

Silvestri: Saunders Comprehensive Review for the NCLEX-RN® Examination, 5th Edition

Fundamentals and Issues of Nursing

Test Bank

MULTIPLE CHOICE

1. The nurse has a prescription to give ear drops to a 2-year-old child. The nurse positions the child's ear properly by pulling the pinna of the ear:
 1. Upward and outward
 2. Downward and outward
 3. Downward and backward
 4. Upward and backward

ANS: 3

Rationale: To administer ear drops properly to a child who is younger than 3 years old, the pinna of the ear should be pulled downward and backward. When giving ear drops to a child older than 3 years, the pinna is pulled upward and backward (“upward and backward”). The other options are incorrect.

Test-Taking Strategy: Use basic principles of administering otic medications to answer this question. Note the age of the child to direct you to the correct option. Remember in a child who is younger than 3 years old, the pinna of the ear should be pulled downward and backward. If this question was difficult, review the procedure for administering ear drops to children.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). Maternal child nursing care (4th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

2. A client who was receiving enteral feedings in the hospital has been started on a regular diet and is almost ready for discharge. The client will be self-administering supplemental tube feedings between meals for a short time after discharge. When the client expresses concern about his or her ability to perform this procedure at home, the nurse would best respond with which of the following?
 1. “Tell me more about your concerns about going home.”
 2. “Do you want to stay in the hospital a few more days?”
 3. “Maybe a friend will do the feeding for you.”
 4. “Have you discussed your feelings with your family and doctor?”

ANS: 1

Rationale: A client often has fears about leaving the secure environment of a health care facility. This client has a specific fear about not being able to handle tube feedings at home. An open communication statement such as “Tell me more about...” often leads to valuable information about the client and his or her concerns. “Maybe a friend will do the feeding for you.” and “Have you discussed your feelings with your family and doctor?” are nontherapeutic responses because they place the client’s issues on hold. “Do you want to stay in the hospital a few more days?” is beyond the scope of practice for the nurse to implement and may not be necessary.

Test-Taking Strategy: Use therapeutic communication techniques to answer the question. “Tell me more about your concerns about going home.” focuses on the client’s feelings. Remember to address the client’s feelings first. Review therapeutic communication techniques if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders. | Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Communication and Documentation

3. The nurse is administering enteral feedings via a nasogastric (NG) tube. The nurse should do which of the following when caring for this client to maintain client safety?
1. Keep the client in a supine position.
 2. Change the NG tube with every other feeding.
 3. Check for tube placement and residual amount at least every 4 hours.
 4. Increase the rate of the feeding if the infusion falls behind schedule.

ANS: 3

Rationale: NG tube feedings are beneficial but present possible complications such as diarrhea, lactose intolerance, dumping syndrome, or excess fluid volume. The most common complication is aspiration pneumonia caused by regurgitation of formula contents from the stomach into the respiratory tract. This risk can be minimized by checking the tube placement; the pH and color of aspirate and residual amount; and by keeping the head of the bed elevated to 30 degrees at all times. Problems with diarrhea may be caused by infusing a formula that is cold, contaminated, or of the wrong consistency or by infusing a formula too rapidly. Nasogastric tubes may be left in place from weeks to months, depending on the type of tube inserted. The feeding bag itself should be changed daily.

Test-Taking Strategy: Use the process of elimination to assist in answering the question. Eliminate “change the NG tube with every other feeding” first because nasogastric tubes

may be left in place from weeks to months, depending on the type of tube inserted. Eliminate “keep the client in a supine position” next because a supine position could cause aspiration pneumonia. Choose “check for tube placement and residual amount at least every 4 hours” over “increase the rate of the feeding if the infusion falls behind schedule” because it is a definitive action that it helps protect the client from aspiration. Review the care of a client receiving NG tube feedings if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Potter, P., & Perry, A. (2009). *Fundamentals of nursing* (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

4. The client with pancreatitis is being weaned from parenteral nutrition (PN). The client asks the nurse why the PN cannot just be stopped. The nurse includes in a response to the client that which of the following complications could occur with sudden termination of PN formula?
1. Dehydration
 2. Hypokalemia
 3. Hypernatremia
 4. Rebound hypoglycemia

ANS: 4

Rationale: Clients receiving PN are receiving high concentrations of glucose. To give the pancreas time to adjust to decreasing glucose loads, the infusion rates are tapered down. Prior to discontinuing the PN, the body must adjust to the lowered glucose level. If the PN were suddenly withdrawn, the client could have rebound hypoglycemia. Although the other options are potential complications, they are not risks associated with discontinuing PN abruptly.

