Answer Key

PART 2

Chapter 1: Pain, pages 9-12

1. **Ans: 4** As charge nurse, you must assess the performance and attitude of the staff in relation to this client. After data are gathered from the nurses, additional information can be obtained from the records and the client as necessary. The educator may be of assistance if knowledge deficit or need for performance improvement is the problem. **Focus:** Supervision, prioritization
2. **Ans: 3** Beliefs, attitudes, and familial influence are part of the sociocultural dimension of pain. Location and radiation of pain address the sensory dimension. Describing pain and its effects addresses the affective dimension. Activity level and function address the behavioral dimension. Asking about knowledge addresses the cognitive dimension. **Focus:** Prioritization
3. **Ans: 1** Antidepressants such as amitriptyline can be given to treat diabetic neuropathy; an added benefit is the sedative effect. Corticosteroids are for pain associated with inflammation. Hydromorphone is a stronger opioid, and it is not the first choice for chronic pain that can be managed with other drugs. Lorazepam is an anxiolytic. **Focus:** Prioritization
4. **Ans: 3** Cancer pain generally worsens with disease progression, and the use of opioids is more generous. Fibromyalgia is more likely to be treated with nonopioid and adjuvant medications. Trigeminal neuralgia is treated with antiseizure medications such as carbamazepine (Tegretol). Phantom limb pain usually subsides after ambulation begins. **Focus:** Prioritization
5. **Ans: 4** In supervision of the new RN, good performance should be reinforced first and then areas of improvement can be addressed. Asking the nurse about knowledge of pain management is also an option; however, it would be a more indirect and time-consuming approach. Making a note and watching do not help the nurse to correct the immediate problem. In-service training might be considered if the problem persists. **Focus:** Supervision, delegation
6. **Ans: 3** Pain rating scales using faces (depicting smiling, neutral, frowning, crying, etc.) are appropriate for young children who may have difficulty describing pain or understanding the correlation of pain to numerical or verbal descriptors. The other tools require abstract reasoning abilities to make analogies and the use of advanced vocabulary. **Focus:** Prioritization
7. **Ans: 3** The client must be believed, and his or her experience of pain must be acknowledged as valid. The data gathered via client reports can then be applied to the other options in developing the treatment plan. **Focus:** Prioritization
8. **Ans: 3** The client with an acute myocardial infarction has the greatest need for IV access and is likely to receive morphine, which will relieve pain by increasing venous capacitance. Other clients may also need IV access for delivery of pain medication, other drugs, or IV fluids, but the need is less urgent. **Focus:** Prioritization
9. **Ans: 1** The goal is to control pain while minimizing side effects. For severe pain, the medication can be titrated upward until the pain is controlled. Downward titration occurs when the pain begins to subside. Adequate dosing is important; however, the concept of controlled dosing applies more to potent vasoactive drugs. **Focus:** Prioritization
10. **Ans: 2** Application of heat and cold is a standard therapy with guidelines for safe use and predictable outcomes, and an LPN/LVN will be implementing this therapy in the hospital, under the supervision of an RN. Therapeutic touch requires additional training and practice. Meditation is not acceptable to all clients, and an assessment of spiritual beliefs should be conducted. TENS is usually applied by a physical therapist. **Focus:** Delegation
11. **Ans: 3** The set of circumstances is least complicated for the child with the fracture, and this would be the best client for a new and relatively inexperienced nurse. The child is likely to have a good response to pain medication, and with gentle encouragement and pain management the anxiety will resolve. The other three children have more complex social and psychologic issues related to pain management. **Focus:** Delegation
12. **Ans: 4** At greatest risk are elderly clients, opiate-naive clients, and those with underlying pulmonary disease. The child has two of the three risk factors. **Focus:** Prioritization
13. **Ans: 1** This client has strong beliefs and emotions related to the issue of the sibling's addiction. First,

encourage expression. This indicates to the client that the feelings are real and valid. It is also an opportunity to assess beliefs and fears. Giving facts and information is appropriate at the right time. Family involvement is important, but it should be kept in mind that their beliefs about drug addiction may be similar to those of the client. **Focus:** Prioritization

