant, would a nurse be most concerned about?
- A. “I wanted to be pregnant, but now I don’t know.”
  - B. “My partner is angry because I got pregnant.”
  - C. “Being pregnant makes me feel very tired.”
  - D. “I don’t want to get too fat while I’m pregnant.”
26. A client is diagnosed with hypercholesterolemia. Which advice by the nurse is appropriate?
- A. “Take medication with morning meal.”
  - B. “Reduce your daily exercise routine.”
  - C. “Continue your daily exercise routine.”
  - D. “Avoid consuming a low cholesterol diet.”
27. Which long–term effect should the nurse expect to observe in a patient who has radiation exposure?
- A. spinal shortening
  - B. hormone deficiency
  - C. increased saliva production
  - D. increased skull density
28. What action should a nurse take when leaving a computer workstation unattended?
- A. Log off or lock the screen before stepping away.
  - B. Close the patient file but leave the system open.
  - C. Minimize the screen and rely on privacy filters.
  - D. Trust colleagues not to access the information.



29. When is the best time for a nurse to document patient care?
  - A. immediately after care is provided
  - B. at the end of the nurse's shift
  - C. before the nurse takes their break
  - D. when convenient during the day
  
30. A patient is brought to the hospital with pulmonary edema. The nurse should assess the patient for
  - A. Kussmaul respirations and dry cough.
  - B. inspiratory stridor and sternal retraction.
  - C. pursed-lip breathing and wheezing.
  - D. noisy and moist breathing in the mouth.
  
31. A nurse notices they feel impatient when caring for patients from a particular cultural background. What is the most ethical and professional action?
  - A. Request to avoid assignment to these patients.
  - B. Reflect on personal biases and seek cultural guidance.
  - C. Treat the patients differently to avoid tension.
  - D. Share the concern only with trusted friends outside work.
  
32. During a multidisciplinary team meeting, a nurse notices that a junior team member's concern about patient care is being dismissed. What is the best action to support effective communication?
  - A. Redirect the conversation without addressing the concern.
  - B. Privately advise the junior member to speak louder next time.
  - C. Respectfully amplify and clarify the team member's concern.
  - D. Report the issue later without intervening during the meeting.
  
33. A nurse notices that broken equipment in the medication room has not been repaired for a week. What is the most appropriate course of action?
  - A. Continue using it while waiting for repairs to happen.
  - B. Do not use and report to the unit manager directly.
  - C. Leave a warning note for colleagues and continue working.
  - D. Ignore the issue and focus on urgent patient care needs.
  
34. A physical therapist and a nurse disagree about when a patient should begin mobility training. What is the nurse's best action?
  - A. Escalate the disagreement to the department head immediately.
  - B. Compromise without further discussion to maintain peace.
  - C. Initiate a respectful conversation to align on patient priorities.
  - D. Continue with the nursing plan regardless of disagreement.
  
35. A nurse wants to influence national healthcare reform. What is the most effective first step to ensure their voice contributes to policy?
  - A. Join a professional organization that shapes legislation.
  - B. Post health-related opinions on a personal social account.
  - C. Discuss opinions with patients during clinical care sessions.
  - D. Write to a colleague about frustrations with current policies.



36. A community lacks access to affordable mental health services. What action best reflects the nurse's role in policy advocacy?
- A. Support law makers to expand funding for services.
  - B. Recommend community members travel to urban clinics.
  - C. Focus only on patients with some type of health coverage.
  - D. Provide community education on self-care and mindfulness.
37. A nurse in a rural area notices an increase in heat-related illnesses during summer months. What conclusion reflects awareness of climate impacts?
- A. The illnesses are due only to poor hydration practices.
  - B. Environmental factors such as rising temperatures are contributors.
  - C. The data likely reflect a random seasonal variation.
  - D. Individuals with health issues are to blame for poor planning.
38. A nurse is experiencing interpersonal conflict with coworkers. Which comment by the nurse would indicate readiness to resolve the conflict?
- A. "I know I can stay focused on our common goals."
  - B. "I can ignore what my coworkers are saying to me."
  - C. "I need to report coworkers' behavior toward me."
  - D. "I know that the current issue will diminish with time."
39. The nurse is assigned to care for a patient who has acquired immune deficiency syndrome (AIDS). The patient asks the nurse, "Would you rub my back, and please don't use gloves?" The nurse should
- A. delegate the back rub to a nursing assistant.
  - B. explain that wearing gloves is mandatory.
  - C. assess the skin integrity of the patient.
  - D. rub patient's back without wearing gloves.
40. An adolescent in active labor requests epidural anesthesia. Her mother is at the bedside and states, "She doesn't need that." After notifying the patient's primary healthcare provider and securing an order, the nurse should
- A. request the patient to select another labor coach.
  - B. inform them about alternative analgesia options.
  - C. prepare the patient for an epidural.
  - D. escort the mother from the room.
41. A hospitalized patient develops a urinary tract infection. Results from a culture reveal vancomycin-resistant *Enterococcus* (VRE). Which action should the nurse take next?
- A. Use a face mask when entering the patient's room.
  - B. Place the patient in negative air-flow room.
  - C. Insert Foley catheter attached to bedside drain bag.
  - D. Move the patient to a private room immediately.
42. While ambulating in the hallway, a patient suddenly becomes lightheaded and dizzy. The nurse should
- A. ease the patient to the hospital floor.
  - B. call for someone to bring a chair.
  - C. assist the patient back to the room.
  - D. instruct the patient to hold the railing.



43. While a patient is receiving tube feeding, which finding should indicate to the nurse that the patient is receiving an inadequate amount of water?
- A. urine at the pH level of 5.2
  - B. urine specific gravity 1.030
  - C. serum sodium 138 mEq/L
  - D. serum total protein 6.5 g/dL
44. A patient is to receive digoxin elixir 0.125 mg once daily. The elixir is available as 0.05 mg/mL. Which volume indicates the correct dose that the nurse should administer to the patient?
- A. 0.05 mL
  - B. 1.0 mL
  - C. 1.5 mL
  - D. 2.5 mL
45. Which instruction should the nurse give to a client who is to begin taking atenolol?
- A. "Avoid sudden discontinuation of the drug."
  - B. "Decrease consumption of alcoholic beverages."
  - C. "Monitor your food and liquid intake and output."
  - D. "Weigh yourself every morning and evening."
46. A client receiving warfarin sodium reports to the nurse that her current menstrual period is prolonged and unusually heavy. Which action should the nurse take?
- A. Review the client's previous hematology test results in the past 3 weeks.
  - B. Obtain an obstetrics–gynecology referral from the health care provider.
  - C. Get an order for prothrombin time with international normalized ratio (INR).
  - D. Obtain a primary healthcare provider's order to decrease the dose of warfarin.
47. A postoperative patient is receiving a fentanyl citrate epidural infusion for pain management. The nurse should place highest priority on which assessment?
- A. level of consciousness
  - B. respiratory rate
  - C. pulse rate
  - D. pain level
48. Which response(s) by a parent would indicate that the nurse's teaching of behavioral modification for the parent's child has been successful? (Select all that apply.)
- A. "I will give a reward immediately after the desired behavior."
  - B. "I will not give my child a desired reward for unwanted actions."
  - C. "I will take away previously earned rewards if child misbehaves."
  - D. "I need to choose a reward that is meaningful for my child."
49. A nurse provides dietary instructions to the parents of a 2-year-old child who has celiac disease. Which food item would be appropriate for the child?
- A. rice cereal bars
  - B. oatmeal cookies
  - C. chicken noodle soup
  - D. peanut butter sandwich



50. Which of the following best demonstrates an advanced nurse's contribution to nursing informatics?
- A. Installing new electronic health record software.
  - B. Developing a clinical decision support tool using outcome data.
  - C. Repairing network issues in a patient care area in the unit.
  - D. Teaching patients how to use wearable fitness trackers.
51. A nurse gives a client instructions about lifestyle changes that are needed in order to live with asthma. Which of these statements, if made by a client, would indicate the need for more information?
- A. "I will obtain an influenza shot every year."
  - B. "I should avoid any physical exercise."
  - C. "I should carry my medication when I travel."
  - D. "I am looking for someone to take my dog."
52. Which goal should the nurse include in the care plan of a client who has glaucoma?
- A. Avoid pupillary dilation.
  - B. Avoid rapid eye movements.
  - C. Restrict fluid intake.
  - D. Restrict sodium intake.
53. A client who is being treated for acute pancreatitis is given dietary instructions about preventing a recurrence. Which of these comments, if made by a client, would indicate a correct understanding of the dietary instructions?
- A. "I will eat plenty of foods that will be high in sugar."
  - B. "I will limit my intake of carbohydrate foods like bread."
  - C. "I will increase foods high in protein, such as meats."
  - D. "I will avoid foods or beverages containing alcohol."
54. The parent of a 3-year-old child calls the nurse and says, "My child just ate half a bottle of vitamin C tablets. What should I do?" Which response by the nurse would be best?
- A. "Give your child a glass of milk to absorb the extra vitamin C."
  - B. "Give your child syrup of ipecac to make him vomit this out."
  - C. "Call the Poison Control Center and share what you just told me."
  - D. "Do nothing. Vitamin C is water-soluble. It will not hurt your child."
55. A multigravida woman has expressed that she would not welcome a child with disabilities. She has now delivered a child with disabilities. It is essential to obtain information about which of these areas? The woman's
- A. relationship with her mother.
  - B. behavior with her child with disabilities.
  - C. connection with her peer group.
  - D. expectations about the infant's disabilities.
56. A nurse should be aware that the inactivated polio virus vaccine, instead of the live polio virus vaccine, should be administered to an infant who has a
- A. 6-year-old sibling receiving chemotherapy.
  - B. 4-year-old sibling who has varicella zoster.
  - C. 1-year-old sibling who has cystic fibrosis.
  - D. father who is being treated for tuberculosis.



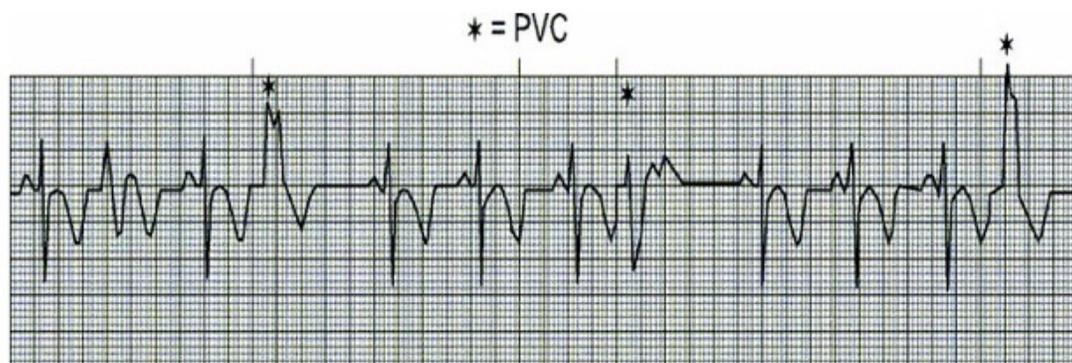
57. While a nurse discusses accident prevention with a mother of a 2-year-old girl, the mother makes these comments to the nurse. Which comment indicates that the mother needs further information?
- A. "I'm storing all of my cleaning products in a locked cabinet in my kitchen."
  - B. "I'm giving her ipecac instantly if she eats/drinks something poisonous."
  - C. "I'm throwing out all our medicines that we no longer use."
  - D. "I'm going to be sure that she doesn't see me taking any pills."
58. The nurse should determine that an infant is developmentally ready for the introduction of solid food when the infant
- A. can sit alone playing with toys for a few minutes.
  - B. no longer demonstrates the tongue extrusion reflex.
  - C. has been weaned from the bottle for two weeks.
  - D. tolerates solids from a bottle with a large nipple hole.
59. Which of these goals of therapy should the nurse include in the care plan of a client who has second-stage Alzheimer's disease?
- A. The client will live comfortably within the limitations of the disease.
  - B. The client will increase sensitivity to the effect of the disease on others.
  - C. The client will engage in working through issues from past experiences.
  - D. The client will identify at least three personal strengths they self-identify.
60. A perimenopausal client wants to avoid using pharmacologic therapy for the relief of hot flashes. What is the best recommendation the nurse could give?
- A. psychologist
  - B. physical therapist
  - C. occupational therapist
  - D. homeopathic specialist
61. A charge nurse is orienting a new nurse to the psychiatric unit and instructing the new nurse about caring for patients who are admitted on an involuntary basis. Which of the following statements by the new nurse would indicate understanding of the teaching?
- A. Care may be given without patient consent if a patient is a danger to self or others.
  - B. Voting rights of the patients are lost while they remain hospitalized on the unit in the hospital.
  - C. Phone privileges are suspended for patients admitted involuntarily in the hospital on the unit.
  - D. Court approval is required for a patient before the patient can be granted day passes off the unit.
62. A patient's intravenous (IV) infusion of 500 mL of D5W with 25,000 units of heparin sodium is running at 12 mL/h. The order is for 700 units/h. Which task should the nurse perform first?
- A. Do nothing; the rate is correct.
  - B. Increase the rate to 14 mL/h.
  - C. Decrease the rate to 10 mL/h.
  - D. Decrease the rate to 7 mL/h.
63. Disclosure of confidential information by the nurse about a patient's condition is ethical and professional when the information is
- A. provided to law enforcement personnel.
  - B. shared with other health team members.
  - C. discussed in private with a family member.
  - D. provided to the employer of the patient.



64. The nurse is instructing an adolescent who is receiving treatment for sickle cell crisis. Which measure should the nurse teach the adolescent to include in the daily routine to prevent a recurrence?
- A. Take multivitamins with iron.
  - B. Limit intake of clear fluids.
  - C. Maintain an aerobic exercise program.
  - D. Avoid a hot and humid environment.
65. Which of the following situations represent a violation of ethical rights in community and public health nursing? (Select all that apply.)
- A. sharing a patient's personal health information without consent
  - B. educating patients about their treatment options in their language
  - C. ensuring informed patient consent before a health procedure
  - D. coercing a community to participate in a health program
  - E. ignoring a patient's cultural beliefs when planning health interventions
  - F. providing different levels of care based on a patient's income
66. Which test is the best indicator of compliance with medication and dietary regimen in a client who has type 2 diabetes?
- A. strong glucose tolerance
  - B. fasting blood glucose
  - C. capillary blood glucose
  - D. glycosylated hemoglobin
67. A public health nurse wants to do a research study on cardiovascular disease in male migrant farmworkers older than 50 years of age. The farm workers speak a different language than the nurse. Which of the following actions by the nurse violates ethical research practices?
- A. The public health nurse holds an informational session for potential research subjects and explains the details of the study using an interpreter from the public health department.
  - B. The public health nurse stores all physical patient data in a secure, locked location within the basement of the hospital and electronic patient data are secured within an encrypted external server.
  - C. The public health nurse tells the migrant farm workers that blood pressure and cholesterol screenings every two months are mandatory for continued employment.
  - D. The public health nurse ensures patients who are found to have hypertension or elevated cholesterol levels during screenings are referred to a provider for follow-up care.
68. Which nursing assessment should be implemented for a client who has benign prostatic hypertrophy?
- A. Palpate the client's bladder for distention.
  - B. Ask if the client experiences flank pain.
  - C. Observe the color of the client's urine.
  - D. Measure the client's urinary specific gravity.
69. Which of the following actions would be considered an ethical violation by a nurse? The nurse
- A. comforts the patient by holding the patient's hand during a painful procedure while in outpatient surgery.
  - B. completes a required competency on infection control practices in the hospital environment.
  - C. refuses to sign as a witness of the consent, believing the surgeon failed to explain the procedure.
  - D. shares the patient's information with another patient to support their grieving process.