Test-Taking Strategy: Use the process of elimination to answer the question. Recall that PN solutions contain high concentrations of glucose; this will easily direct you to “rebound hypoglycemia.” Review the components of a PN solution and the considerations related to weaning if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Gahart, B., & Nazareno, A. (2010). *2010 Intravenous medications: a handbook for nurses and health professionals* (26th ed.). St. Louis: Mosby. | Ignatavicius, D., & Workman, M. (2010). *Medical-surgical nursing: patient-centered collaborative care* (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

5. The nurse hears in intershift report that a client receiving parenteral nutrition (PN) at 100 mL/hr has bilateral crackles and 1+ pedal edema. When the nurse obtains a daily weight, the nurse notes that the client has gained 4 lb in 2 days. Which of the following nursing actions should the nurse take first?
1. Encourage the client to cough and deep-breathe.
 2. Compare the intake and output records of the last 2 days.
 3. Slow the PN infusion rate to 50 mL/hr per infusion pump.
 4. Administer the prescribed daily diuretic, and check the client in 2 hours.

ANS: 2

Rationale: The client is showing signs of fluid retention and possible excess fluid intake, as noted by the presence of crackles, edema, and weight gain. Noting the client's intake and output records adds to the database of information, which should then be reported. The problem may or may not be related to the PN. (Other possible causes are impaired respiratory, cardiovascular, or renal function.)

Test-Taking Strategy: Use the process of elimination, focusing on the client data provided in the question. Also note the strategic word "first." Eliminate "slow the PN infusion rate to 50 mL/hr per infusion pump" because the nurse should not decrease the infusion rate without a physician's prescription. Additionally, it is not recommended to increase or decrease the rate of PN infusions because of the problems of hyperosmolar diuresis, hypoglycemia, or hyperglycemia. Eliminate "encourage the client to cough and deep-breathe" because this action will have little if any effect on peripheral edema and weight gain. Eliminate "administer the prescribed daily diuretic, and check the client in 2 hours" because this action may delay necessary and immediate treatment and is incorrect. Review the complications and associated nursing interventions of parenteral nutrition (PN) if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

6. The nurse is caring for a client receiving parenteral nutrition (PN) via a central line. The nurse should monitor which of the following to detect the development of the **most** common complication of PN?
1. Temperature
 2. Daily weight
 3. Intake and output (I&O)
 4. Serum blood urea nitrogen (BUN) level

ANS: 1

Rationale: The most common complication associated with PN is infection. Monitoring the temperature would provide data that would indicate infection in the client. Monitoring the serum BUN level would not provide information related to infection and is most closely related to assessing renal function. Weighing the client daily and monitoring I&O would provide information related to fluid volume overload.

Test-Taking Strategy: Use the process of elimination to assist in answering the question. Focus on the subject of the question, the most common complication of PN. Eliminate “daily weight” and “intake and output (I&O)” first because they are comparable or alike. Recall that infection is the most common complication to make your final selection. Review the complications associated with PN if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Analyzing

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Assessment

7. The nurse is providing care to a client with continuous tube feedings through a nasogastric (NG) tube. The nurse should avoid doing which of the following, which is not part of the standard care for a client receiving enteral nutrition?
1. Check the residual every 4 hours.
 2. Check for placement every 4 hours.
 3. Hang a new feeding bag every 72 hours.
 4. Check for placement prior to administering medications through the tube.

ANS: 3

Rationale: A feeding bag and tubing should be changed every 24 hours (or per agency protocol) to reduce risk of bacterial contamination. Placement and residual should be checked at least every 4 hours during administration of continuous tube feedings and prior to giving medications through the tube.

Test-Taking Strategy: Note the strategic words “avoid” and “not” in the question. These words indicate a negative event query and the need to select the incorrect action. Visualize the procedure to assist in answering the question. Eliminate each of the incorrect options because they are comparable or alike. If you had difficulty with this question, review the nursing care associated with continuous tube feedings.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders. | Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

8. The nurse is monitoring the nutritional status of the client receiving enteral nutrition. The nurse monitors which of the following to determine the effectiveness of the tube feedings for this client?
1. Daily weight
 2. Calorie count
 3. Serum protein level
 4. Daily intake and output

ANS: 1

Rationale: The most accurate measurement of the effectiveness of nutritional management of the client is through the use of daily weighing. These should be done every day at the same time (preferably early morning), in the same clothes, and using the same scale. “Calorie count,” “serum protein level,” and “daily intake and output” assist in measuring nutrition and hydration status. However, the effectiveness of the diet is measured by maintenance of body weight.