14. **Ans: 3** Diaphoresis is one of the early signs that occur between 6 and 12 hours after withdrawal. Fever, nausea, and abdominal cramps are late signs that occur between 48 and 72 hours after withdrawal. **Focus:** Prioritization
15. **Ans: 1** The nursing assistant is able to assist the client with hygiene issues and knows the principles of safety and comfort for this procedure. Monitoring the client, teaching techniques, and evaluating outcomes are nursing responsibilities. **Focus:** Delegation
16. **Ans: 4** Administering placebos is generally considered unethical. Consult the charge nurse as a resource person who can help you clarify the situation and locate and review the hospital policy. If the physician is insistent, he or she could give the placebo. While following your own ethical code is correct, you must ensure that the client is not abandoned and that care continues. **Focus:** Prioritization
17. **Ans: 2** Complete information should be obtained from the family during the initial comprehensive history taking and assessment. If this information is not obtained, the nursing staff will have to rely on observation of nonverbal behavior and careful documentation to determine pain and relief patterns. **Focus:** Prioritization
18. **Ans: 5, 3, 1, 2, 4** All of the clients are in relatively stable condition. The client with the pneumothorax has priority, because chest tubes can leak or become dislodged or blocked. Lung sounds and respiratory effort should be evaluated. The woman who is going for diagnostic testing should be assessed and medicated before she leaves for the procedure. In a client with meningitis, a headache is not an unexpected complaint, but neurologic status and pain should be assessed. The report of postoperative pain is expected, but this client is getting reasonable relief most of the time. Caring for and assessing the confused client is likely to be very time consuming; leaving her to the last prevents delaying care for all the others. **Focus:** Prioritization
19. **Ans: 4** Assess the pain for changes in location, quality, and intensity, as well as changes in response to medication. This assessment will guide the next steps. **Focus:** Prioritization
20. **Ans: 3** The side-lying, knee-chest position opens the retroperitoneal space and provides relief. The pillow supplies a splinting action. Diversional therapy is not the best choice for acute pain, especially if the activity requires concentration. TENS is more appropriate for chronic muscular pain. The additional stimulation of massage may be distressing for this client. **Focus:** Prioritization
21. **Ans: 4** If the pain is constant, the best schedule is around the clock, to provide steady analgesia and pain control. The other options may actually require higher dosages to achieve control. **Focus:** Prioritization
22. **Ans: 2, 3, 6** The clients with the cast, toe amputation, and arthritis are in stable condition and need ongoing assessment and pain management that are within the scope of practice of an LPN/LVN under the supervision of an RN. The RN should take responsibility for preoperative teaching, and the terminal cancer client needs a comprehensive assessment to determine the reason for refusal of medication. The trauma client needs serial assessments to detect occult trauma. **Focus:** Assignment
23. **Ans: 5, 2, 1, 3, 4** Using the SBAR format, the nurse first identifies himself or herself, gives the client's name, and describes the current situation. Next, relevant background information, such as the client's diagnosis, medications, and laboratory data, is stated. The assessment includes both client assessment data that are of concern and the nurse's analysis of the situation. Finally, the nurse makes a recommendation indicating what action he or she thinks is needed. **Focus:** Prioritization
24. **Ans: 2, 5, 6** The client who is second day postoperative, the client who has pain at the IV site, and the client with the kidney stone have predictable needs and require routine care that a new nurse can manage. The anxious client with chronic pain needs an in-depth assessment of the psychological and emotional components of pain and expert intervention. The client with HIV infection has complex complaints that require expert assessment skills. The client pending discharge will need special and detailed instructions. **Focus:** Assignment
25. **Ans: 3** Directly ask the client about the pain and perform a complete pain assessment. This information will determine which action to take next. **Focus:** Prioritization
26. **Ans: 2** This statement is a veiled suicide threat, and clients with pain disorder and depression have a high risk for suicide. New injuries must be evaluated, but this type of complaint is not uncommon for clients with pain disorder. Risk for substance abuse is very high and should eventually be addressed. He can threaten to sue, but current circumstances do not support his case. **Focus:** Prioritization
27. **Ans: 4** Measuring output and obtaining a specimen are within the scope of practice of the nursing assistant. Insertion of the Foley catheter in this client should be done by the RN, because clients with obstruction and retention are usually very difficult to catheterize, and the nurse must evaluate the pain response during the

procedure. The assistant's knowledge of sterile technique is not the issue for this particular client. **Focus:** Delegation