70. A patient who has had a stroke with right hemiplegia is drooling from the right side of the mouth. The best action for the nurse to take is to
- provide thick and thin fluids to evaluate the patient's ability to swallow.
  - refrain from giving anything by mouth until swallowing is evaluated.
  - place food in the right side of the patient's mouth when feeding.
  - lean the patient to the right to prevent aspiration when feeding.
71. Which laboratory value for a patient with a full-thickness wound would be most important for the nurse to investigate further?
- hemoglobin 11 g/dL
  - albumin 2.5 g/dL
  - blood urea nitrogen 22 mg/dL
  - fasting blood glucose 115 mg/dL
72. Which measure(s) should be implemented in the care plan of a child who has acute bacterial meningitis? (Select all that apply.)
- Assure that broad-spectrum intravenous antibiotic coverage is initiated.
  - Limit fluid intake to decrease the likelihood of pulmonary edema.
  - Move child to a private room and initiate respiratory isolation.
  - Foster a calm, quiet environment to limit stimulation.
73. A nurse is teaching a client about levodopa. Which statement, if made by the client, would indicate to the nurse that the teaching was effective?
- "Eating a high protein meal will help with absorption."
  - "Taking a multivitamin will counter effects of anemia."
  - "If I miss a dose, I can take an extra pill the next time."
  - "Chewing gum may help if I experience a dry mouth."
74. The nurse observes a nursing assistant caring for a 92-year-old patient who walks away and leaves the patient's bed rail down. After raising the rail, the nurse's most appropriate intervention would be to
- tell the nursing assistant openly in the hall that it is not appropriate.
  - add a safety order to the nursing care plan followed in the unit.
  - tell all nursing assistants in next meeting not to leave bed rails down.
  - talk privately with the nursing assistant about the inappropriate behavior.
75. The nurse is caring for a patient with a sudden onset of cardiac dysrhythmia as shown below. The nurse should consider which action as the highest priority before notifying the primary healthcare provider?





- A. administering atropine sulfate (Atropisol) PRN
  - B. reviewing the current serum electrolyte values
  - C. preparing for insertion of a temporary pacemaker
  - D. documenting the results of the cardiac rhythm strip
76. A patient who had a prostatectomy 24 hours ago is receiving continuous bladder irrigation (CBI). There is dark red urine in the drainage bag of the Foley catheter. What is the priority nursing action?
- A. Call the primary healthcare provider.
  - B. Obtain the patient's vital signs.
  - C. Obtain complete blood cell count.
  - D. Increase the patient's CBI flow rate.
77. A patient who is suspected of having bacterial meningitis arrives at the emergency department. Which action should the nurse take first?
- A. Complete a nursing history.
  - B. Obtain procedural vital signs.
  - C. Prepare for a lumbar puncture.
  - D. Place on droplet precautions.
78. An older adult client reports decreased muscle strength and agility. Which intervention should the community health nurse suggest to improve client outcomes?
- A. Request a prescription for alendronate.
  - B. Increase calcium intake in the diet.
  - C. Use a walker when ambulating.
  - D. Begin a regular exercise plan.
79. A nurse sustains a needle-stick injury while preparing an injection. Which statement made by the nurse indicates a correct understanding of human immunodeficiency virus (HIV) transmission?
- A. "I would not have to worry if I had been wearing medical grade gloves."
  - B. "I don't have to worry about getting the virus because the needle is sterile."
  - C. "I will need to receive an injection of gamma globulin to prevent infection."
  - D. "I will have to be tested in 6 months to see if I've been exposed to the virus."
80. The mother of a 3-year-old child asks a nurse when it is appropriate to place her child in a booster seat. The best nursing response is that the child should
- A. be more than 40 lb (18 kg).
  - B. be five years of age or older.
  - C. be able to sit with feet dangling.
  - D. be taller than 4 ft (122 cm).
81. When teaching a client about the adverse effects of codeine and ferrous sulfate, the nurse should encourage consumption of foods high in
- A. carbohydrates.
  - B. fiber.
  - C. protein.
  - D. calcium.



82. A patient who is 6 hours postpartum informs the nurse that she is lightheaded and dizzy. Assessment reveals a weak pulse with a rate of 105 beats/min and blood pressure of 106/58 mmHg. The patient's skin is cool and pale in color. The nurse should
- obtain a glucose finger-stick.
  - auscultate the heart sounds.
  - apply a pulse oximeter.
  - palpate the uterine fundus.
83. A nurse is planning care for a patient who has been admitted for alcohol detoxification. The most appropriate short-term goal for the patient would be to
- acknowledge the unhealthy effects of alcohol.
  - develop insight into the patient's illness.
  - identify personal strengths of the patient.
  - maintain physical integrity during withdrawal.
84. Which instruction should the nurse provide to a parent about ways to comfort a newborn after a painful heel stick?
- "Swaddle the newborn."
  - "Administer paracetamol."
  - "Apply an anesthetic to heel."
  - "Provide with visual distractions."
85. A client in a support group has a hearing loss. The group asks the nurse how to improve communication with the client. Which response by the nurse is most appropriate?
- "Write down on paper what you want to say."
  - "Speak loudly while using expressive body language."
  - "Speak in short sentences while facing the client."
  - "Have the person next to the client repeat what is said."
86. Alendronate sodium is prescribed for a client. The nurse should educate the client to
- take the medication before going to bed.
  - change positions slowly to prevent dizziness.
  - take the medication with food at every meal.
  - remain upright for 30 minutes after medication.
87. The nursing care plan for a patient who dislikes other people and satisfies a need for power and control by manipulating others should include which of these interventions?
- Maintain clear and consistent limits with the patient.
  - Demonstrate warmth and defend the patient when in trouble.
  - Delegate control and support the actions of the patient.
  - Trust the patient and provide opportunities for leadership.
88. A patient has a blood pressure of 230/140 mmHg. The primary care provider prescribes sodium nitroprusside by intravenous infusion. A charge nurse observes a staff nurse performing all of these actions while caring for the patient. Which one would require immediate intervention by the charge nurse?
- covering the patient's infusion with aluminum foil
  - placing the patient's body in a semi-Fowler's position
  - preparing to insert an indwelling urethral (Foley) catheter
  - allowing the patient to sit on the side of the stretcher



89. Which of the following statements about morals and values in nursing is true and accurate? Nurses should
- A. be self-aware of their own morals and values to understand those of their patients better.
  - B. only concern themselves with what is moral and ethical according to the law of the state in which they reside.
  - C. immediately request a different patient assignment when they do not agree with a patient's morals or values.
  - D. change a patient's values and beliefs if that patient believes something that is morally wrong.
90. A novice nurse working on a medical-surgical unit suspects an elderly patient who lives with her daughter is a victim of elder abuse. What is the BEST action for the nurse to take at this time?
- A. Call the police station and file a police report, listing the suspected abuse.
  - B. Notify the nurse manager or nursing supervisor of the suspected abuse.
  - C. Confront the patient's daughter the next time she comes to visit her mother.
  - D. Ask another nurse to switch patients due to the serious nature of the concerns.
91. The school nurse is planning substance abuse prevention activities for the month. A primary prevention activity that the nurse would include in the program would be
- A. conducting in-school smoking cessation classes.
  - B. performing periodic drug testing on students.
  - C. providing students after-school addiction treatments.
  - D. teaching sessions on tobacco use health hazards.
92. The nurse instructs a patient who has had a total knee replacement to take acetylsalicylic acid (aspirin) once a day after discharge. Which of the following patient statements best indicates that the patient understands why the aspirin was prescribed for him?
- A. "Aspirin will help to prevent blood clots."
  - B. "Aspirin will control any inflammation."
  - C. "I'll be taking aspirin to relieve my joint pain."
  - D. "I'll take aspirin if I develop a high fever."
93. Which of the following statements is true and accurate about quantitative research? Quantitative research
- A. examines the thoughts and feelings of those participating in the study.
  - B. collects data in a way that yields subjective and biased data in the research.
  - C. is rarely used in nursing research studies due to the nature of the patient.
  - D. is based on numeric data and often supports evidence-based practice changes.
94. After a teaching session with a nurse, a patient learns that smoking increases the risk of type 2 diabetes and the risk of various diabetes complications, such as heart disease and stroke. In which domain did learning take place? Learning has occurred in the
- A. kinesthetic domain.
  - B. cognitive domain.
  - C. affective domain.
  - D. psychomotor domain.
95. A nurse is teaching a post-operative client how to do breathing exercises. Which of the following observations best indicates that learning has occurred in the psychomotor domain? The patient
- A. verbalizes to the nurse five signs and symptoms of post-operative infection.
  - B. successfully demonstrates post-operative deep breathing to the nurse.



- C. watches a video about how to perform post-operative breathing exercises.
  - D. reads a pamphlet on the importance of post-operative breathing exercises.
96. Which of the following best describes evidence-based practice (EBP) in nursing?
- A. Relying on personal experience, insight, and intuition to make appropriate clinical decisions.
  - B. Using the most validated research, clinical expertise, and patient preferences to guide nursing care.
  - C. Following hospital policies and procedures without considering new innovative research.
  - D. Implementing only physician-recommended treatments without questioning their effectiveness.
97. What is the primary purpose of Electronic Health Records (EHRs) in nursing?
- A. to replace nurses and health professionals in patient care
  - B. to facilitate better documentation and patient safety
  - C. to increase in-patient and out-patient hospital expenses
  - D. to limit all patient access to any of their health records
98. Which of the following is an advantage of using telehealth in nursing care?
- A. reduces patient access to their health care
  - B. increases patient wait times for consultations
  - C. improves patient access to health care
  - D. eliminates the need for physical examinations
99. In medication administration, which action helps prevent medication errors?
- A. using Barcode scanning system
  - B. printing the prescription order
  - C. obtaining verbal medication orders
  - D. using manual transcription
100. What is the role of artificial intelligence (AI) in modern nursing practice?
- A. replacing nurses in all aspects of care
  - B. assisting in clinical decision-making
  - C. eliminating the need for human assessment
  - D. reducing the need for medical research
101. A patient receiving a continuous infusion of morphine sulfate continues to have pain. The nurse should (Select all that apply.)
- A. assess the patient's pain.
  - B. increase the rate of infusion.
  - C. check the infusion site.
  - D. consult with the pharmacist.
102. A nurse encourages early ambulation for a patient who had a hysterectomy 1 day ago. Before the patient ambulates, the nurse should anticipate performing which action?
- A. checking the 24-hour intake and output
  - B. premedicating with PRN pain medication
  - C. asking a physical therapist to assist
  - D. using assistive devices on the unit



103. After a patient has a coronary angiogram, the nurse should assess peripheral circulation by palpating the pulse at which point?
- A. carotid
  - B. brachial
  - C. femoral
  - D. dorsal
104. Which is the best action the nurse should take when caring for a patient at risk of developing glomerulonephritis?
- A. Obtain a throat culture if a sore throat is reported.
  - B. Obtain a urine culture if abdominal pain is reported.
  - C. Monitor the patient for bladder distention.
  - D. Assess for signs of flank pain and tenderness.
105. Which action should the nurse take to reduce hoarseness in a patient recovering from a thyroidectomy?
- A. Instruct the patient to take ice chips frequently.
  - B. Offer the patient frequent gargles with a saline solution.
  - C. Discourage the patient from any unnecessary talking.
  - D. Apply lidocaine spray to the patient's throat every 4 hours.
106. The nurse should assess a client who has a retinal detachment for
- A. tunnel vision at dawn and dusk.
  - B. loss of central vision in either eye.
  - C. a curtain obscuring the client's vision.
  - D. black spots in the client's visual field.
107. A patient with acute asthma has increased dyspnea, bilateral wheezing, and oxygen saturation (SaO<sub>2</sub>) level of 93%. Which nursing action is most appropriate?
- A. Teach the use of fluticasone propionate.
  - B. Administer albuterol inhaler to patient.
  - C. Increase the oxygen flow rate to 8 L/min.
  - D. Instruct slow, deep open mouth breaths.
108. The nurse instructs a patient who has tonic-clonic seizures about home care. Which statement by the patient indicates to the nurse a correct understanding of the information?
- A. "I will avoid flashing video, television, and computer screens."
  - B. "I will take antiseizure medication until my seizures subside."
  - C. "I will limit intake of foods with protein and moderate sugar."
  - D. "I will take tub baths instead of showers because it is safer."
109. Which assessment finding should the nurse expect for a patient with a serum potassium level of 2.8 mEq/L?
- A. irregular pulse
  - B. abdominal cramps
  - C. dry mucous membranes
  - D. postural hypotension



110. A patient with acute cholecystitis reports severe abdominal pain. The nurse should administer meperidine hydrochloride and implement which intervention?
- A. Set up bedside suction.
  - B. Apply a cardiac monitor.
  - C. Conduct fall risk assessment.
  - D. Perform a bladder scan.
111. What is the most appropriate benefit of robotic-assisted technology in nursing practice?
- A. replaces nurses in performing all clinical procedures
  - B. improves interventions with frequent nurse and patient interactions
  - C. supports nurses in repetitive and physically demanding tasks
  - D. limits patient interaction to free up more time for documentation
112. Which of the following interventions should be added to the nursing care plan for a patient who has difficulty swallowing after a stroke?
- A. Serve food to patients at room temperature.
  - B. Thicken liquids for patients before feeding.
  - C. Rearrange head of bed to 180° during feedings.
  - D. Place food as far back in the mouth as possible.
113. A hospitalized infant being treated for gastroenteritis is started on oral feedings of clear liquids. Within an hour of the feeding, the infant has three frequencies of watery stools. Which of these actions should the nurse take initially?
- A. Weigh the infant immediately.
  - B. Stop the infant's oral feedings.
  - C. Dilute clear liquids with sterile water.
  - D. Check the characteristics of the stool.
114. To determine if a patient's recurrent laryngeal nerve has been damaged following a thyroidectomy, the nurse should assess for
- A. frequency of swallowing.
  - B. dryness of oral mucosa.
  - C. strength of mandibular muscles.
  - D. ability of speaking.
115. A goal of nursing care for a patient who has untreated long-standing hyperparathyroidism is to
- A. minimize physical activity.
  - B. control environmental stimulation.
  - C. prevent pathological fractures.
  - D. decrease sodium intake.
116. A patient is scheduled for a below-the-knee (BK) amputation. When discussing the consent form signature with the patient, the nurse offers the patient to ask questions about the procedure. Based on the patient's lack of understanding of the procedure, which of these actions by the nurse is appropriate?
- A. Ignore the patient's concerns about the surgery.
  - B. Provide diversional activities to allay fears.
  - C. Provide further explanation regarding the surgery.
  - D. Describe the details of postop care to the patient.