Test-Taking Strategy: The strategic word in the question is “effectiveness.” This tells you that the correct option is an outcome rather than a tool to measure the outcome. With this in mind, eliminate “calorie count,” and “daily intake and output” first because these are tools that the nurse uses to measure nutritional and fluid status. Eliminate “serum protein level” next, because it reflects only one component of the diet, namely, protein. If you had difficulty with this question, review the methods of monitoring the effectiveness of the tube feedings.

PTS: 1

DIF: Level of Cognitive Ability: Evaluating

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Evaluation

9. A client is scheduled for insertion of a peripherally inserted central catheter (PICC) and the nurse explains the advantages of this catheter. The nurse determines that the client needs additional information about the catheter if the client makes which statement?
1. “It is reasonable in cost.”
 2. “There is less pain and discomfort than other types of catheters.”
 3. “This type of catheter is very reliable.”
 4. “It is specifically designed for short-term use.”

ANS: 4

Rationale: PICCs are intended to be used for clients who need long-term catheter placement. They can be left in place for several months. It is reasonable in cost because the catheter does not need routine replacement, as do traditional peripheral IV catheters. The catheter is more comfortable for the client because there is no repeated venipuncture with catheter change. The catheter is also very reliable. It is less likely to infiltrate and can be used for administration of a number of different types of medications.

Test-Taking Strategy: Note the strategic words “needs additional information.” These words indicate a negative event query and tell you that the correct option will be an incorrect statement about this type of catheter. Use general nursing knowledge about the purposes of this catheter to choose correctly. The strategic words “short-term” will assist in directing you to “It is specifically designed for short-term use.” Review the characteristics of a PICC if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Evaluating

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Teaching and Learning

10. A nurse is making initial rounds on the nursing unit to check the condition of assigned clients. The nurse notes that a client’s intravenous (IV) site is cool, pale, and swollen, and the solution is not infusing. The nurse interprets that which of the following complications has been experienced by the client?
1. Phlebitis
 2. Infection
 3. Infiltration
 4. Thrombosis

ANS: 3

Rationale: An infiltrated IV is one that has dislodged from the vein and is lying in subcutaneous tissue. The pallor, coolness, and swelling are the result of IV fluid being deposited in the subcutaneous tissue. When the pressure in the tissues exceeds the pressure in the tubing, the flow of the IV solution will stop. The corrective action is to clamp the IV tubing, remove the catheter, and prepare to start a new IV line. The other three options are likely to be accompanied by warmth at the site, not coolness.

Test-Taking Strategy: To answer this question accurately, you must be familiar with the signs and symptoms that accompany various complications of IV therapy. Remember that pallor, coolness, and swelling are associated with infiltration. If this question was difficult, review the signs of infiltration.

PTS: 1

DIF: Level of Cognitive Ability: Understanding

REF: Ignatavicius, D., & Workman, M. (2010). *Medical-surgical nursing: patient-centered collaborative care* (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Assessment

11. The nurse has been assigned to the care of four adult clients who are receiving continuous intravenous (IV) infusions. The nurse planning the work assignment for the shift makes a notation to check the IV sites of these clients at which of the following frequencies?
1. Every hour
 2. Every 2 hours
 3. Every 3 hours
 4. Every 4 hours

ANS: 1

Rationale: Safe nursing practice includes monitoring an IV infusion at least once per hour in an adult client. The IV may be checked even more frequently, depending on whether medication also is being infused.

Test-Taking Strategy: Focus on the subject, and note that the question addresses adult clients. Remember that IV infusions need to be checked hourly for an adult client. If this question was difficult, review care to the client receiving IV fluids.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Perry, A., & Potter, P. (2010). *Clinical nursing skills and techniques* (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Planning

12. The client had a 1000-mL bag of 5% dextrose in 0.9% sodium chloride hung at 15:00. The nurse, making rounds at 15:45, finds the client is complaining of a pounding headache, is dyspneic with chills, is apprehensive, and has an increased pulse rate. The intravenous (IV) bag has 400 mL remaining. The nurse should take which of the following actions first?
1. Shut off the infusion.
 2. Sit the client up in bed.
 3. Remove the angiocatheter and IV.
 4. Place the client in Trendelenburg's position.