28. **Ans: 3** Assessing the pain is the priority in this acute care setting, because there is a risk of infection or hemorrhage. The other options might be appropriate based on your assessment findings. **Focus:** Prioritization
29. **Ans: 2** Talk to the client about insulin and ketoacidosis. If she is already aware of the dangers of an elevated blood glucose level, then her refusal suggests ongoing suicidal intent and the provider should be notified so that steps can be taken to override her refusal (potentially a court order). A blood glucose level of over 600 mg/dL is typically a criterion for transfer to intensive care, but arranging for transfer is not the priority. Withholding the pain medication is unethical, and merely documenting refusal of insulin is inappropriate because of possible ongoing suicidal intent. **Focus:** Prioritization

Chapter 2: Cancer, pages 13-16

1. **Ans: 1** Oral hygiene is within the scope of duties of the nursing assistant. It is the responsibility of the nurse to observe response to treatments and to help the patient deal with loss or anxiety. The nursing assistant can be directed to weigh the patient but should not be expected to know when to initiate that measurement. **Focus:** Delegation
2. **Ans: 4** The patient's physical condition is currently stable, but emotional needs are affecting his or her ability to receive the information required to make an informed decision. The other diagnoses are relevant, but if the patient leaves the clinic the interventions may be delayed or ignored. **Focus:** Prioritization
3. **Ans: 1** Pancreatic cancer is more common in African Americans, males, and smokers. Other associated factors include alcohol use, diabetes, obesity, history of pancreatitis, exposure to organic chemicals, consumption of a high-fat diet, and previous abdominal irradiation. **Focus:** Prioritization
4. **Ans: 3** A child with a fever and low neutrophil count is at risk for overwhelming sepsis and secondary infections. A potassium level of 2.3 mEq/L is low, but not excessively low, and should be monitored. Nosebleeds are common, and patient and parents should be taught to apply direct pressure to the nose, have the child sit upright, and not disturb the clot. Severe spontaneous hemorrhage is not expected until the platelet count drops below 20,000 mm^3. Children can withstand low hemoglobin levels. The nurse should help the patient and parents regulate activity to prevent excessive fatigue. **Focus:** Prioritization
5. **Ans: 2** Administering enemas and antibiotics is within the scope of practice of LPNs/LVNs. Although some states may allow the LPN/LVN to administer blood, in general, administering blood, providing preoperative teaching, and assisting with central line insertion are the responsibilities of the RN. **Focus:** Prioritization
6. **Ans: 1. Nurse practitioner, 2. Nutritionist, 3. LPN/LVN, 4. Nurse practitioner, 5. RN** The nurse practitioner is often the provider who performs the physical examinations and recommends diagnostic testing. The nutritionist can give information about diet. The LPN/LVN will know the standard seven warning signs and can educate through standard teaching programs. The RN has primary responsibility for educating people about risk factors. **Focus:** Assignment
7. **Ans: 3** Further assess what the patient means by "having control over my own life and death." This could be an indirect statement of suicidal intent. A patient who believes he will be cured should also be assessed for misunderstanding what the physician said; however, the patient may need to use denial as a temporary defense mechanism. The patient's acknowledgment that the treatments are for control of symptoms or plans for the immediate future suggest an understanding of what the physician said. **Focus:** Prioritization
8. **Ans: 3** The nursing assistant can observe the amount that the patient eats (or what is gone from the tray) and report to the nurse. Assessing patterns of fatigue and skin reaction is the responsibility of the RN. The initial recommendation for exercise should come from the physician. **Focus:** Delegation
9. **Ans: 3** Paresthesia is a side effect associated with some chemotherapy drugs such as vincristine. The physician can modify the dosage or discontinue the drug. Fatigue, nausea, vomiting, and anorexia are common side effects of many chemotherapy medications. The nurse can assist the patient by planning for rest periods, giving antiemetics as ordered, and encouraging small meals containing high-protein and high-calorie foods. **Focus:** Prioritization
10. **Ans: 1** WBC count is especially important, because chemotherapy can cause decreases in WBCs, particularly neutrophils, which leave the patient vulnerable to infection. The other tests are important in the total management but are less directly specific to chemotherapy in general. **Focus:** Prioritization
11. **Ans: 3** Giving medications is within the scope of practice of the LPN/LVN. Assisting the patient in brushing and flossing should be delegated to the nursing assistant. Explaining contraindications is the responsibility of the RN. Recommendations for saliva substitutes should come from the physician or pharmacist. **Focus:** Delegation
12. **Ans: 1** Chemotherapy drugs should be given by nurses who have received additional training in how to safely prepare and deliver the drugs and protect