117. Which of these instructions should be given at the time a patient is discharged from the hospital following a hysterectomy and bilateral oophorectomies?
- A. "Limit your fluid intake for tomorrow."
  - B. "Avoid extremes of temperature tonight."
  - C. "Get 10 hours of restful sleep each night."
  - D. "Increase intake of calcium-rich foods."
118. The nurse is taking a sleep history from a client who has a new onset of insomnia. Which question should the nurse ask first?
- A. "How have your sleep patterns changed?"
  - B. "Do you take naps during the day?"
  - C. "Is your bedroom peaceful in the evening?"
  - D. "Have you taken any steps to improve sleep?"
119. The nurse is caring for a patient who has a central venous catheter. The catheter disconnects from the intravenous (IV) tubing during morning care, and the nurse suspects that an air embolism has occurred. The nurse should immediately place the patient in which position?
- A. supine, with the head higher in the bed than the feet
  - B. on the left side, with the feet higher than the head
  - C. Trendelenburg position, with head higher than feet
  - D. prone position, lying on their back, with head raised
120. A patient who sustained a head injury has a doll's eye reflex. Which action should the nurse take first?
- A. Continue to monitor the eyes and document.
  - B. Place the patient on the right side of the bed.
  - C. Notify the primary healthcare provider of the finding.
  - D. Cover eyes with gauze moistened with saline solution.
121. Which task(s) should the nurse perform when obtaining informed consent for surgery?  
(Select all that apply.)
- A. Witness the signature of the patient.
  - B. Explain the procedure to the patient.
  - C. Verify understanding of the procedure.
  - D. Verify consent signature given willingly.
122. Which question is most appropriate for a nurse to ask a child's parents to determine their child's risk for poisoning?
- A. "Where are your cleaning supplies usually stored at home?"
  - B. "How many hours does your child sleep during the night?"
  - C. "What kinds of outdoor games does your child often play?"
  - D. "Does your child have any problems making new friends?"
123. The nurse is discussing home care with the adult son of an elderly mother who has had a fractured hip repaired. The client's child demonstrates a correct understanding of the nurse's instructions by making which statement(s)? (Select all that apply.)
- A. "I will clean and polish all my mother's floors and furniture for her."
  - B. "I will remove all the small area rugs from my mother's home."
  - C. "I will buy a long, warm robe for my mother to wear at home."
  - D. "I will buy some night-lights for my mother's bedroom and hallway."



124. A patient who is in treatment for panic disorder is confronted with a new situation while in group therapy. The patient begins to sweat and shake, is short of breath, and has palpitations. Which immediate nursing action would be most appropriate?
- A. Instruct the patient with a commanding tone.
  - B. Accompany the patient to the patient's room.
  - C. Use guided imagery as a relaxation technique.
  - D. Explain that it is necessary to control one's fears.
125. A patient is admitted from home with weakness on the left side. The patient displays right-sided facial drooping and drooling. The primary healthcare provider's orders include continuing the patient's home medications. Which action by the nurse is most appropriate?
- A. Administer medications with small sips of filtered water.
  - B. Crush medications and administer them in applesauce.
  - C. Hold medications and obtain an order for a swallowing evaluation.
  - D. Administer medications if able to swallow without coughing.
126. A client has started taking a selective serotonin reuptake inhibitor. Which information about the medication should the nurse provide to the client?
- A. "Take the medication as needed but only up to 3 times daily during the week."
  - B. "The medication has minor side effects that usually improve within 2 to 3 days."
  - C. "You should experience a positive effect from the medication within 24 hours."
  - D. "You can stop taking the medication when you feel better for a solid 6 months."
127. A patient who is in cardiogenic shock is receiving an intravenous (IV) infusion of dopamine hydrochloride. Which finding would best indicate to the nurse that the medication is achieving the desired therapeutic effect?
- A. absence of a heart arrhythmia
  - B. presence of adventitious breath sounds
  - C. a pulse oximetry reading of 85%
  - D. a capillary refill time of less than 3 seconds
128. An adult client with depression is to begin treatment with tranylcypromine sulfate, a monoamine oxidase inhibitor (MAOI). Which nursing measure should be carried out before starting the MAOI?
- A. weighing the client before treatment
  - B. checking results of a complete blood cell count
  - C. finding out if the client had a quantitative sweat test
  - D. taking the client's blood pressure
129. A patient had hip replacement surgery. Which instruction should the nurse give to the patient to decrease the risk of deep vein thrombosis?
- A. "Perform bilateral plantar flexion and extension exercises every hour."
  - B. "Keep a pillow under the unaffected knee while in bed."
  - C. "Maintain the affected extremity in a neutral position."
  - D. "Prevent flexion of the extremities while sitting upright."
130. Which instruction about how to safely improve mobility should the nurse give a client who has Parkinson's disease and is concerned about falling while walking?
- A. "Use short strides when walking."
  - B. "Watch your feet when walking."
  - C. "Walk with a wide-based gait."
  - D. "Use toe-heel walking method."



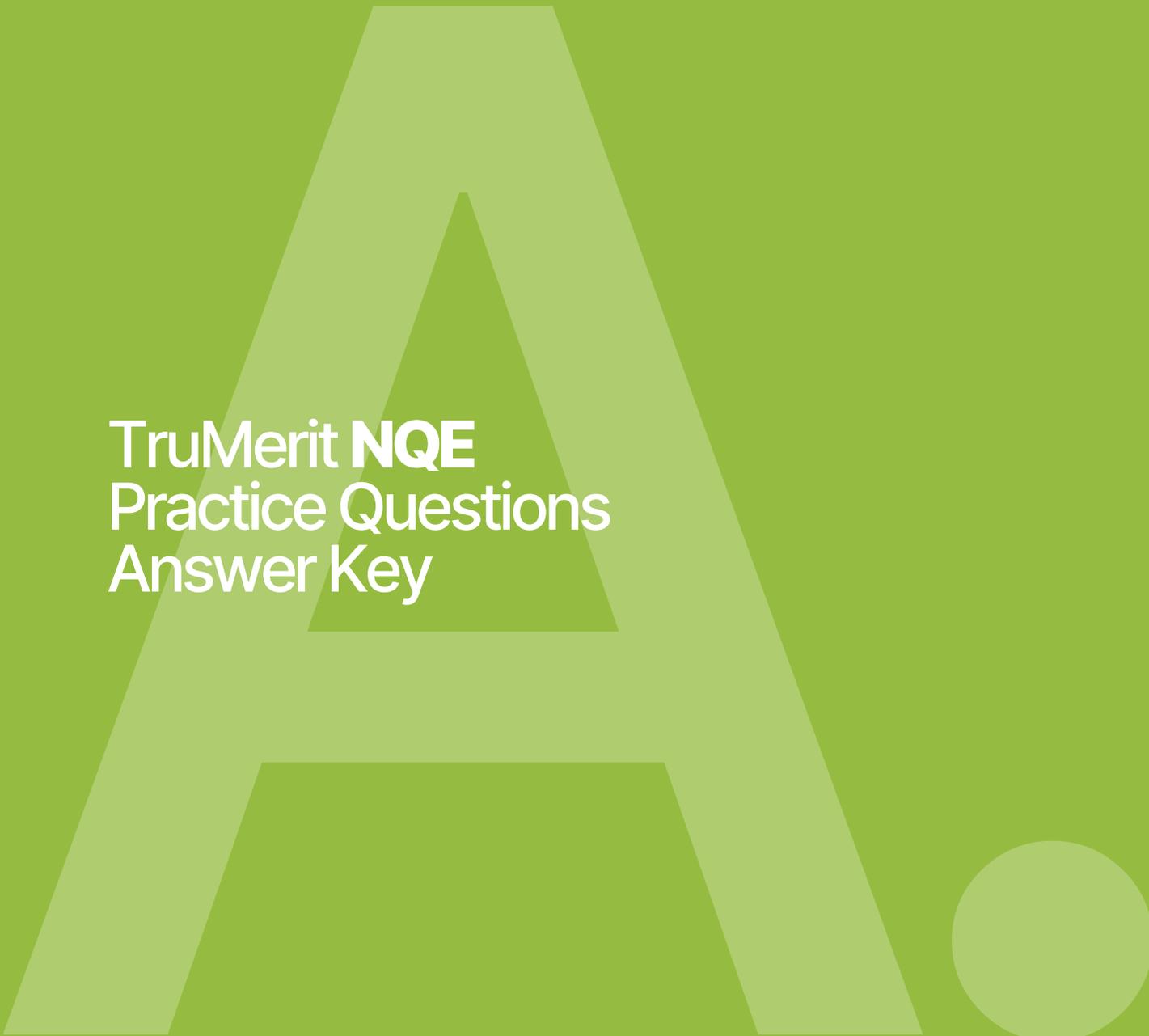
131. A nurse should recognize which finding in a client who has a spinal cord injury that indicates the development of autonomic dysreflexia?
- A. sudden onset headache
  - B. absence of reflexes below injury
  - C. shortness of breath
  - D. pale, dry skin above the injury
132. Which practice(s) should a nurse include in the care of a client with an arteriovenous fistula for hemodialysis? (Select all that apply.)
- A. Assess pulses distal to the fistula.
  - B. Auscultate over access site for a bruit.
  - C. Monitor the client's blood pressure.
  - D. Palpate the access site for a thrill.
133. After receiving the shift report, the nurse should first provide care for which of the four patients below?
- A. a patient with postoperative pain medication.
  - B. a patient with hemorrhoids with blood in stool.
  - C. a patient who has reported nausea.
  - D. a patient with new onset of delirium.
134. A patient is admitted to the hospital with hepatitis A infection. Which instruction should the nurse give to the patient about preventing transmission to others?
- A. "Avoid donating blood until the physician approves you to."
  - B. "Avoid taking medications that are toxic to the liver."
  - C. "Advise the primary caregiver to avoid respiratory contact."
  - D. "Advise your family to receive the immune globulin vaccine."
135. Which of these actions should a nurse take first when initiating cardiopulmonary resuscitation?
- A. Determine responsiveness.
  - B. Palpate carotid pulse.
  - C. Begin chest compressions.
  - D. Monitor respirations.
136. A patient who is being treated for cancer develops anorexia. Which of these nursing measures would be appropriate to improve the patient's appetite?
- A. giving the heaviest calorie-rich meal at the end of the day
  - B. providing a quiet, pleasant atmosphere at mealtimes
  - C. offering foods that are smooth textured and soft
  - D. encouraging fluid intake between each bite of food
137. When changing a patient's abdominal dressing, a nurse observes that the wound is dehisced, and a small portion of the bowel is eviscerated. Which of these actions should the nurse take first?
- A. Apply a sterile saline dressing over the wound.
  - B. Place a pressure dressing over the wound.
  - C. Report the findings to the primary care provider.
  - D. Irrigate the wound with diluted hydrogen peroxide.



138. A patient who has had a cerebrovascular accident has right-sided hemiplegia and dysphagia. Which of these measures should the nurse incorporate into the patient's feeding care plan?
- A. Give the patient liquid foods through a syringe in the mouth.
  - B. Position the patient on the right side of the bed during feedings.
  - C. Stand on the patient's right side of the bed when feeding.
  - D. Place the food in the left side of the patient's mouth.
139. A patient who had a surgical reduction of a fractured femur reports chest pain and dyspnea. In addition to calling the primary care provider, a nurse should initially
- A. administer prescribed oxygen to the patient.
  - B. give prescribed pain medication to the patient.
  - C. instruct the patient to deep-breathe and cough.
  - D. call the laboratory for the latest blood gas results.
140. A Red Cross nurse works at an emergency shelter set up in a high school gymnasium following a series of devastating tornadoes in a local community. The nurse expects to document nursing care of patients seen in this shelter in which of the following ways?
- A. The nurse will record on the shelter's electronic health record the details provided to patients.
  - B. The nurse will set up and maintain paper charts for patients seen in the shelter.
  - C. The nurse will provide care to patients in shelters but is not required to document nursing care.
  - D. The nurse will use a personal laptop to document nursing care provided to patients in the shelter.
141. Four patients have recently entered the emergency shelter following an earthquake. Which patient will the nurse see first?
- A. A 22-year-old female with a history of cerebral palsy is in her wheelchair, and she complains of a sore back.
  - B. A 45-year-old man was hit with a piece of flying debris and has a superficial bleeding wound on his right lower extremity.
  - C. A 15-year-old girl with a history of asthma is short of breath and using her accessory muscles to breathe.
  - D. A 70-year-old man has reported to a nurse that he is diabetic and has not yet taken his insulin today.
142. A homeless barefooted patient presents to the emergency department during a winter storm with mottled, bluish white bilateral lower extremities. Which action would be most appropriate for the nurse to take?
- A. massaging the patient's lower extremities
  - B. encouraging the patient to ambulate
  - C. placing elastic compression stockings lower extremities
  - D. placing the patient's lower extremities in warm water
143. Which nursing measure has the highest priority when home care is provided for an older adult who is taking medication?
- A. Instruct the patient to discontinue use of patient's vitamin use.
  - B. Provide the patient with some tips on not missing the doses.
  - C. Recommend to the client the environmental safety strategies.
  - D. Assess the patient's financial resources by talking with family.



144. A patient is admitted to the hospital with severe renal colic due to renal calculi. Which nursing intervention should be implemented first?
- A. Instruct the patient to strain all their urine.
  - B. Assess for an elevated temperature immediately.
  - C. Administer an analgesic medication as ordered.
  - D. Encourage the patient to increase fluid intake.
145. A community health nurse is prioritizing patient needs due to a major weather emergency expected to hit her area. Flooding and long-term power outages are anticipated. Which of the following patients will receive the highest priority on her list?
- A. a 65-year-old male who lives alone in his home and ambulates independently with a cane
  - B. a 30-year-old diabetic female who is 24 weeks pregnant and lives with her husband; they have a generator
  - C. a 62-year-old man with emphysema who is homebound and oxygen dependent, requiring a power source
  - D. a 32-year-old female with multiple sclerosis who is wheelchair bound and lives with her parents
146. Which of the following factors impact the emergency response of a community to an infectious disease/agent? (Select all that apply.)
- A. The rate of the spread of the infection in the community and area.
  - B. The readiness of adequate nurse and healthcare staffing in hospital.
  - C. The availability of media reports of daily deaths related to an infection.
  - D. The accessibility of personal protective equipment (PPE) for safety.
  - E. The accessibility of hospital beds and essential medical equipment
147. A nurse is caring for a patient who had a cesarean delivery 2 hours ago. Which order should the nurse question?
- A. Discontinue the Foley catheter on postpartum day 1.
  - B. Ambulate with assistance for 4 hours after surgery.
  - C. Administer cefazolin sodium every 8 hours for 24 hours.
  - D. Repeat the complete blood cell count in 8 hours.
148. While assessing a client receiving oral anticoagulant therapy in the homecare setting, the nurse observes bleeding gums. Which nursing action would be most appropriate?
- A. Obtain an order for an international normalized ratio.
  - B. Send the client to the emergency department.
  - C. Instruct the client to use a medium-bristle toothbrush.
  - D. Encourage the client to gargle with saltwater.
149. If digoxin is achieving its primary desired effect for a client with congestive heart failure, the nurse should expect to obtain which finding in the client?
- A. Decrease in pulse rate.
  - B. Increase in pulse deficit.
  - C. Distention of neck veins.
  - D. Lowering of blood pressure.
150. Which instruction for home management should a nurse give to a client who has osteoporosis?
- A. "Continue with your walking program."
  - B. "Limit lower-extremity weight bearing."
  - C. "Increase your dietary intake of protein."
  - D. "Schedule daily rest periods after lunch."

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TruMerit **NQE**  
Practice Questions  
Answer Key



1. A patient is admitted to the hospital after sustaining a fractured hip. The nurse should expect to observe that the affected extremity appears to be
  - A. abducted.
  - B. internally rotated.
  - C. \* shortened.
  - D. hyperextended.

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** A classic sign of a hip fracture is that the affected leg appears shortened due to muscle contraction and displacement of the fracture fragments.

2. Which measure should be included in the care plan of a patient after removal of a suprapubic tube?
  - A. \* Change abdominal dressing as necessary.
  - B. Check the specific gravity of urine twice daily.
  - C. Instruct to lie on abdomen several times a day.
  - D. Encourage to drink fruit juices high in potassium.