ANS: 1

Rationale: The client's symptoms are compatible with speed shock (fluid volume overload). This may be verified by noting that 600 mL has infused in the course of 45 minutes. The first action of the nurse from the options presented is to shut off the infusion. The nurse may elevate the head of bed to aid the client's breathing. Placing the client in Trendelenburg's position is not an appropriate action and will increase the dyspnea. The nurse also notifies the physician. The angiocatheter does not need to be removed. It may continue to be needed when the complication has been managed.

Test-Taking Strategy: Note that the question contains the strategic word "first." Focus on the data in the question, and note that the data indicate fluid volume overload. This will direct you to "shut off the infusion." Review nursing actions related to fluid volume overload for a client receiving intravenous fluids if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Potter, P., & Perry, A. (2009). *Fundamentals of nursing* (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

13. The nurse notes that the site of a client's peripheral intravenous (IV) catheter is reddened, warm, painful, and slightly edematous proximal to the insertion point of the IV catheter. After taking appropriate steps to care for the client, the nurse documents in the medical record that the client has experienced:
1. Phlebitis of the vein
 2. Infiltration of the IV line
 3. Hypersensitivity to the IV solution
 4. Allergic reaction to the IV catheter material

ANS: 1

Rationale: Phlebitis at an IV site can be distinguished by client discomfort at the site, as well as by redness, warmth, and swelling proximal to the catheter. The IV line should be discontinued, and a new line should be inserted at a different site. The remaining options are incorrect.

Test-Taking Strategy: Remember that options that are comparable or alike are not likely to be correct. In this case, "hypersensitivity to the IV solution" and "allergic reaction to the IV catheter material" are comparable or alike and therefore are eliminated. Focus on the data in the question to select "phlebitis of the vein" over "infiltration of the IV line." Also recalling the signs of common IV complications will assist in answering correctly. Review the signs and symptoms of phlebitis if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

14. The nurse has a written prescription to discontinue an intravenous (IV) line. The nurse obtains which of the following supplies from the unit supply area for use in applying pressure to the site after removing the IV catheter?
1. Band-Aid
 2. Alcohol swab
 3. Betadine swab
 4. Sterile 2 × 2 gauze

ANS: 4

Rationale: A dry sterile dressing, such as sterile 2 × 2 gauze, is used to apply pressure to the discontinued IV site. This material is absorbent, sterile, and nonirritating. A Betadine swab or alcohol swab would irritate the opened puncture site and would not stop the blood flow. A Band-Aid may be used to cover the site after hemostasis has occurred.

Test-Taking Strategy: Visualize this procedure and think about each of the items identified in the options to answer the question. The strategic words in the question are “applying pressure.” This will direct you to “sterile 2 × 2 gauze.” Review this procedure for removing an IV if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders. | Perry, A., & Potter, P. (2010). Clinical nursing skills and techniques (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Physiological Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

15. The nurse is preparing a continuous intravenous (IV) infusion at the medication cart. As the nurse prepares to attach the distal end of the IV tubing to a needleless device, the tubing drops and hits the top of the medication cart. Which of the following is the appropriate action by the nurse?
1. Change the IV tubing.
 2. Attach a new needleless device.
 3. Wipe the tubing port with Betadine.
 4. Scrub the needleless device with an alcohol swab.

ANS: 1

Rationale: The nurse should change the IV tubing because it has become contaminated and could cause systemic infection to the client. Wiping the port with Betadine is insufficient and would be contraindicated in any case, because the tubing will be attached directly to an angiocatheter in the client's vein. The needleless device has not been contaminated and does not need replacement or cleansing.

Test-Taking Strategy: Focus on the subject, contamination of the tubing. Note the relationship between the subject and "change the IV tubing." Review aseptic technique if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Potter, P., & Perry, A. (2009). *Fundamentals of nursing* (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

16. The nurse is collecting data from an African-American client scheduled for surgery. Which of the following questions would be of least priority for the nurse to ask on initial assessment?
1. "Do you ever experience chest pain?"
 2. "Do you have any difficulty breathing?"
 3. "Do you have a close family relationship?"
 4. "Do you frequently have episodes of headache?"