themselves from exposure. The other options express concerns, but the general principles of drug administration apply. **Focus:** Assignment

13. **Ans: 1, 3, 2, 4** Tumor lysis syndrome is an emergency involving electrolyte imbalances and potential renal failure. A patient scheduled for surgery should be assessed and prepared for surgery. A patient with breakthrough pain needs assessment, and the physician may need to be contacted for a change of dosage or medication. Anticipatory nausea and vomiting has a psychogenic component that requires assessment, teaching, reassurance, and administration of antiemetics. **Focus:** Prioritization
14. **Ans: 1** Back pain is an early sign of spinal cord compression occurring in 95% of patients. The other symptoms are later signs. **Focus:** Prioritization
15. **Ans: 2, 7, 1, 3, 6, 4, 5** Determine level of consciousness and responsiveness, and changes from baseline. Oxygen should be administered immediately in the presence of respiratory distress or risk for decreased oxygenation and perfusion. Pulse oximetry can be used for continuous monitoring. Adequate pulse, blood pressure, and respirations are required for cerebral perfusion. Increased temperature may signal infection or sepsis. Blood glucose levels should be checked even if the patient is not diabetic. Severe hypoglycemia should be immediately treated per protocol. A patent IV line may be needed for delivery of emergency drugs. Electrolyte and ammonia levels are relevant data for this patient, and abnormalities in these parameters may be contributing to change in mental status. **Focus:** Prioritization
16. **Ans: 3** The case manager has a relationship with the patient, knows the specific details of agreements made with the patient, and is the most capable of helping him to decrease anxiety and preoccupation with physical symptoms. In general, presenting reality does not have an impact on patients with hypochondriasis. Encouraging expression of feelings and giving in to the patient's wishes contribute to secondary gains of maintaining the sick role. **Focus:** Prioritization
17. **Ans: 2** Potentially life-threatening hypercalcemia can occur in cancers with destruction of bone. Other laboratory values are pertinent for overall patient management but are less specific to bone cancers. **Focus:** Prioritization
18. **Ans: 2, 4** Debulking of tumor and laminectomy are palliative procedures. These patients can be placed in the same room. The patient with a low neutrophil count and the patient who has had a bone marrow harvest need protective isolation. **Focus:** Assignment
19. **Ans: 4** Help the mother to understand that the child may be angry about being left in the hospital or about her inability to prevent the illness and protect the child. Reminding the child about the food and the purpose of the food does not address the strong emotions underlying the outburst. Allowing the mother and child time alone is a possibility, but the assumption would be that the mother understands the child's behavior and is prepared to deal with the behavior in a constructive manner. Asking the mother to leave the child suggests that the mother is a source of stress. **Focus:** Prioritization
20. **Ans: 2** Tumor lysis syndrome can result in severe electrolyte imbalances and potential renal failure. The other laboratory values are important to monitor to identify general chemotherapy side effects but are less pertinent to tumor lysis syndrome. **Focus:** Prioritization
21. **Ans: 1, 3, 4, 5** After age 21, women should have annual Pap smears, regardless of sexual activity. African American men should begin prostate-specific antigen testing at age 45. Annual mammograms are recommended for women over the age of 40. (Note at the time of publication: Age of 40 is being challenged; however, the American Cancer Society continues to recommend mammograms at age 40.) Colonoscopy is recommended for those with average risk starting at age 50. Annual fecal occult blood testing is recommended for all adults. Women aged 70 or older who have normal results on three consecutive Pap tests may elect to forego additional screenings for cervical cancer. **Focus:** Prioritization
22. **Ans: 2** Hyponatremia is a concern; therefore, fluid restrictions would be ordered. Urinalysis is less pertinent; however, the nurse should monitor for increased urine specific gravity. The diet may need to include sodium supplements. Fluid bolus is unlikely to be ordered for patients with SIADH; however, IV normal saline or hypertonic saline solutions may be given very cautiously. **Focus:** Prioritization
23. **Ans: 1, 2, 4, 6** Measuring vital signs and reporting on specific parameters, practicing good hand washing, and gathering equipment are within the scope of duties for a nursing assistant. Assessing for symptoms of infections and superinfections is the responsibility of the RN. **Focus:** Delegation
24. **Ans: 2** An LPN/LVN is versed in medication administration and able to teach patients standardized information. The other options require more in-depth assessment, planning, and teaching, which should be performed by the RN. **Focus:** Delegation
25. **Ans: 4** Helping the patient to eat is within the scope of responsibilities of a nursing assistant. Assessing ability and willingness to drink and checking for extent of mucosal ulceration is the responsibility of an RN. Plain water or saline rinses are preferable if the child cannot gargle or spit out fluids. The RN should assess and administer oral preparations as needed. **Focus:** Delegation
26. **Ans: 3** Explain that you are not chemotherapy certified so that the charge nurse can quickly rearrange the patient assignments. You can assess the patient, site, and infusion; however, you do not have the expertise to recognize the side effects of the medication or to