**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** After removal of a suprapubic catheter, the insertion site is essentially an open wound that needs to be kept clean and dry to prevent infection. Regularly changing the abdominal dressing helps protect the site, promotes healing, and prevents contamination.

3. Which nursing intervention should take priority in the care of a patient immediately after excision of a pituitary tumor?
  - A. monitoring vital signs every 4 hours
  - B. encouraging coughing and deep breathing
  - C. \* maintaining accurate intake and output records
  - D. maintaining NPO/NBM dietary status

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** After pituitary tumor excision, there is a high risk of diabetes insipidus due to possible damage to the pituitary gland, leading to imbalances in fluid regulation. Accurate intake and output monitoring is essential to detect and manage this complication promptly.

4. A nurse is monitoring a patient who is in labor. The nurse should recognize which fetal heart finding as an early indicator of maternal sepsis?
  - A. \* tachycardia
  - B. variable decelerations
  - C. audible murmur
  - D. irregular rate

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care:**

**Rationale:** Fetal tachycardia (a baseline heart rate >160 bpm) is often one of the earliest signs of maternal infection or sepsis. It may indicate that the fetus is responding to maternal fever, inflammation, or intra-amniotic infection, even before other clinical signs become apparent in the mother.



5. When working with a group of clients who are depressed, what is the best action a nurse could take?
- A. Limit the duration of the nurse–client relationships.
  - B. \* Promote achievable goals with the clients.
  - C. Restrict social involvement among the clients.
  - D. Conduct daily motivational sessions with the clients.

**Domain 4: Education & Research, Subdomain A: Education**

**Rationale:** Depressed clients often struggle with low motivation, hopelessness, and a sense of failure. Promoting realistic, attainable goals helps build confidence, supports self–efficacy, and encourages gradual improvement. Achievable goals provide structure and measurable progress, which are vital for recovery.

6. A primary healthcare provider orders an enteric–coated medication for a patient who is fed through a percutaneous endoscopic gastrostomy (PEG) tube. The nurse should
- A. request the pharmacist supply a different medication.
  - B. crush the tablet and administer the medication.
  - C. dissolve the tablet and administer the medication.
  - D. \* withhold the medication and call the primary provider.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Enteric–coated medications should not be crushed or altered for PEG tube administration due to the risk of gastric irritation or reduced efficacy. The nurse should withhold the medication and notify the provider to request an alternative formulation (e.g., liquid or non–enteric–coated).

7. A nurse should monitor a child with attention deficit hyperactivity disorder (ADHD) who is taking methylphenidate for a change in
- A. bladder function.
  - B. bowel pattern.
  - C. \* child’s appetite.
  - D. visual acuity.

**Domain 7: Physiological Integrity, Subdomain B Pharmacological & Parenteral Therapies**

**Rationale:** Methylphenidate, a central nervous system stimulant, commonly causes decreased appetite, which can lead to weight loss and growth suppression in children. Monitoring nutritional intake and weight is essential.

8. Which measure should the nurse include in the care plan of an adolescent female recently diagnosed with genital herpes?
- A. \* Administer sitz baths several times throughout the day.
  - B. Apply talcum powder to the perineum after bathing.
  - C. Encourage adolescent female to wear silk underwear.
  - D. Observe for side effects of anthelmintic medications.

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** Genital herpes is a viral infection that causes painful sores and inflammation in the



genital area. Sitz baths, which involve soaking the perineal area in warm water, help to:

- Soothe and relieve the pain and itching caused by herpes lesions.
- Promote healing by increasing blood flow to the affected area.
- Reduce inflammation and discomfort.

9. Which intervention should the nurse plan to use when caring for a patient with thrombophlebitis of the right lower extremity?
- A. Keep the patient in a high-Fowler position.
  - B. Apply cold moist compresses to reduce edema.
  - C. \* Assess the patient for signs and symptoms of pulmonary embolus.
  - D. Exercise the patient's right lower extremity to decrease muscle spasms.

#### **Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Thrombophlebitis, especially deep vein thrombosis (DVT), can lead to a pulmonary embolism (PE) if a clot dislodges. Monitoring for signs such as sudden shortness of breath, chest pain, or hemoptysis is critical. This is a priority intervention.

10. A teenager seeks contraceptive counseling without informing her parents. This is permitted by local law. Which nursing action is most appropriate?
- A. Contact the parents to involve them in the discussion.
  - B. \* Provide the service confidentially and assess for safety.
  - C. Encourage the patient to wait until a parent is present.
  - D. Discuss with the teenager the benefits of abstinence.

#### **Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** When legally permitted, adolescents have the right to confidential reproductive health services. The nurse should honor confidentiality, ensure the adolescent is safe, and provide care without parental involvement unless there's a safety concern.

11. A nurse overhears the patient's visitor asking the patient about their private medical history. The patient appears uncomfortable but does not object. What is the nurse's priority?
- A. Leave the room to allow the private conversation to continue.
  - B. \* Ask the visitor to step out, then confirm if patient wants privacy.
  - C. Assume patient's consent and continue with tasks that are assigned.
  - D. Immediately remove the visitor without asking for patient input.

#### **Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** The nurse should advocate for patient privacy, especially when signs of discomfort are observed. Confirming the patient's wishes after ensuring a private setting respects autonomy guidelines.

12. A client who is being treated for psychosis tells the nurse, "The doctor told me that my mother is doing the devil's work." Which interpretation of this remark is accurate? The client is
- A. attempting to get validation of the doctor's statement.
  - B. showing distrust in the nurse's capability.
  - C. \* ineffectively controlling their disorganized thoughts.
  - D. trying to make the doctor look incompetent.



### Domain 2: Ethics, Subdomain A: Ethics

**Rationale:** Psychosis often includes disorganized thinking, delusions, or hallucinations. The statement reflects a thought disorder and not a factual or manipulative intent.

13. A patient with borderline personality disorder is in the psychiatric unit for treatment of an acute episode. The patient's condition has improved, and discharge planning is being done. Which behavior(s) by the patient would indicate to the nurse that the patient is ready for discharge? (Select all that apply.)
- A. The patient directs the patient group activities for 2 weeks.
  - B. \* The patient invites her mother to stay with her after discharge.
  - C. The patient requests off-unit passes to visit friends at a restaurant.
  - D. \* The patient complies with a mutually agreed contract for 1 week.

### Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort

**B:** Seeking healthy social support post-discharge reflects progress in relationship building and readiness for reintegration.

**D:** Compliance with agreed-upon plans and boundaries is a positive behavioral change and suggests increased emotional regulation and accountability.

14. The nurse should be most concerned about which laboratory result for a client who takes clozapine?
- A. blood urea nitrogen level 12 mg/dL
  - B. serum potassium level 4.5 mEq/L
  - C. serum lithium level 1.3 mEq/L
  - D. \* white blood cell count 4,500/cu mm

### Domain 7: Physiological Integrity, Subdomain B Pharmacological & Parenteral Therapies

**Rationale:** Clozapine can cause agranulocytosis, a potentially fatal drop in white blood cells. A WBC of 4,500/cu mm is borderline low and warrants close monitoring or intervention.

15. Which finding(s) should a nurse typically observe when assessing a patient who has acute gout? (Select all that apply.)
- A. mild discomfort of the spine
  - B. \* pain of a metatarsophalangeal joint
  - C. \* elevated serum uric acid
  - D. decreased erythrocyte sedimentation rate

### Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation

**B:** Acute gout commonly affects the first metatarsophalangeal joint (big toe), presenting as severe pain, redness, and swelling.

**C:** Gout is caused by hyperuricemia, which leads to uric acid crystal deposits in joints, resulting in inflammation and pain.

16. Which nursing action best demonstrates social responsibility in promoting equitable access to healthcare?
- A. Focus outreach on private patients to ensure follow-up.
  - B. \* Organize mobile clinics targeting underserved populations.
  - C. Refer patients to emergency rooms for all urgent needs.
  - D. Encourage online booking only for most appointments.



**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain B Population Health**

**Rationale:** This action addresses health disparities by delivering care to populations with limited access, reflecting a commitment to social justice and equity.

17. A viral video is circulating with inaccurate claims about vaccine side effects. What should the nurse prioritize when addressing this with patients?
- A. \* Debunk the video using scientific evidence and patient education.
  - B. Warn patients not to use social media for health advice.
  - C. Refer patients to the hospital's legal department for more help.
  - D. Avoid discussing the video to prevent controversy.

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain B Population Health**

**Rationale:** Nurses have a duty to counter misinformation with accurate, evidence-based education to support informed decision-making and public health safety.

18. How can a nurse most effectively contribute to local healthcare policy development?
- A. Attend policy meetings to listen but avoid direct engagement.
  - B. Collaborate with interdisciplinary teams and present clinical data.
  - C. \* Present the policy issue and ask for feedback from stakeholders.
  - D. Submit written concerns from staff to hospital administration.

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain B Population Health**

**Rationale:** Engaging stakeholders ensures inclusive, collaborative policy development, improves buy-in, and allows the nurse to advocate with evidence and support.

19. Which action(s) by a nurse best supports environmental sustainability in a rural health setting? (Select all that apply.)
- A. Refer all of the patients to in-person consultations.
  - B. \* Recommend reusable home equipment for chronic care.
  - C. Discourage use of digital health tools for elderly patients.
  - D. \* Allow unlimited telehealth access to rural patients.

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain B Population Health**

**B:** Encouraging reusable supplies reduces medical waste and supports sustainability in resource-limited environments.

**D:** Telehealth reduces travel, fuel use, and costs while improving healthcare access in rural areas, contributing to sustainability and equity.

20. A hospital implements a green initiative to reduce single-use plastics. What is the nurse's role in supporting this planetary health goal?
- A. \* Educate staff on safe alternatives to single-use plastics.
  - B. Request additional single-use supplies for emergencies.
  - C. Focus only on patient outcomes, not environmental issues.
  - D. Avoid engaging in facility-level sustainability discussions.

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain B Population Health**

**Rationale:** Nurses are frontline leaders in environmental sustainability efforts. By educating staff on evidence-based, safe alternatives to single-use plastics, nurses support institutional green initiatives and contribute to planetary health and resource conservation.



21. A patient who has a diagnosis of acute stroke is conscious when admitted to the hospital. Which nursing action should be given priority?
- A. Inserting an indwelling urinary catheter.
  - B. Applying antiembolic stockings to patient's legs.
  - C. Reporting the diagnosis to the physician.
  - D. \* Assessing neurological status of the patient.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** In acute stroke, frequent neurological assessments are critical to detect changes in condition, guide treatment decisions, and prevent complications. This is a priority nursing action based on the ABCs and the time-sensitive nature of stroke management.

22. The nurse is caring for a patient who had an abdominal-perineal resection earlier today. Which observation should be reported to the physician promptly?
- A. absence of the patient's bowel sounds
  - B. \* blood in the urine of the patient
  - C. edema of the patient's stoma
  - D. dressings' serosanguineous drainage

**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** Blood in the urine (hematuria) following an abdominal-perineal resection may indicate ureteral or bladder injury, a serious postoperative complication that requires immediate medical evaluation.

23. The nurse administers a nitroglycerin tablet to a patient who has known stable angina. After 5 minutes, the nurse checks the patient's blood pressure and finds that it is 80/50 mmHg. What is the priority nursing intervention?
- A. Start an intravenous (IV) line.
  - B. Obtain an electrocardiogram.
  - C. Provide emotional support to the patient.
  - D. \*Lay the patient flat, and call the physician.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Nitroglycerin can cause significant hypotension. The priority is to lay the patient flat to improve cerebral perfusion and then notify the physician. This prevents syncope and further complications.

24. Which statement about dressings used for venous access devices would be most important for guiding the nurse's practice?
- A. Transparent polyurethane dressings have a greater risk for infection than gauze dressings.
  - B. If blood is oozing from the catheter insertion site, transparent polyurethane dressings should be used.
  - C. \* Both gauze and transparent polyurethane dressings should be sealed along the entire perimeter of the dressing.
  - D. Triple antibiotic ointment should be used with gauze dressings to thoroughly protect the catheter insertion site.



**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** To maintain sterility and reduce infection risk, all dressings over venous access sites should be sealed completely. Incomplete sealing can allow microorganisms to enter and lead to catheter-related bloodstream infections.

25. Which statement, if made by a person who is 12 weeks pregnant, would a nurse be most concerned about?
- A. "I wanted to be pregnant, but now I don't know."
  - B. \* "My partner is angry because I got pregnant."
  - C. "Being pregnant makes me feel very tired."
  - D. "I don't want to get too fat while I'm pregnant."

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** This statement may suggest intimate partner violence (IPV) or lack of support, both of which are high-risk factors in pregnancy. This requires immediate follow-up, safety assessment, and potential referral to social services.

26. A client is diagnosed with hypercholesterolemia. Which advice by the nurse is appropriate?
- A. "Take medication with morning meal."
  - B. "Reduce your daily exercise routine."
  - C. \* "Continue your daily exercise routine."
  - D. "Avoid consuming a low cholesterol diet."

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Exercise helps lower LDL cholesterol and triglycerides, while raising HDL (good) cholesterol. Nurses should reinforce continuation of a healthy, active lifestyle as part of managing hypercholesterolemia.

27. Which long-term effect should the nurse expect to observe in a patient who has radiation exposure?
- A. spinal shortening
  - B. \* hormone deficiency
  - C. increased saliva production
  - D. increased skull density

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Radiation exposure, particularly involving the head or neck, can damage endocrine glands (like the thyroid or pituitary), leading to long-term hormone deficiencies. This is a known delayed effect of radiation therapy.

28. What action should a nurse take when leaving a computer workstation unattended?
- A. \* Log off or lock the screen before stepping away.
  - B. Close the patient file but leave the system open.
  - C. Minimize the screen and rely on privacy filters.
  - D. Trust colleagues not to access the information.



### **Domain 2: Ethics, Subdomain A: Ethics**

**Rationale:** To maintain patient confidentiality and data security, the nurse must log off or lock the computer. This protects sensitive health information.

29. When is the best time for a nurse to document patient care?
- A. \* immediately after care is provided
  - B. at the end of the nurse's shift
  - C. before the nurse takes their break
  - D. when convenient during the day

### **Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort**

**Rationale:** Timely documentation ensures accuracy and reflects real-time patient status. It helps with communication among the healthcare team and reduces risk of errors or omissions in patient records.

30. A patient is brought to the hospital with pulmonary edema. The nurse should assess the patient for
- A. Kussmaul respirations and dry cough.
  - B. inspiratory stridor and sternal retraction.
  - C. pursed-lip breathing and wheezing.
  - D. \* noisy and moist breathing in the mouth.

### **Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** Pulmonary edema causes fluid accumulation in the alveoli and airways, leading to moist, bubbly, or crackling breath sounds. Noisy moist breathing is a hallmark sign that requires urgent intervention.

31. A nurse notices they feel impatient when caring for patients from a particular cultural background. What is the most ethical and professional action?
- A. Request to avoid assignment to these patients.
  - B. \* Reflect on personal biases and seek cultural guidance.
  - C. Treat the patients differently to avoid tension.
  - D. Share the concern only with trusted friends outside work.

### **Domain 3 Leadership & Personal Responsibility, Subdomain A: Personal traits**

**Rationale:** Recognizing personal bias is an important first step toward culturally competent care. The ethical and professional response involves self-reflection and actively seeking education or guidance to improve interactions with patients from different backgrounds. This approach supports equitable care and personal growth.