ANS: 3

Rationale: In the African-American culture, it is considered to be intrusive to ask personal questions on the initial contact or meeting. African Americans are highly verbal and express feelings openly to family or friends, but what transpires within the family is viewed as private. Psycho-social data are the least priority during the initial data collection. Additionally, cardiovascular, neurological, and respiratory data include physiological assessments that would be the priority.

Test-Taking Strategy: Note the strategic words "least priority." Use Maslow's Hierarchy of Needs theory to answer the question. "Do you ever experience chest pain?" "Do you have any difficulty breathing?" and "Do you frequently have episodes of headache?" address physiological needs. "Do you have a close family relationship?" addresses psychosocial needs. Review the characteristics of this culture if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Understanding

REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Assessment

17. The nurse is providing discharge instructions to an Asian-American client regarding prescribed dietary modifications. During the teaching session, the client continuously turns away from the nurse. Which of the following nursing actions is most appropriate?
1. Continue with the instructions verifying client understanding.
 2. Walk around to the client so that you continuously face the client.
 3. Identify the importance of the instructions for the maintenance of health care.
 4. Give the client a dietary booklet, and return later to continue with the instructions.

ANS: 1

Rationale: Most Asian-American individuals maintain a formal distance with each other, which is a form of respect. Many are uncomfortable with face-to-face communications, especially when there is direct eye contact. If the client turns away from the nurse during a conversation, the best action is to continue with the conversation. Walking around to the client so that the nurse faces the client is in direct conflict with cultural practices. Identifying the importance of the instructions for the maintenance of health care may be viewed as degrading. Returning later to continue with the explanation may be viewed as a rude gesture.

Test-Taking Strategy: Understanding the characteristics of this cultural group will assist in answering the question. Eliminate “identify the importance of the instructions for the maintenance of health care” and “give the client a dietary booklet, and return later to continue with the instructions” first, because these are nontherapeutic actions. From the remaining two options, “continue with the instructions verifying client understanding” is the most therapeutic. If you had difficulty with this question, review the communication practices of this cultural group.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

18. The nurse is planning to instruct the Hispanic-American client about nutrition and dietary restrictions. When developing the plan for the instructions, the nurse is aware that this ethnic group:
1. Primarily eats raw fish
 2. Enjoys eating red meat
 3. Views food as a primary form of socialization
 4. Eats bland food and food that lacks color, flavor, and texture

ANS: 3

Rationale: Hispanic-American foods are rich in color, flavor, texture, and spiciness. In the Hispanic-American culture, any occasion is seen as a time to celebrate with food and to enjoy the companionship of family and friends. Because food is a primary form of socialization in the Hispanic-American culture, they may have difficulty adhering to a prescribed diet. Asian Americans eat raw fish, rice, and soy sauce. European Americans prefer carbohydrates and red meat.

Test-Taking Strategy: Knowledge regarding the food practices and preferences and the meaning of food in the Hispanic-American culture is required to answer this question. Remember that food is viewed as a primary form of socialization in the Hispanic-American culture. If you had difficulty with this question, review the food preferences associated with this culture.

PTS: 1

DIF: Level of Cognitive Ability: Understanding

REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Planning

19. The nurse is preparing to assist a Jewish-American client with eating lunch. A kosher meal is delivered to the client. Which of the following nursing actions is most appropriate in assisting the client with the meal?
1. Unwrap the eating utensils for the client.
 2. Replace the plastic utensils with metal eating utensils.
 3. Carefully place the food from the paper plates to glass plates.
 4. Ask the client to unwrap the eating utensils, and allow the client to prepare the meal for eating.

ANS: 4

Rationale: Kosher meals arrive on paper plates and with plastic utensils sealed. Health care providers should not unwrap the utensils or place the food on another serving dish. Although the nurse may want to be helpful in assisting the client with the meal, the only appropriate option for this client is “ask the client to unwrap the eating utensils, and allow the client to prepare the meal for eating.”

Test-Taking Strategy: Knowledge regarding the rituals associated with kosher meals is required to answer this question. “Replace the plastic utensils with metal eating utensils” and “carefully place the food from the paper plates to glass plates” are comparable or alike and can be eliminated first. For the remaining options, it is necessary to be familiar with kosher rituals to direct you to “ask the client to unwrap the eating utensils, and allow the client to prepare the meal for eating.” If you had difficulty with this question, review these cultural characteristics.

PTS: 1
 DIF: Level of Cognitive Ability: Applying
 REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby.
 OBJ: Client Needs: Psychosocial Integrity
 TOP: Content Area: Fundamentals
 MSC: Integrated Process: Nursing Process—Implementation

20. The nurse is assigned to collect data from a Hispanic-American client during the hospital admission. When meeting the client, the nurse should plan to do which of the following?
1. Avoid touching the client.
 2. Greet the client with a handshake.
 3. Smile and use humor throughout the entire admission process.
 4. Avoid any affirmative nods during the conversations with the client.

ANS: 2

Rationale: To demonstrate respect, compassion, and understanding, health care providers should greet Hispanic-American clients with a handshake. On establishing rapport, providers may further demonstrate approval and respect through touch, smiling, and affirmative nods of the head. Given the diversity of dialects and the nuances of language, culturally congruent use of humor is difficult to accomplish and therefore should be avoided.

Test-Taking Strategy: Knowledge regarding the cultural communication patterns of the Hispanic-American client is required to answer this question. Reading each option carefully and using the process of elimination should assist in directing you to “greet the client with a handshake.” Review the characteristics of this cultural group if you had difficulty with this question.

PTS: 1
 DIF: Level of Cognitive Ability: Applying
 REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby.
 OBJ: Client Needs: Psychosocial Integrity
 TOP: Content Area: Fundamentals
 MSC: Integrated Process: Nursing Process—Planning

21. The nurse is assisting in developing a postoperative plan of care for a 40-year-old male Filipino-American client scheduled for an appendectomy. The nurse includes which of the following in the plan of care?
1. Offer pain medication on a regular basis as prescribed.
 2. Offer pain medication when nonverbal signs of discomfort are identified.
 3. Inform the client that he will need to ask for pain medication when needed.
 4. Allow the client to maintain control and request pain medication on his own.

ANS: 1

Rationale: Filipino-Americans view pain as part of living an honorable life. The client may appear stoic and be tolerant of a high degree of pain. Health care providers need to offer, and in fact encourage, pain relief interventions for the Filipino-American client who does not complain of pain, despite physiological indicators. “Offer pain medication on a regular basis as prescribed” is the most appropriate intervention to include in the plan of care.

Test-Taking Strategy: Use the process of elimination and knowledge of cultural responses to pain in the Filipino-American client to answer this question. Remember that in this culture the client may appear stoic and be tolerant of a high degree of pain. If you had difficulty with this question, review these cultural characteristics.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Planning

22. The nurse is planning the menu for a Chinese-American client with the hospital dietitian. On collaboration with the dietitian, the meal plan is designed to include which of the following foods generally included in the diet of this cultural group?
1. Milk
 2. Vegetables
 3. Rice pudding
 4. Fruit and yogurt

ANS: 2

Rationale: The Chinese-American diet is generally vegetarian, although meat is often served. Native Chinese generally do not drink milk or eat milk products because of a genetic tendency for lactose intolerance. Most Chinese-Americans do not eat desserts high in sugar; their desserts are usually fruits.

Test-Taking Strategy: Knowledge regarding the food rituals related to the Chinese-American culture is required to answer this question. Remember that the Chinese-American diet is generally vegetarian. If you had difficulty with this question, review the dietary characteristics of this culture.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby. | Nix, S. (2009). *Williams’ basic nutrition and diet therapy* (13th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity
TOP: Content Area: Fundamentals
MSC: Integrated Process: Nursing Process—Planning

23. The nurse is preparing to assist in examining a Hispanic-American child who was brought to the clinic by the mother. During assessment of the child, the nurse would avoid which of the following?
1. Admiring the child
 2. Taking the child's temperature
 3. Obtaining an interpreter if necessary
 4. Asking the mother questions about the child

ANS: 1

Rationale: Hispanic-American clients may believe in *mal ojo* (evil eye). They believe that an individual becomes ill as a result of excessive admiration by another. "Taking the child's temperature," "obtaining an interpreter if necessary," and "asking the mother questions about the child" are appropriate interventions. It is appropriate for the nurse to obtain an interpreter if the child or mother does not speak the same language as the nurse.