32. During a multidisciplinary team meeting, a nurse notices that a junior team member's concern about patient care is being dismissed. What is the best action to support effective communication?
- A. Redirect the conversation without addressing the concern.
  - B. Privately advise the junior member to speak louder next time.
  - C. \* Respectfully amplify and clarify the team member's concern.
  - D. Report the issue later without intervening during the meeting.



### Domain 3 Leadership & Personal Responsibility, Subdomain B: Colleagues & Work Environment

**Rationale:** Effective leadership involves creating a safe, inclusive environment where all team members feel heard. By respectfully amplifying and clarifying the junior member's concern, the nurse demonstrates advocacy, promotes collaboration, and ensures all relevant clinical input is considered in patient care.

33. A nurse notices that broken equipment in the medication room has not been repaired for a week. What is the most appropriate course of action?
- A. Continue using it while waiting for repairs to happen.
  - B. \* Do not use and report to the unit manager directly.
  - C. Leave a warning note for colleagues and continue working.
  - D. Ignore the issue and focus on urgent patient care needs.

### Domain 3 Leadership & Personal Responsibility, Subdomain B: Colleagues & Work Environment

**Rationale:** Using broken equipment can compromise patient safety. The appropriate and professional action is to stop using it and directly report it to the responsible authority (e.g., the unit manager) to ensure timely repair and prevent harm.

34. A physical therapist and a nurse disagree about when a patient should begin mobility training. What is the nurse's best action?
- A. Escalate the disagreement to the department head immediately.
  - B. Compromise without further discussion to maintain peace.
  - C. \* Initiate a respectful conversation to align on patient priorities.
  - D. Continue with the nursing plan regardless of disagreement.

### Domain 3 Leadership & Personal Responsibility, Subdomain B: Colleagues & Work Environment

**Rationale:** Collaborative care relies on open communication and mutual respect among healthcare professionals. Rather than escalating the issue or making a unilateral decision, initiating a respectful discussion fosters interdisciplinary teamwork and ensures the patient's best interest is prioritized.

35. A nurse wants to influence national healthcare reform. What is the most effective first step to ensure their voice contributes to policy?
- A. \* Join a professional organization that shapes legislation.
  - B. Post health-related opinions on a personal social account.
  - C. Discuss opinions with patients during clinical care sessions.
  - D. Write to a colleague about frustrations with current policies.

### Domain 3 Leadership & Personal Responsibility, Subdomain C: Health Policy

**Rationale:** Professional organizations often engage in legislative advocacy and policy reform efforts. Joining one provides nurses with a collective voice, tools, and a platform to influence healthcare policy at a broader, more impactful level.

36. A community lacks access to affordable mental health services. What action best reflects the nurse's role in policy advocacy?
- A. \* Support law makers to expand funding for services.
  - B. Recommend community members travel to urban clinics.
  - C. Focus only on patients with some type of health coverage.
  - D. Provide community education on self-care and mindfulness.



### Domain 3 Leadership & Personal Responsibility, Subdomain C: Health Policy

**Rationale:** While direct education helps in the short term, advocating for increased funding addresses the systemic issue. Supporting policies or lawmakers that prioritize mental health funding reflects a nurse's role as a policy advocate for community health.

37. A nurse in a rural area notices an increase in heat-related illnesses during summer months. What conclusion reflects awareness of climate impacts?
- A. The illnesses are due only to poor hydration practices.
  - B. \* Environmental factors such as rising temperatures are contributors.
  - C. The data likely reflect a random seasonal variation.
  - D. Individuals with health issues are to blame for poor planning.

### Domain 3 Leadership & Personal Responsibility, Subdomain C: Health Policy

**Rationale:** Response B shows awareness of the broader social and environmental determinants of health. Climate change, such as increasing heatwaves, directly impacts health outcomes, and recognizing this is key to informed community care and advocacy.

38. A nurse is experiencing interpersonal conflict with coworkers. Which comment by the nurse would indicate readiness to resolve the conflict?
- A. \* "I know I can stay focused on our common goals."
  - B. "I can ignore what my coworkers are saying to me."
  - C. "I need to report coworkers' behavior toward me."
  - D. "I know that the current issue will diminish with time."

### Domain 3 Leadership & Personal Responsibility, Subdomain A: Personal traits

**Rationale:** This statement reflects emotional maturity, team orientation, and a willingness to resolve conflict constructively. Staying focused on shared goals is a hallmark of professionalism and effective interpersonal communication in healthcare settings.

39. The nurse is assigned to care for a patient who has acquired immune deficiency syndrome (AIDS). The patient asks the nurse, "Would you rub my back, and please don't use gloves?" The nurse should
- A. delegate the back rub to a nursing assistant.
  - B. explain that wearing gloves is mandatory.
  - C. \* assess the skin integrity of the patient.
  - D. rub patient's back without wearing gloves.

### Domain 2: Ethics, Subdomain A: Ethics

**Rationale:** Before making a decision about wearing gloves, the nurse must assess the patient's skin. If there are no breaks in the skin and the nurse is comfortable, gloves may not be necessary. However, assessment comes first to guide safe and ethical care.

40. An adolescent in active labor requests epidural anesthesia. Her mother is at the bedside and states, "She doesn't need that." After notifying the patient's primary healthcare provider and securing an order, the nurse should
- A. request the patient to select another labor coach.
  - B. inform them about alternative analgesia options.
  - C. \* prepare the patient for an epidural.
  - D. escort the mother from the room.



**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** An adolescent in labor who is legally capable of making medical decisions has the right to request pain relief. Once the order is obtained, the nurse should prioritize the patient's wishes. Respecting her autonomy and acting accordingly aligns with patient advocacy and ethical nursing practice.

41. A hospitalized patient develops a urinary tract infection. Results from a culture reveal vancomycin-resistant *Enterococcus* (VRE). Which action should the nurse take next?
- A. Use a face mask when entering the patient's room.
  - B. Place the patient in negative air-flow room.
  - C. Insert Foley catheter attached to bedside drain bag.
  - D. \* Move the patient to a private room immediately.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** VRE (Vancomycin-Resistant *Enterococcus*) is a multidrug-resistant organism requiring contact precautions. A private room helps prevent transmission to other patients.

42. While ambulating in the hallway, a patient suddenly becomes lightheaded and dizzy. The nurse should
- A. \* ease the patient to the hospital floor.
  - B. call for someone to bring a chair.
  - C. assist the patient back to the room.
  - D. instruct the patient to hold onto the railing.

**Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort**

**Rationale:** If a patient becomes dizzy or lightheaded, the nurse should immediately assist them to the floor to prevent injury from falling. Safety is the priority.

43. While a patient is receiving tube feeding, which finding should indicate to the nurse that the patient is receiving an inadequate amount of water?
- A. urine at the pH level of 5.2
  - B. \* urine specific gravity 1.030
  - C. serum sodium 138 mEq/L
  - D. serum total protein 6.5 g/dL

**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** A high specific gravity (normal: 1.005–1.030) indicates concentrated urine, suggesting dehydration or inadequate fluid intake, common with tube feedings lacking enough free water.

44. A patient is to receive digoxin elixir 0.125 mg once daily. The elixir is available as 0.05 mg/mL. Which volume indicates the correct dose that the nurse should administer to the patient?
- A. 0.05 mL
  - B. 1.0 mL
  - C. 1.5 mL
  - D. \* 2.5 mL



**Domain 7: Physiological Integrity, Subdomain B Pharmacological & Parenteral Therapies**

**Rationale:** To calculate: Required dose: 0.125 mg. Available: 0.05 mg/mL  
 $0.125 \div 0.05 = 2.5$  mL. The correct volume to administer is 2.5 mL.

45. Which instruction should the nurse give to a client who is to begin taking atenolol?
- A. \* "Avoid sudden discontinuation of the drug."
  - B. "Decrease consumption of alcoholic beverages."
  - C. "Monitor your food and liquid intake and output."
  - D. "Weigh yourself every morning and evening."

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Atenolol, a beta-blocker, should not be stopped abruptly due to the risk of rebound hypertension, angina, or arrhythmias. It should be tapered under supervision.

46. A client receiving warfarin sodium reports to the nurse that her current menstrual period is prolonged and unusually heavy. Which action should the nurse take?
- A. Review the client's previous hematology test results in the past 3 weeks.
  - B. Obtain an obstetrics-gynecology referral from the health care provider.
  - C. \* Get an order for prothrombin time with international normalized ratio (INR).
  - D. Obtain a primary healthcare provider's order to decrease the dose of warfarin.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Heavy menstruation may indicate excessive anticoagulation. The INR determines clotting status and guides whether the dose of warfarin needs adjustment.

47. A postoperative patient is receiving a fentanyl citrate epidural infusion for pain management. The nurse should place highest priority on which assessment?
- A. level of consciousness
  - B. \* respiratory rate
  - C. pulse rate
  - D. pain level

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Fentanyl is a potent opioid that can cause respiratory depression. Monitoring respiratory rate is the highest priority in patients receiving opioid infusions.

48. Which response(s) by a parent would indicate that the nurse's teaching of behavioral modification for the parent's child has been successful? (Select all that apply.)
- A. \* "I will give a reward immediately after the desired behavior."
  - B. \* "I will not give my child a desired reward for unwanted actions."
  - C. "I will take away previously earned rewards if child misbehaves."
  - D. \* "I need to choose a reward that is meaningful for my child."

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:**

- A: Reinforces desired behavior effectively.
- B: Withholding reward for unwanted behavior is essential to discourage it.
- D: A reward must be meaningful to motivate the child.



49. A nurse provides dietary instructions to the parents of a 2-year-old child who has celiac disease. Which food item would be appropriate for the child?
- A. \* rice cereal bars
  - B. oatmeal cookies
  - C. chicken noodle soup
  - D. peanut butter sandwich

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** Children with celiac disease must avoid gluten (found in wheat, barley, rye, oats). Rice cereal bars are gluten-free and appropriate.

50. Which of the following best demonstrates an advanced nurse's contribution to nursing informatics?
- A. Installing new electronic health record software.
  - B. \* Developing a clinical decision support tool using outcome data.
  - C. Repairing network issues in a patient care area in the unit.
  - D. Teaching patients how to use wearable fitness trackers.

**Domain 5: Technology & Innovation, Subdomain A: Technology & Innovation**

**Rationale:** Advanced practice nurses contribute to informatics by integrating data into tools that support evidence-based decision-making, enhancing clinical care.

51. A nurse gives a client instructions about lifestyle changes that are needed in order to live with asthma. Which of these statements, if made by a client, would indicate the need for more information?
- A. "I will obtain an influenza shot every year."
  - B. \* "I should avoid any physical exercise."
  - C. "I should carry my medication when I travel."
  - D. "I am looking for someone to take my dog."

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** Clients with asthma should not avoid exercise; instead, they should learn to manage their condition with medications and precautions. Response B shows misunderstanding.

52. Which goal should the nurse include in the care plan of a client who has glaucoma?
- A. \* Avoid pupillary dilation.
  - B. Avoid rapid eye movements.
  - C. Restrict fluid intake.
  - D. Restrict sodium intake.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** In glaucoma, pupillary dilation increases intraocular pressure, potentially worsening optic nerve damage. Therefore, dilation must be avoided.

53. A client who is being treated for acute pancreatitis is given dietary instructions about preventing a recurrence. Which of these comments, if made by a client, would indicate a correct understanding of the dietary instructions?
- A. "I will eat plenty of foods that will be high in sugar."
  - B. "I will limit my intake of carbohydrate foods like bread."



- C. "I will increase foods high in protein, such as meats."
- D. \* "I will avoid foods or beverages containing alcohol."

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** Alcohol is a major trigger for pancreatitis and must be avoided to prevent recurrence. The other answers do not reflect the correct dietary restrictions.

54. The parent of a 3-year-old child calls the nurse and says, "My child just ate half a bottle of vitamin C tablets. What should I do?" Which response by the nurse would be best?
- A. "Give your child a glass of milk to absorb the extra vitamin C."
  - B. "Give your child syrup of ipecac to make him vomit this out."
  - C. \* "Call the Poison Control Center and share what you just told me."
  - D. "Do nothing. Vitamin C is water-soluble. It will not hurt your child."

**Domain 8: Emergency & Disaster Management, Subdomain B: Critical Incidents**

**Rationale:** For any poisoning or ingestion, the first step is to contact Poison Control. They provide specific, evidence-based instructions for treatment based on the substance and dose.

55. A multigravida woman has expressed that she would not welcome a child with disabilities. She has now delivered a child with disabilities. It is essential to obtain information about which of these areas? The woman's
- A. relationship with her mother.
  - B. behavior with her child with disabilities.
  - C. connection with her peer group.
  - D. expectations about the infant's disabilities.

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** If the mother strongly desired a healthy child, her behavior toward her child with disabilities could be negatively affected. Early observation helps identify risks for bonding issues or neglect.

56. A nurse should be aware that the inactivated polio virus vaccine, instead of the live polio virus vaccine, should be administered to an infant who has a
- A. \* 6-year-old sibling receiving chemotherapy.
  - B. 4-year-old sibling who has varicella zoster.
  - C. 1-year-old sibling who has cystic fibrosis.
  - D. father who is being treated for tuberculosis.

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** The live polio vaccine could pose a risk of transmission to immunocompromised individuals, such as a sibling on chemotherapy. Use of the inactivated polio vaccine (IPV) is safer.

57. While a nurse discusses accident prevention with a mother of a 2-year-old girl, the mother makes these comments to the nurse. Which comment indicates that the mother needs further information?
- A. "I'm storing all of my cleaning products in a locked cabinet in my kitchen."
  - B. \* "I'm giving her ipecac instantly if she eats/drinks something poisonous."
  - C. "I'm throwing out all our medicines that we no longer use."
  - D. "I'm going to be sure that she doesn't see me taking any pills."



**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** Syrup of ipecac is no longer recommended for poisoning. The current guideline is to call Poison Control immediately. Statement B shows outdated and dangerous knowledge.

58. The nurse should determine that an infant is developmentally ready for the introduction of solid food when the infant
- A. can sit alone playing with toys for a few minutes.
  - B. \* no longer demonstrates the tongue extrusion reflex.
  - C. has been weaned from the bottle for two weeks.
  - D. tolerates solids from a bottle with a large nipple hole.

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** The tongue extrusion reflex (pushing food out) must be gone before starting solids, usually around 4–6 months. It indicates the infant is ready to handle solids safely.

59. Which of these goals of therapy should the nurse include in the care plan of a client who has second-stage Alzheimer's disease?
- A. \* The client will live comfortably within the limitations of the disease.
  - B. The client will increase sensitivity to the effect of the disease on others.
  - C. The client will engage in working through issues from past experiences.
  - D. The client will identify at least three personal strengths they self-identify.

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** In Stage 2 Alzheimer's, the focus is on comfort, safety, and adapting to cognitive decline. This goal is realistic and patient-centered.

60. A perimenopausal client wants to avoid using pharmacologic therapy for the relief of hot flashes. What is the best recommendation the nurse could give?
- A. psychologist
  - B. physical therapist
  - C. occupational therapist
  - D. \* homeopathic specialist

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** If the client prefers non-pharmacologic therapy, referral to a homeopathic specialist offers alternative treatments. The other options are not directly related to managing hot flashes.

61. A charge nurse is orienting a new nurse to the psychiatric unit and instructing the new nurse about caring for patients who are admitted on an involuntary basis. Which of the following statements by the new nurse would indicate understanding of the teaching?
- A. \* Care may be given without patient consent if a patient is a danger to self or others.
  - B. Voting rights of the patients are lost while they remain hospitalized on the unit in the hospital.
  - C. Phone privileges are suspended for patients admitted involuntarily in the hospital on the unit.
  - D. Court approval is required for a patient before the patient can be granted day passes off the unit.



**Domain 2: Ethics, Subdomain A: Ethics**

**Rationale:** Involuntary admission allows treatment without consent only if the patient poses a threat to self or others. This protects safety while upholding ethical care.

62. A patient's intravenous (IV) infusion of 500 mL of D5W with 25,000 units of heparin sodium is running at 12 mL/h. The order is for 700 units/h. Which task should the nurse perform first?
- A. Do nothing; the rate is correct.
  - B. \* Increase the rate to 14 mL/h.
  - C. Decrease the rate to 10 mL/h.
  - D. Decrease the rate to 7 mL/h.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** To deliver 700 units/hr from 500 mL with 25,000 units:

- $25,000 \div 500 = 50$  units/mL
- $700 \div 50 = 14$  mL/hr

63. Disclosure of confidential information by the nurse about a patient's condition is ethical and professional when the information is
- A. provided to law enforcement personnel.
  - B. \* shared with other health team members.
  - C. discussed in private with a family member.
  - D. provided to the employer of the patient.

**Domain 2: Ethics, Subdomain A: Ethics**

**Rationale:** Confidential information can ethically be shared only with staff involved in the patient's care to support treatment decisions and care coordination.

64. The nurse is instructing an adolescent who is receiving treatment for sickle cell crisis. Which measure should the nurse teach the adolescent to include in the daily routine to prevent a recurrence?
- A. Take multivitamins with iron.
  - B. Limit intake of clear fluids.
  - C. Maintain an aerobic exercise program.
  - D. \* Avoid a hot and humid environment.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** Heat and humidity cause dehydration and trigger sickle cell crises. Patients should be taught to avoid such environments to prevent recurrence.

65. Which of the following situations represent a violation of ethical rights in community and public health nursing? (Select all that apply.)
- A. \* sharing a patient's personal health information without consent
  - B. educating patients about their treatment options in their language
  - C. ensuring informed patient consent before a health procedure
  - D. \* coercing a community to participate in a health program
  - E. \* ignoring a patient's cultural beliefs when planning health interventions
  - F. \* providing different levels of care based on a patient's income



## Domain 2: Ethics, Subdomain A: Ethics

### Rationale:

A: Sharing health info without consent violates confidentiality.

D: Coercing participation breaches autonomy.

E: Ignoring beliefs disrespects cultural competency.

F: Unequal care based on income breaches justice.

66. Which test is the best indicator of compliance with medication and dietary regimen in a client who has type 2 diabetes?
- A. strong glucose tolerance
  - B. fasting blood glucose
  - C. capillary blood glucose
  - D. \* glycosylated hemoglobin

## Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort

**Rationale:** HbA1c reflects average blood glucose over 2–3 months, offering the best indicator of long-term diabetes control and regimen adherence.

67. A public health nurse wants to do a research study on cardiovascular disease in male migrant farmworkers older than 50 years of age. The farm workers speak a different language than the nurse. Which of the following actions by the nurse violates ethical research practices?
- A. The public health nurse holds an informational session for potential research subjects and explains the details of the study using an interpreter from the public health department.
  - B. The public health nurse stores all physical patient data in a secure, locked location within the basement of the hospital and electronic patient data are secured within an encrypted external server.
  - C. \* The public health nurse tells the migrant farm workers that blood pressure and cholesterol screenings every two months are mandatory for continued employment.
  - D. The public health nurse ensures patients who are found to have hypertension or elevated cholesterol levels during screenings are referred to a provider for follow-up care.

## Domain 2: Ethics, Subdomain A: Ethics

**Rationale:** Coercing participation by threatening employment violates ethical research principles, especially informed consent and autonomy.

68. Which nursing assessment should be implemented for a client who has benign prostatic hypertrophy?
- A. \* Palpate the client's bladder for distention.
  - B. Ask if the client experiences flank pain.
  - C. Observe the color of the client's urine.
  - D. Measure the client's urinary specific gravity.

## Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination

**Rationale:** BPH can cause urinary retention. Palpating for bladder distention helps assess incomplete emptying or obstruction.

69. Which of the following actions would be considered an ethical violation by a nurse? The nurse
- A. comforts the patient by holding the patient's hand during a painful procedure while in outpatient surgery.



- B. completes a required competency on infection control practices in the hospital environment.
- C. refuses to sign as a witness of the consent, believing the surgeon failed to explain the procedure.
- D. \* shares the patient's information with another patient to support their grieving process.

**Domain 2: Ethics, Subdomain A: Ethics**

**Rationale:** This is a breach of confidentiality. Patient information must not be shared with others without consent, even with good intentions.

70. A patient who has had a stroke with right hemiplegia is drooling from the right side of the mouth. The best action for the nurse to take is to
- A. provide thick and thin fluids to evaluate the patient's ability to swallow.
  - B. \* refrain from giving anything by mouth until swallowing is evaluated.
  - C. place food in the right side of the patient's mouth when feeding.
  - D. lean the patient to the right to prevent aspiration when feeding.

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Stroke patients are at risk for aspiration. Swallowing must be assessed before any oral intake to ensure safety.

71. Which laboratory value for a patient with a full-thickness wound would be most important for the nurse to investigate further?
- A. hemoglobin 11 g/dL
  - B. \* albumin 2.5 g/dL
  - C. blood urea nitrogen 22 mg/dL
  - D. fasting blood glucose 115 mg/dL

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** Normal albumin is 3.5–5.0 g/dL. Low albumin indicates poor nutrition, which can impair wound healing.

72. Which measure(s) should be implemented in the care plan of a child who has acute bacterial meningitis? (Select all that apply.)
- A. \* Assure that broad-spectrum intravenous antibiotic coverage is initiated.
  - B. Limit fluid intake to decrease the likelihood of pulmonary edema.
  - C. \* Move child to a private room and initiate respiratory isolation.
  - D. \* Foster a calm, quiet environment to limit stimulation.

**Domain 8: Emergency & Disaster Management, Subdomain B: Critical Incidents**

**Rationale:**

- A: Broad-spectrum antibiotics are initiated immediately.
  - C: Isolation prevents transmission of droplet-spread infections.
  - D: Quiet environments reduce ICP and agitation.
73. A nurse is teaching a client about levodopa. Which statement, if made by the client, would indicate to the nurse that the teaching was effective?
- A. "Eating a high protein meal will help with absorption."
  - B. "Taking a multivitamin will counter effects of anemia."



- C. "If I miss a dose, I can take an extra pill the next time."
- D. \* "Chewing gum may help if I experience a dry mouth."

**Domain 4: Education & Research, Subdomain A: Education**

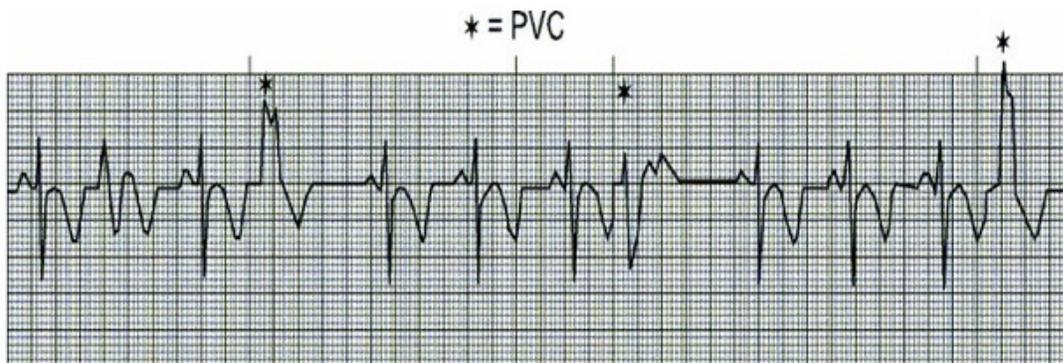
**Rationale:** Dry mouth is a common side effect of levodopa. Chewing gum stimulates saliva and helps relieve discomfort.

74. The nurse observes a nursing assistant caring for a 92-year-old patient who walks away and leaves the patient's bed rail down. After raising the rail, the nurse's most appropriate intervention would be to
- A. tell the nursing assistant openly in the hall that it is not appropriate.
  - B. add a safety order to the nursing care plan followed in the unit.
  - C. tell all nursing assistants in next meeting not to leave bed rails down.
  - D. \* talk privately with the nursing assistant about the inappropriate behavior.

**Domain 8: Emergency & Disaster Management, Subdomain B: Critical Incidents**

**Rationale:** Professionalism requires private correction of unsafe behavior to maintain dignity and promote learning.

75. The nurse is caring for a patient with a sudden onset of cardiac dysrhythmia as shown below. The nurse should consider which action as the highest priority before notifying the primary healthcare provider?



- A. administering atropine sulfate (Atropisol) PRN
- B. \* reviewing the current serum electrolyte values.
- C. preparing for insertion of a temporary pacemaker.
- D. documenting the results of the cardiac rhythm strip.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** Electrolyte imbalances (e.g., low  $K^+$  or  $Mg^{2+}$ ) are common causes of dysrhythmias and must be corrected before further interventions.

76. A patient who had a prostatectomy 24 hours ago is receiving continuous bladder irrigation (CBI). There is dark red urine in the drainage bag of the Foley catheter. What is the priority nursing action?
- A. Call the primary healthcare provider.
  - B. Obtain the patient's vital signs.
  - C. Obtain complete blood cell count.
  - D. \* Increase the patient's CBI flow rate.



**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** Dark red urine post-prostatectomy may indicate clot formation. Increasing the CBI rate helps flush clots and reduce bleeding risk.

77. A patient who is suspected of having bacterial meningitis arrives at the emergency department. Which action should the nurse take first?
- A. Complete a nursing history.
  - B. Obtain procedural vital signs.
  - C. Prepare for a lumbar puncture.
  - D. \* Place on droplet precautions.

**Domain 8: Emergency & Disaster Management, Subdomain B: Critical Incidents**

**Rationale:** Bacterial meningitis is highly contagious. Droplet precautions must be initiated immediately to prevent spread to others.

78. An older adult client reports decreased muscle strength and agility. Which intervention should the community health nurse suggest to improve client outcomes?
- A. Request a prescription for alendronate.
  - B. Increase calcium intake in the diet.
  - C. Use a walker when ambulating.
  - D. \* Begin a regular exercise plan.

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Regular exercise helps maintain strength, balance, and mobility, especially in older adults experiencing decline in agility.

79. A nurse sustains a needle-stick injury while preparing an injection. Which statement made by the nurse indicates a correct understanding of human immunodeficiency virus (HIV) transmission?
- A. "I would not have to worry if I had been wearing medical grade gloves."
  - B. \* "I don't have to worry about getting the virus because the needle is sterile."
  - C. "I will need to receive an injection of gamma globulin to prevent infection."
  - D. "I will have to be tested in 6 months to see if I've been exposed to the virus."

**Domain 2: Ethics, Subdomain A: Ethics**

**Rationale:** If the needle is sterile, there is no blood contamination, and therefore no risk of HIV transmission. The nurse correctly identifies the safety.

80. The mother of a 3-year-old child asks a nurse when it is appropriate to place her child in a booster seat. The best nursing response is that the child should
- A. \* be more than 40 lb (18 kg).
  - B. be five years of age or older.
  - C. be able to sit with feet dangling.
  - D. be taller than 4 ft (122 cm).

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** A booster seat is appropriate when the child reaches over 40 lb (18 kg), ensuring proper fit of the seat belt across the chest and hips, not the abdomen or neck.



81. When teaching a client about the adverse effects of codeine and ferrous sulfate, the nurse should encourage consumption of foods high in
- A. carbohydrates.
  - B. \* fiber.
  - C. protein.
  - D. calcium.

**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** Codeine and ferrous sulfate both commonly cause constipation. High-fiber foods help promote bowel movements and reduce this adverse effect.

82. A patient who is 6 hours postpartum informs the nurse that she is lightheaded and dizzy. Assessment reveals a weak pulse with a rate of 105 beats/min and blood pressure of 106/58 mmHg. The patient's skin is cool and pale in color. The nurse should
- A. obtain a glucose finger-stick.
  - B. auscultate the heart sounds.
  - C. apply a pulse oximeter.
  - D. \* palpate the uterine fundus.

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** Postpartum hemorrhage is a leading cause of maternal morbidity. Signs (dizziness, pallor, tachycardia) suggest hypovolemic shock. First step: assess for uterine atony via fundal palpation.

83. A nurse is planning care for a patient who has been admitted for alcohol detoxification. The most appropriate short-term goal for the patient would be to
- A. acknowledge the unhealthy effects of alcohol.
  - B. develop insight into the patient's illness.
  - C. identify personal strengths of the patient.
  - D. \* maintain physical integrity during withdrawal.

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** In early alcohol detox, the priority is physiological safety, preventing seizures, falls, or injury from withdrawal symptoms.

84. Which instruction should the nurse provide to a parent about ways to comfort a newborn after a painful heel stick?
- A. \* "Swaddle the newborn."
  - B. "Administer paracetamol."
  - C. "Apply an anesthetic to heel."
  - D. "Provide with visual distractions."

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** Swaddling promotes comfort and decreases pain perception in newborns after minor procedures like heel sticks.

85. A client in a support group has a hearing loss. The group asks the nurse how to improve communication with the client. Which response by the nurse is most appropriate?
- A. "Write down on paper what you want to say."
  - B. "Speak loudly while using expressive body language."
  - C. \* "Speak in short sentences while facing the client."
  - D. "Have the person next to the client repeat what is said."



**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain A: Patient & Family Advocacy**

**Rationale:** Facing the client and using short sentences helps with lip reading and auditory comprehension in those with hearing loss.

86. Alendronate sodium is prescribed for a client. The nurse should educate the client to
- A. take the medication before going to bed.
  - B. change positions slowly to prevent dizziness.
  - C. take the medication with food at every meal.
  - D. \* remain upright for 30 minutes after medication.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Alendronate can cause esophageal irritation. Upright positioning reduces the risk of esophagitis or ulceration.

87. The nursing care plan for a patient who dislikes other people and satisfies a need for power and control by manipulating others should include which of these interventions?
- A. \* Maintain clear and consistent limits with the patient.
  - B. Demonstrate warmth and defend the patient when in trouble.
  - C. Delegate control and support the actions of the patient.
  - D. Trust the patient and provide opportunities for leadership.

**Domain 3: Leadership & Personal Responsibility, Subdomain B: Colleagues & Work Environment**

**Rationale:** Patients who manipulate others need firm boundaries to prevent disruptive behavior and establish therapeutic rapport.

88. A patient has a blood pressure of 230/140 mmHg. The primary care provider prescribes sodium nitroprusside by intravenous infusion. A charge nurse observes a staff nurse performing all of these actions while caring for the patient. Which one would require immediate intervention by the charge nurse?
- A. covering the patient's infusion with aluminum foil
  - B. placing the patient's body in a semi-Fowler's position
  - C. preparing to insert an indwelling urethral (Foley) catheter
  - D. \* allowing the patient to sit on the side of the stretcher

**Domain 3: Leadership & Personal Responsibility, Subdomain B: Colleagues & Work Environment**

**Rationale:** The charge nurse must immediately intervene because allowing the patient to sit upright while receiving IV sodium nitroprusside creates an immediate fall and hypotension risk.