Test-Taking Strategy: Note the strategic word "avoid" in the question. Therefore select the option that identifies an incorrect action. "Taking the child's temperature," "obtaining an interpreter if necessary," and "asking the mother questions about the child" can be easily eliminated because these are therapeutic and appropriate interventions. If you had difficulty with this question, review the cultural characteristics of the Hispanic-American population.

PTS: 1
DIF: Level of Cognitive Ability: Applying
REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby. | Jarvis, C. (2008). *Physical examination & health assessment* (5th ed.). St. Louis: Saunders.
OBJ: Client Needs: Psychosocial Integrity
TOP: Content Area: Fundamentals
MSC: Integrated Process: Nursing Process—Implementation

24. The nurse plans to do dietary teaching with an African-American client. The nurse understands that foods preferred by individuals of this culture are which of the following?
1. Rice
 2. Fruits
 3. Red meat
 4. Fried foods

ANS: 4

Rationale: African-American food preferences include pork, greens, rice, and fried foods. Asian-American food preferences include raw fish, rice, and soy sauce. Hispanic Americans prefer beans, fried foods, spicy foods, chilies, and carbonated beverages. European Americans prefer carbohydrates and red meat.

Test-Taking Strategy: Knowledge regarding the food practices and preferences related to the various cultures is required to answer the question. Correlate fried foods with African Americans. This may assist when answering other questions similar to this one. If you had difficulty with this question, review the food preferences associated with the African-American culture.

PTS: 1

DIF: Level of Cognitive Ability: Understanding

REF: Giger, J., & Davidhizar, R. (2008). *Transcultural nursing: assessment and intervention* (5th ed.). St. Louis: Mosby. | Nix, S. (2009). *Williams' basic nutrition and diet therapy* (13th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Planning

25. The registered nurse (RN) gives an inaccurate dose of a medication to a client. Following an assessment of the client, the nurse completes an incident report. The RN notifies the nursing supervisor of the medication error and calls the physician to report the occurrence. The nurse who administered the inaccurate medication dose understands that the:
1. Error will result in suspension.
 2. Incident will be reported to the board of nursing.
 3. Incident will be documented in the personnel file.
 4. Incident report is a method of promoting quality care and risk management.

ANS: 4

Rationale: Documentation of unusual occurrences, incidents, and accidents and the nursing actions taken as a result is maintained by the institution or agency and allows the RN and administration to review the quality of care and determine any potential risks. Based on the information provided in the question, the RN's error will not result in suspension nor will it be documented in the personnel file. The error and the situation presented in the question are not a reason for notifying the board of nursing.

Test-Taking Strategy: Focus on the information provided in the question. Knowing the purpose of incident reports will assist in eliminating “error will result in suspension,” “incident will be reported to the board of nursing,” and “incident will be documented in the personnel file.” Note that the correct option is also the umbrella option and focuses on safety. If you had difficulty with this question, review the purpose of incident reports.

PTS: 1

DIF: Level of Cognitive Ability: Understanding

REF: Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamentals

MSC: Integrated Process: Communication and Documentation

26. The registered nurse (RN) has been caring for a terminally ill client. The RN has developed a close relationship with the family of the client. Which of the following nursing interventions will the RN avoid in dealing with the family during this difficult time?
1. Making decisions for the family
 2. Encouraging family discussion of feelings
 3. Accepting the family's expressions of anger
 4. Facilitating the use of spiritual practices identified by the family

ANS: 1

Rationale: Maintaining effective and open communication among family members affected by death and grief is of utmost importance. The RN needs to maintain and enhance communication, as well as preserve the family's sense of self-direction and control. "Encouraging family discussion of feelings" is likely to enhance communications. "Accepting the family's expressions of anger" is also an effective technique, and the family needs to know that someone will be there who is supportive and nonjudgmental. "Facilitating the use of spiritual practices identified by the family" is also an effective intervention, because spiritual practices give meaning to life and have an impact on how people react to crisis. "Making decisions for the family" removes autonomy and decision making from the family at a time when they are already experiencing feelings of loss of control. This is an ineffective intervention that can impair communication.

Test-Taking Strategy: Note the strategic word "avoid" in the question. This word indicates a negative event query and the need to select the incorrect action. Use the process of elimination, focusing on therapeutic communication techniques. This will easily direct you to "making decisions for the family." Review therapeutic techniques for individuals in crisis if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Potter, P., & Perry, A. (2009). Fundamentals of nursing (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Psychosocial Integrity

TOP: Content Area: Fundamentals MSC: Integrated Process: Caring

27. A registered nurse (RN) who works on the night shift enters the medication room and finds a co-worker with a tourniquet wrapped around the upper arm. The co-worker is about to insert a needle, attached to a syringe containing a clear liquid, into the

antecubital area. The **most** appropriate initial action by the RN is which of the following?