89. Which of the following statements about morals and values in nursing is true and accurate?
- Nurses should
- A. \* be self-aware of their own morals and values to understand those of their patients better.
  - B. only concern themselves with what is moral and ethical according to the law of the state in which they reside.
  - C. immediately request a different patient assignment when they do not agree with a patient's morals or values.
  - D. change a patient's values and beliefs if that patient believes something that is morally wrong.



**Domain 3: Leadership & Personal Responsibility, Subdomain A: Personal Traits untreated long-standing hyperparathyroidism**

**Rationale:** Self-awareness allows nurses to remain nonjudgmental and provide patient-centered care even when values differ.

90. A novice nurse working on a medical-surgical unit suspects an elderly patient who lives with her daughter is a victim of elder abuse. What is the BEST action for the nurse to take at this time?
- A. Call the police station and file a police report, listing the suspected abuse.
  - B. \* Notify the nurse manager or nursing supervisor of the suspected abuse.
  - C. Confront the patient's daughter the next time she comes to visit her mother.
  - D. Ask another nurse to switch patients due to the serious nature of the concerns.

**Domain 3: Leadership & Personal Responsibility, Subdomain B: Colleagues & Work Environment**

**Rationale:** Suspected elder abuse must be reported according to institutional policy, starting with the chain of command.

91. The school nurse is planning substance abuse prevention activities for the month. A primary prevention activity that the nurse would include in the program would be
- A. conducting in-school smoking cessation classes.
  - B. performing periodic drug testing on students.
  - C. providing students after-school addiction treatments.
  - D. \* teaching sessions on tobacco use health hazards.

**Domain 3: Leadership & Personal Responsibility, Subdomain C: Health Policy**

**Rationale:** Primary prevention aims to stop disease before it occurs. Teaching about hazards is preventive education.

92. The nurse instructs a patient who has had a total knee replacement to take acetylsalicylic acid (aspirin) once a day after discharge. Which of the following patient statements best indicates that the patient understands why the aspirin was prescribed for him?
- A. \* "Aspirin will help to prevent blood clots."
  - B. "Aspirin will control any inflammation."
  - C. "I'll be taking aspirin to relieve my joint pain."
  - D. "I'll take aspirin if I develop a high fever."

**Domain 4: Education & Research, Subdomain A: Education**

**Rationale:** Post-op patients are at risk for DVT/PE. Low-dose aspirin helps inhibit platelet aggregation, reducing the risk of clotting.

93. Which of the following statements is true and accurate about quantitative research? Quantitative research
- A. examines the thoughts and feelings of those participating in the study.
  - B. collects data in a way that yields subjective and biased data in the research.
  - C. is rarely used in nursing research studies due to the nature of the patient.
  - D. \* is based on numeric data and often supports evidence-based practice changes.

**Domain 4: Education & Research, Subdomain B: Research and Data**

**Rationale:** Quantitative research uses measurable variables and statistics, forming the basis for evidence-based practice.



94. After a teaching session with a nurse, a patient learns that smoking increases the risk of type 2 diabetes and the risk of various diabetes complications, such as heart disease and stroke. In which domain did learning take place? Learning has occurred in the
- A. kinesthetic domain.
  - B. \* cognitive domain.
  - C. affective domain.
  - D. psychomotor domain.

**Domain 4: Education & Research, Subdomain A: Education**

**Rationale:** Learning facts and understanding risks (e.g., smoking and diabetes) represents the cognitive (thinking) domain.

95. A nurse is teaching a post-operative client how to do breathing exercises. Which of the following observations best indicates that learning has occurred in the psychomotor domain? The patient
- A. verbalizes to the nurse five signs and symptoms of post-operative infection.
  - B. \* successfully demonstrates post-operative deep breathing to the nurse.
  - C. watches a video about how to perform post-operative breathing exercises.
  - D. reads a pamphlet on the importance of post-operative breathing exercises.

**Domain 4: Education & Research, Subdomain A: Education**

**Rationale:** Psychomotor domain involves doing a skill. Demonstrating breathing exercises is a behavioral change from learning.

96. Which of the following best describes evidence-based practice (EBP) in nursing?
- A. Relying on personal experience, insight, and intuition to make appropriate clinical decisions.
  - B. \* Using the most validated research, clinical expertise, and patient preferences to guide nursing care.
  - C. Following hospital policies and procedures without considering new innovative research.
  - D. Implementing only physician-recommended treatments without questioning their effectiveness.

**Domain 4: Education & Research, Subdomain B: Research and Data**

**Rationale:** EBP combines research evidence, clinical expertise, and patient preferences to guide safe, effective care.

97. What is the primary purpose of Electronic Health Records (EHRs) in nursing?
- A. to replace nurses and health professionals in patient care
  - B. \* to facilitate better documentation and patient safety
  - C. to increase in-patient and out-patient hospital expenses
  - D. to limit all patient access to any of their health records

**Domain 5: Technology & Innovation, Subdomain A: Technology & Innovation**

**Rationale:** EHRs improve communication, reduce errors, and allow for accurate, timely charting, enhancing safety.

98. Which of the following is an advantage of using telehealth in nursing care?
- A. reduces patient access to their health care
  - B. increases patient wait times for consultations
  - C. \* improves patient access to health care
  - D. eliminates the need for physical examinations



**Domain 5: Technology & Innovation, Subdomain A: Technology & Innovation**

**Rationale:** Telehealth enables remote care, especially for patients in rural or underserved areas, thereby improving access.

99. In medication administration, which action helps prevent medication errors?
- A. \* using Barcode scanning system
  - B. printing the prescription order
  - C. obtaining verbal medication orders
  - D. using manual transcription

**Domain 5: Technology & Innovation, Subdomain A: Technology & Innovation**

**Rationale:** Barcode scanning ensures 5 rights (right med, dose, time, etc.), reducing medication administration errors.

100. What is the role of artificial intelligence (AI) in modern nursing practice?
- A. replacing nurses in all aspects of care
  - B. \* assisting in clinical decision-making
  - C. eliminating the need for human assessment
  - D. reducing the need for medical research

**Domain 5: Technology & Innovation, Subdomain A: Technology & Innovation**

**Rationale:** AI can analyze large data sets quickly to support diagnosis, risk prediction, and decision support tools.

101. A patient receiving a continuous infusion of morphine sulfate continues to have pain. The nurse should (Select all that apply.)
- A. \* assess the patient's pain.
  - B. increase the rate of infusion.
  - C. \* check the infusion site.
  - D. consult with the pharmacist.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:**

**A:** Pain assessment is the first step before any action.

**C:** Check infusion site for patency or infiltration, especially if pain is uncontrolled.

102. A nurse encourages early ambulation for a patient who had a hysterectomy 1 day ago. Before the patient ambulates, the nurse should anticipate performing which action?
- A. checking the 24-hour intake and output
  - B. \* premedicating with PRN pain medication
  - C. asking a physical therapist to assist
  - D. using assistive devices on the unit

**Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort**

**Rationale:** Pain can impede ambulation; giving meds beforehand promotes mobility and patient cooperation.

103. After a patient has a coronary angiogram, the nurse should assess peripheral circulation by palpating the pulse at which point?
- A. carotid
  - B. brachial



- C. femoral
- D. \* dorsal

**Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort**

**Rationale:** The dorsalis pedis pulse is used to assess distal circulation after femoral artery access during angiogram.

104. Which is the best action the nurse should take when caring for a patient at risk of developing glomerulonephritis?
- A. \* Obtain a throat culture if a sore throat is reported.
  - B. Obtain a urine culture if abdominal pain is reported.
  - C. Monitor the patient for bladder distention.
  - D. Assess for signs of flank pain and tenderness.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** Strep infections can lead to glomerulonephritis. A throat culture identifies the precipitating cause.

105. Which action should the nurse take to reduce hoarseness in a patient recovering from a thyroidectomy?
- A. Instruct the patient to take ice chips frequently.
  - B. Offer the patient frequent gargles with a saline solution.
  - C. \* Discourage the patient from any unnecessary talking.
  - D. Apply lidocaine spray to the patient's throat every 4 hours.

**Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort**

**Rationale:** Voice rest reduces strain on vocal cords and prevents hoarseness from recurrent laryngeal nerve irritation.

106. The nurse should assess a client who has a retinal detachment for
- A. tunnel vision at dawn and dusk.
  - B. loss of central vision in either eye.
  - C. \* a curtain obscuring the client's vision.
  - D. black spots in the client's visual field.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** A "curtain" or shadow-like loss of vision is a classic sign of retinal detachment.

107. A patient with acute asthma has increased dyspnea, bilateral wheezing, and oxygen saturation (SaO<sub>2</sub>) level of 93%. Which nursing action is most appropriate?
- A. Teach the use of fluticasone propionate.
  - B. \* Administer albuterol inhaler to patient.
  - C. Increase the oxygen flow rate to 8 L/min.
  - D. Instruct slow, deep open mouth breaths.

**Domain 8: Emergency & Disaster Management, Subdomain A: Emergency & Disaster Management**

**Rationale:** Albuterol is a bronchodilator used to treat acute bronchospasm in asthma.

108. The nurse instructs a patient who has tonic-clonic seizures about home care. Which statement by the patient indicates to the nurse a correct understanding of the information?
- A. \* "I will avoid flashing video, television, and computer screens."



- B. "I will take antiseizure medication until my seizures subside."
- C. "I will limit intake of foods with protein and moderate sugar."
- D. "I will take tub baths instead of showers because it is safer."

**Domain 4: Education & Research, Subdomain A: Education**

**Rationale:** This statement indicates correct understanding because flashing or flickering lights can trigger seizures, especially in patients with photosensitive epilepsy. Avoiding these stimuli helps reduce the risk of seizure occurrence.

109. Which assessment finding should the nurse expect for a patient with a serum potassium level of 2.8 mEq/L?
- A. \* irregular pulse
  - B. abdominal cramps
  - C. dry mucous membranes
  - D. postural hypotension

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** Hypokalemia (K+ 2.8) can cause cardiac arrhythmias, reflected as irregular heart rhythms.

110. A patient with acute cholecystitis reports severe abdominal pain. The nurse should administer meperidine hydrochloride and implement which intervention?
- A. Set up bedside suction.
  - B. Apply a cardiac monitor.
  - C. \* Conduct fall risk assessment.
  - D. Perform a bladder scan.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Meperidine is an opioid that may cause dizziness or sedation. Assessing fall risk is a safety priority.

111. What is the most appropriate benefit of robotic-assisted technology in nursing practice?
- A. replaces nurses in performing all clinical procedures
  - B. improves interventions with frequent nurse and patient interactions
  - C. \* supports nurses in repetitive and physically demanding tasks
  - D. limits patient interaction to free up more time for documentation

**Domain 5: Technology & Innovation, Subdomain A: Technology & Innovation**

**Rationale:** Robotics can help with lifting, moving, or surgical assistance, reducing nurse fatigue.

112. Which of the following interventions should be added to the nursing care plan for a patient who has difficulty swallowing after a stroke?
- A. Serve food to patients at room temperature.
  - B. \* Thicken liquids for patients before feeding.
  - C. Rearrange head of bed to 180° during feedings.
  - D. Place food as far back in the mouth as possible.

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Thickened liquids reduce the risk of aspiration in patients with dysphagia post-stroke.

113. A hospitalized infant being treated for gastroenteritis is started on oral feedings of clear liquids. Within an hour of the feeding, the infant has three frequencies of watery stools. Which of these actions should



the nurse take initially?

- A. Weigh the infant immediately.
- B. \* Stop the infant's oral feedings.
- C. Dilute clear liquids with sterile water.
- D. Check the characteristics of the stool.

**Domain 6: Health Promotion & Maintenance, Subdomain A: Reproduction, Pregnancy, & Well-Child Care**

**Rationale:** Increased diarrhea suggests intolerance. First action: stop feeds to prevent further fluid loss.

114. To determine if a patient's recurrent laryngeal nerve has been damaged following a thyroidectomy, the nurse should assess for
- A. frequency of swallowing.
  - B. dryness of oral mucosa.
  - C. strength of mandibular muscles.
  - D. \* ability of speaking.

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Damage to the recurrent laryngeal nerve can cause voice changes or hoarseness.

115. A goal of nursing care for a patient who has untreated long-standing hyperparathyroidism is to
- A. minimize physical activity.
  - B. control environmental stimulation.
  - C. \* prevent pathological fractures.
  - D. decrease sodium intake.

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Chronic hyperparathyroidism leads to bone resorption, increasing fracture risk.

116. A patient is scheduled for a below-the-knee (BK) amputation. When discussing the consent form signature with the patient, the nurse offers the patient to ask questions about the procedure. Based on the patient's lack of understanding of the procedure, which of these actions by the nurse is appropriate?
- A. Ignore the patient's concerns about the surgery.
  - B. Provide diversional activities to allay fears.
  - C. \* Provide further explanation regarding the surgery.
  - D. Describe the details of postop care to the patient.

**Domain 6: Health Promotion & Maintenance**

**Rationale:** Consent is not valid if the patient doesn't understand. It's the provider's role to re-explain the procedure.

117. Which of these instructions should be given at the time a patient is discharged from the hospital following a hysterectomy and bilateral oophorectomies?
- A. "Limit your fluid intake for tomorrow."
  - B. "Avoid extremes of temperature tonight."
  - C. "Get 10 hours of restful sleep each night."
  - D. \* "Increase intake of calcium-rich foods."



### Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination

**Rationale:** Removal of ovaries reduces estrogen, which can lead to bone loss. Calcium supports bone health.

118. The nurse is taking a sleep history from a client who has a new onset of insomnia. Which question should the nurse ask first?
- A. \* "How have your sleep patterns changed?"
  - B. "Do you take naps during the day?"
  - C. "Is your bedroom peaceful in the evening?"
  - D. "Have you taken any steps to improve sleep?"

### Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation

**Rationale:** First step in sleep assessment is understanding the baseline vs current patterns.

119. The nurse is caring for a patient who has a central venous catheter. The catheter disconnects from the intravenous (IV) tubing during morning care, and the nurse suspects that an air embolism has occurred. The nurse should immediately place the patient in which position?
- A. supine, with the head higher in the bed than the feet
  - B. \* on the left side, with the feet higher than the head
  - C. Trendelenburg position, with head higher than feet
  - D. prone position, lying on their back, with head raised

### Domain 8: Emergency & Disaster Management, Subdomain B: Critical Incidents

**Rationale:** When an air embolism is suspected (which can occur if a central venous catheter becomes disconnected), positioning the patient properly is a critical emergency intervention. The goal is to trap the air bubble in the right side of the heart and prevent it from entering the pulmonary circulation, where it can cause a pulmonary embolism or obstruct blood flow.

120. A patient who sustained a head injury has a doll's eye reflex. Which action should the nurse take first?
- A. Continue to monitor the eyes and document.
  - B. Place the patient on the right side of the bed.
  - C. \* Notify the primary healthcare provider of the finding.
  - D. Cover eyes with gauze moistened with saline solution.

### Domain 6: Health Promotion & Maintenance, Subdomain C: End of life Care

**Rationale:** Doll's eyes reflex (absent oculocephalic reflex) suggests brainstem dysfunction, requiring immediate evaluation.

121. Which task(s) should the nurse perform when obtaining informed consent for surgery?  
(Select all that apply.)
- A. \* Witness the signature of the patient.
  - B. Explain the procedure to the patient.
  - C. \* Verify understanding of the procedure.
  - D. \* Verify consent signature given willingly.

### Domain 2: Ethics, Subdomain A: Ethics

**Rationale:**

- A: Nurse must witness the signature.
- C: Nurse ensures patient understands procedure.
- D: Consent must be given voluntarily.