1. Call security.
2. Call the police.
3. Call the nursing supervisor.
4. Lock the co-worker in the medication room until help is obtained.

ANS: 3

Rationale: The nurse practice act requires reporting impaired nurses. The board of nursing has jurisdiction over the practice of nursing and may develop plans for treatment and supervision. This incident needs to be reported to the nursing supervisor, who will then report to the board of nursing and other authorities as required. “Lock the co-worker in the medication room until help is obtained” is an inappropriate and unsafe action. Security may be called if a disturbance occurs, but there are no data in the question to support this. Therefore, this is not the initial action.

Test-Taking Strategy: Use the principles of prioritizing when answering this question. Note the strategic word “initial” in the question. Eliminate “lock the co-worker in the medication room until help is obtained” first because this is an inappropriate and unsafe action. Recall the lines of organizational structure to assist in directing you to “call the nursing supervisor.” If you had difficulty with this question, review the nurse’s responsibilities when substance abuse is suspected or occurs.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Ignatavicius, D., & Workman, M. (2010). Medical-surgical nursing: patient-centered collaborative care (6th ed.). St. Louis: Saunders.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

28. A hospitalized client tells the registered nurse (RN) that a living will is being prepared and that the lawyer will be bringing the will to the hospital today for witness signatures. The client asks the RN for assistance in obtaining a witness to the will. The **most** appropriate response to the client is which of the following?
1. “I will sign as a witness to your signature.”
 2. “You will need to find a witness on your own.”
 3. “Whoever is available at the time will sign as a witness for you.”
 4. “I will call the nursing supervisor to seek assistance regarding your request.”

ANS: 4

Rationale: Living wills are required to be in writing and signed by the client. The client’s signature must be either witnessed by specified individuals or notarized. Many states prohibit any employee, including a nurse of a facility where the declaring is receiving care, from being a witness. “You will need to find a witness on your own.” is

nontherapeutic and not a helpful response. The RN should seek the assistance of the nursing supervisor.

Test-Taking Strategy: Note the strategic words “most appropriate.” “I will sign as a witness to your signature.” and “Whoever is available at the time will sign as a witness for you.” are comparable or alike and should be eliminated first. “You will need to find a witness on your own.” is eliminated because it is a nontherapeutic response. Review legal implications associated with wills if you had difficulty with this question.

PTS: 1

DIF: Level of Cognitive Ability: Applying

REF: Potter, P., & Perry, A. (2009). *Fundamentals of nursing* (7th ed.). St. Louis: Mosby.

OBJ: Client Needs: Safe and Effective Care Environment

TOP: Content Area: Fundamentals

MSC: Integrated Process: Nursing Process—Implementation

29. The nurse caring for a newly admitted client is reviewing the medication prescription sheet in preparation for administering medications to the client. The nurse notes that the physician has prescribed a medication dose that is twice the amount that the client has reported taking prior to admission. The **most** appropriate nursing action is to:
1. Contact the physician directly.
 2. Administer the medication as prescribed.
 3. Question the client regarding the accuracy of the reported dosage.
 4. Ask the physician about the prescription the next time the physician makes rounds.

ANS: 1

Rationale: If the nurse determines that a physician’s prescription is unclear or if the nurse has a question about a prescription, the nurse should contact the physician prior to implementing it. Under no circumstances should the nurse carry out the prescription unless the prescription is clarified. Questioning the client regarding the accuracy of the dosage of the medication may seem like a viable option, but this action may also cause the client to become upset. The nurse would not administer the medication nor would the nurse administer an altered dosage. Waiting until the physician makes rounds delays treatment.

Test-Taking Strategy: Use the process of elimination to answer the question. Eliminate “administer the medication as prescribed” and “ask the physician about the prescription the next time the physician makes rounds” first by applying general principles related to medication administration and safety. From the remaining options, select “contact the physician directly” over “question the client regarding the accuracy of the reported dosage” because this is the action that will clarify the prescription and ensure a safe environment for the client. Review medication administration principles and guidelines related to physician’s prescriptions if you had difficulty with this question.

PTS: 1