122. Which question is most appropriate for a nurse to ask a child's parents to determine their child's risk for poisoning?
- A. \* "Where are your cleaning supplies usually stored at home?"
  - B. "How many hours does your child sleep during the night?"
  - C. "What kinds of outdoor games does your child often play?"
  - D. "Does your child have any problems making new friends?"

**Domain 1: Patients, Families, Communities, & Professionalism, Subdomain B Population Health**

**Rationale:** The most common poisoning in children is due to household chemicals. Storage location is a key risk factor.

123. The nurse is discussing home care with the adult son of an elderly mother who has had a fractured hip repaired. The client's child demonstrates a correct understanding of the nurse's instructions by making which statement(s)? (Select all that apply.)
- A. "I will clean and polish all my mother's floors and furniture for her."
  - B. \* "I will remove all the small area rugs from my mother's home."
  - C. "I will buy a long, warm robe for my mother to wear at home."
  - D. \* "I will buy some night-lights for my mother's bedroom and hallway."

**Domain 4: Education & Research, Subdomain A: Education**

**Rationale:**

**B:** Small area rugs increase the risk of tripping and falling, especially in elderly patients recovering from hip surgery, so removing them helps prevent falls.

**D:** Night-lights improve visibility during nighttime movements in the bedroom and hallway, reducing the risk of falls.

124. A patient who is in treatment for panic disorder is confronted with a new situation while in group therapy. The patient begins to sweat and shake, is short of breath, and has palpitations. Which immediate nursing action would be most appropriate?
- A. Instruct the patient with a commanding tone.
  - B. \* Accompany the patient to the patient's room.
  - C. Use guided imagery as a relaxation technique.
  - D. Explain that it is necessary to control one's fears.

**Item Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Taking the patient to a quieter, private setting helps reduce stimuli that can worsen panic symptoms and allows the nurse to provide focused support.

125. A patient is admitted from home with weakness on the left side. The patient displays right-sided facial drooping and drooling. The primary healthcare provider's orders include continuing the patient's home medications. Which action by the nurse is most appropriate?
- A. Administer medications with small sips of filtered water.
  - B. Crush medications and administer them in applesauce.
  - C. \* Hold medications and obtain an order for a swallowing evaluation.
  - D. Administer medications if able to swallow without coughing.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** The patient shows signs of potential swallowing difficulty, so holding medications and obtaining a swallowing evaluation prevents aspiration and choking.



126. A client has started taking a selective serotonin reuptake inhibitor. Which information about the medication should the nurse provide to the client?
- A. "Take the medication as needed but only up to 3 times daily during the week."
  - B. \* "The medication has minor side effects that usually improve within 2 to 3 days."
  - C. "You should experience a positive effect from the medication within 24 hours."
  - D. "You can stop taking the medication when you feel better for a solid 6 months."

**Domain 4: Education & Research, Subdomain A: Education**

**Rationale:** SSRIs often cause mild side effects initially, which usually improve within 2 to 3 days as the body adjusts to the medication.

127. A patient who is in cardiogenic shock is receiving an intravenous (IV) infusion of dopamine hydrochloride. Which finding would best indicate to the nurse that the medication is achieving the desired therapeutic effect?
- A. absence of a heart arrhythmia
  - B. presence of adventitious breath sounds
  - C. a pulse oximetry reading of 85%
  - D. \* a capillary refill time of less than 3 seconds

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** A capillary refill time under 3 seconds indicates improved peripheral perfusion, showing that dopamine is effectively enhancing cardiac output.

128. An adult client with depression is to begin treatment with tranylcypromine sulfate, a monoamine oxidase inhibitor (MAOI). Which nursing measure should be carried out before starting the MAOI?
- A. weighing the client before treatment
  - B. checking results of a complete blood cell count
  - C. finding out if the client had a quantitative sweat test
  - D. \* taking the client's blood pressure

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** MAOIs can cause hypertensive crises; therefore, baseline blood pressure measurement is crucial before starting treatment.

129. A patient had hip replacement surgery. Which instruction should the nurse give to the patient to decrease the risk of deep vein thrombosis?
- A. \* "Perform bilateral plantar flexion and extension exercises every hour."
  - B. "Keep a pillow under the unaffected knee while in bed."
  - C. "Maintain the affected extremity in a neutral position."
  - D. "Prevent flexion of the extremities while sitting upright."

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Performing bilateral plantar flexion and extension exercises promotes blood circulation in the legs, reducing the risk of deep vein thrombosis after hip surgery.

130. Which instruction about how to safely improve mobility should the nurse give a client who has Parkinson's disease and is concerned about falling while walking?
- A. "Use short strides when walking."
  - B. "Watch your feet when walking."
  - C. \* "Walk with a wide-based gait."
  - D. "Use toe-heel walking method."



**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** A wide-based gait increases stability and balance for patients with Parkinson's disease, lowering the risk of falls.

131. A nurse should recognize which finding in a client who has a spinal cord injury that indicates the development of autonomic dysreflexia?
- A. \* sudden onset headache
  - B. absence of reflexes below injury
  - C. shortness of breath
  - D. pale, dry skin above the injury

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** Sudden severe headache is a classic symptom of autonomic dysreflexia, signaling dangerously high blood pressure that requires immediate intervention.

132. Which practice(s) should a nurse include in the care of a client with an arteriovenous fistula for hemodialysis? (Select all that apply.)
- A. \* Assess pulses distal to the fistula.
  - B. \* Auscultate over access site for a bruit.
  - C. Monitor the client's blood pressure.
  - D. \* Palpate the access site for a thrill.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:**

**A:** Assessing distal pulses ensures that the fistula is not compromising blood flow to the hand or distal extremity.

**B:** Auscultating for a bruit confirms that the fistula is patent and functioning properly.

**D:** Palpating for a thrill over the fistula site checks for normal vibration, which indicates adequate blood flow through the access.

133. After receiving the shift report, the nurse should first provide care for which of the four patients below?
- A. a patient with postoperative pain medication.
  - B. a patient with hemorrhoids with blood in stool.
  - C. a patient who has reported nausea.
  - D. \* a patient with new onset of delirium.

**Domain 7: Physiological Integrity, Subdomain C: Physical Adaptation**

**Rationale:** New onset delirium represents an acute neurological change that can signal serious underlying issues requiring immediate attention.

134. A patient is admitted to the hospital with hepatitis A infection. Which instruction should the nurse give to the patient about preventing transmission to others?
- A. "Avoid donating blood until the physician approves you to."
  - B. "Avoid taking medications that are toxic to the liver."
  - C. "Advise the primary caregiver to avoid respiratory contact."
  - D. \* "Advise your family to receive the immune globulin vaccine."



**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Family members of a patient with hepatitis A should receive immune globulin to prevent transmission due to the virus's high contagiousness.

135. Which of these actions should a nurse take first when initiating cardiopulmonary resuscitation?
- A. \* Determine responsiveness.
  - B. Palpate carotid pulse.
  - C. Begin chest compressions.
  - D. Monitor respirations.

**Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort**

**Rationale:** Determining responsiveness is the first step in CPR to assess the patient's status before proceeding with further interventions.

136. A patient who is being treated for cancer develops anorexia. Which of these nursing measures would be appropriate to improve the patient's appetite?
- A. giving the heaviest calorie-rich meal at the end of the day
  - B. \* providing a quiet, pleasant atmosphere at mealtimes
  - C. offering foods that are smooth textured and soft
  - D. encouraging fluid intake between each bite of food

**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** A quiet, pleasant atmosphere helps improve the patient's appetite by reducing stress and creating a comfortable eating environment.

137. When changing a patient's abdominal dressing, a nurse observes that the wound is dehisced, and a small portion of the bowel is eviscerated. Which of these actions should the nurse take first?
- A. \* Apply a sterile saline dressing over the wound.
  - B. Place a pressure dressing over the wound.
  - C. Report the findings to the primary care provider.
  - D. Irrigate the wound with diluted hydrogen peroxide.

**Domain 7: Physiological Integrity, Subdomain A: Basic Care & Comfort**

**Rationale:** Applying a sterile saline dressing over an eviscerated wound keeps the bowel moist and prevents infection until surgical repair can be done.

138. A patient who has had a cerebrovascular accident has right-sided hemiplegia and dysphagia. Which of these measures should the nurse incorporate into the patient's feeding care plan?
- A. Give the patient liquid foods through a syringe in the mouth.
  - B. Position the patient on the right side of the bed during feedings.
  - C. Stand on the patient's right side of the bed when feeding.
  - D. \* Place the food in the left side of the patient's mouth.

**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** Placing food in the unaffected (left) side of the mouth facilitates safer swallowing for a patient with right-sided weakness after a stroke.

139. A patient who had a surgical reduction of a fractured femur reports chest pain and dyspnea. In addition to calling the primary care provider, a nurse should initially
- A. \* administer prescribed oxygen to the patient.
  - B. give prescribed pain medication to the patient.



- C. instruct the patient to deep breathe and cough.
- D. call the laboratory for the latest blood gas results.

**Domain 8: Emergency & Disaster Management, Subdomain B: Critical Incidents**

**Rationale:** Administering oxygen is a priority for a patient with chest pain and dyspnea to ensure adequate tissue oxygenation, especially when a fat embolism is suspected.

140. A Red Cross nurse works at an emergency shelter set up in a high school gymnasium following a series of devastating tornadoes in a local community. The nurse expects to document nursing care of patients seen in this shelter in which of the following ways?
- A. The nurse will record on the shelter's electronic health record the details provided to patients.
  - B. \* The nurse will set up and maintain paper charts for patients seen in the shelter.
  - C. The nurse will provide care to patients in shelters but is not required to document nursing care.
  - D. The nurse will use a personal laptop to document nursing care provided to patients in the shelter.

**Domain 8: Emergency & Disaster Management, Subdomain A: Emergency & Disaster Management**

**Rationale:** In emergency shelters, electronic systems are often unavailable, so maintaining paper charts ensures proper documentation of patient care.

141. Four patients have recently entered the emergency shelter following an earthquake. Which patient will the nurse see first?
- A. A 22-year-old female with a history of cerebral palsy is in her wheelchair, and she complains of a sore back.
  - B. A 45-year-old man was hit with a piece of flying debris and has a superficial bleeding wound on his right lower extremity.
  - C. \* A 15-year-old girl with a history of asthma is short of breath and using her accessory muscles to breathe.
  - D. A 70-year-old man has reported to a nurse that he is diabetic and has not yet taken his insulin today.

**Domain 8: Emergency & Disaster Management, Subdomain A: Emergency & Disaster Management**

**Rationale:** Respiratory distress with accessory muscle use is life-threatening and requires immediate nursing attention.

142. A homeless barefooted patient presents to the emergency department during a winter storm with mottled, bluish white bilateral lower extremities. Which action would be most appropriate for the nurse to take?
- A. massaging the patient's lower extremities
  - B. encouraging the patient to ambulate
  - C. placing elastic compression stockings lower extremities
  - D. \* placing the patient's lower extremities in warm water

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Warm water helps restore circulation in frostbitten extremities, reducing tissue damage and promoting recovery.

143. Which nursing measure has the highest priority when home care is provided for an older adult who is taking medication?
- A. Instruct the patient to discontinue use of patient's vitamin use.
  - B. Provide the patient with some tips on not missing the doses.
  - C. \* Recommend to the client the environmental safety strategies.



D. Assess the patient's financial resources by talking with family.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Environmental safety strategies help prevent medication errors and falls in older adults taking multiple medications at home.

144. A patient is admitted to the hospital with severe renal colic due to renal calculi. Which nursing intervention should be implemented first?
- A. Instruct the patient to strain all their urine.
  - B. Assess for an elevated temperature immediately.
  - C. \* Administer an analgesic medication as ordered.
  - D. Encourage the patient to increase fluid intake.

**Domain 7: Physiological Integrity, Subdomain E: Human Nutrition & Elimination**

**Rationale:** Pain relief is the immediate priority in patients with renal colic to manage severe discomfort effectively.

145. A community health nurse is prioritizing patient needs due to a major weather emergency expected to hit her area. Flooding and long-term power outages are anticipated. Which of the following patients will receive the highest priority on her list?
- A. a 65-year-old male who lives alone in his home and ambulates independently with a cane
  - B. a 30-year-old diabetic female who is 24 weeks pregnant and lives with her husband; they have a generator
  - C. \* a 62-year-old man with emphysema who is homebound and oxygen dependent, requiring a power source
  - D. a 32-year-old female with multiple sclerosis who is wheelchair bound and lives with her parents

**Domain 8: Emergency & Disaster Management, Subdomain A: Emergency & Disaster Management**

**Rationale:** A patient dependent on oxygen and requiring power is at greatest risk during power outages and must be prioritized.

146. Which of the following factors impact the emergency response of a community to an infectious disease/agent? (Select all that apply.)
- A. \* The rate of the spread of the infection in the community and area.
  - B. \* The readiness of adequate nurse and healthcare staffing in hospital.
  - C. The availability of media reports of daily deaths related to an infection.
  - D. \* The accessibility of personal protective equipment (PPE) for safety.
  - E. \* The accessibility of hospital beds and essential medical equipment

**Domain 8: Emergency & Disaster Management, Subdomain A: Emergency & Disaster Management**

**Rationale:**

**A:** The speed of infection spread directly impacts the urgency and scope of the emergency response needed.

**B:** Adequate healthcare staffing is essential for managing increased patient loads during an infectious disease outbreak.

**D:** Access to personal protective equipment is vital to protect healthcare workers and prevent disease transmission.

**E:** Availability of hospital beds and equipment determines the capacity to care for infected patients effectively.



147. A nurse is caring for a patient who had a cesarean delivery 2 hours ago. Which order should the nurse question?
- A. Discontinue the Foley catheter on postpartum day 1.
  - B. \* Ambulate with assistance for 4 hours after surgery.
  - C. Administer cefazolin sodium every 8 hours for 24 hours.
  - D. Repeat the complete blood cell count in 8 hours.

**Domain 6: Health Promotion & Maintenance, Subdomain A**

**Rationale:** Ambulating 4 hours post-cesarean may be too soon and unsafe; such orders should be questioned for patient safety.

148. While assessing a client receiving oral anticoagulant therapy in the homecare setting, the nurse observes bleeding gums. Which nursing action would be most appropriate?
- A. \* Obtain an order for an international normalized ratio.
  - B. Send the client to the emergency department.
  - C. Instruct the client to use a medium-bristle toothbrush.
  - D. Encourage the client to gargle with saltwater.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Bleeding gums suggest possible over-anticoagulation; checking the INR helps evaluate coagulation status and adjust therapy.

149. If digoxin is achieving its primary desired effect for a client with congestive heart failure, the nurse should expect to obtain which finding in the client?
- A. \* Decrease in pulse rate.
  - B. Increase in pulse deficit.
  - C. Distention of neck veins.
  - D. Lowering of blood pressure.

**Domain 7: Physiological Integrity, Subdomain B: Pharmacological & Parenteral Therapies**

**Rationale:** Digoxin improves cardiac contractility and often results in a slower, more efficient heart rate in heart failure patients.

150. Which instruction for home management should a nurse give to a client who has osteoporosis?
- A. \* "Continue with your walking program."
  - B. "Limit lower-extremity weight bearing."
  - C. "Increase your dietary intake of protein."
  - D. "Schedule daily rest periods after lunch."

**Domain 6: Health Promotion & Maintenance, Subdomain B: Adult Care & Rehabilitation**

**Rationale:** Weight-bearing exercise, such as walking, helps maintain bone density and slows the progression of osteoporosis.