give specialized care that may be needed. Asking the nurse to stay is not the best solution, because the care of the patient and the effects of the medication continue after the infusion has been completed. Looking up the side effects of the drug is okay for your own information, but you are still not qualified to deal with this situation. In addition, knowing how to properly discontinue the infusion and dispose of the equipment are essential for your own safety and the safety of others. **Focus:** Prioritization

27. **Ans: 2** If the radiation implant has obviously been expelled (i.e., is on the bed linens), use a pair of forceps to place the radiation source in a lead container. The other options would be appropriate after safety of the patient and personnel are ensured. **Focus:** Prioritization and supervision

Chapter 3: Fluid, Electrolyte, and Acid-Base Problems, pages 17-20

1. **Ans: 2** A nursing assistant can reinforce additional fluid intake once it is part of the care plan. Administering IV fluids, developing plans, and teaching families require additional education and skills that are within the scope of practice of an RN. **Focus:** Delegation, supervision
2. **Ans: 1** Normally neck veins are distended when the client is in the supine position. These veins flatten as the client moves to a sitting position. The other three responses are characteristic of the nursing diagnosis of Excess Fluid Volume. **Focus:** Prioritization
3. **Ans: 1, 2, 3, 4** The LPN/LVN scope of practice and educational preparation includes oral care and routine observation. State practice acts vary as to whether LPNs/LVNs are permitted to perform assessment. The client should be reminded to avoid most commercial mouthwashes, which contain alcohol, a drying agent. Initiating a dietary consult is within the purview of the RN or physician. **Focus:** Delegation, supervision
4. **Ans: 4** Bilateral moist crackles indicate fluid-filled alveoli, which interferes with gas exchange. Furosemide is a potent loop diuretic that will help mobilize the fluid in the lungs. The other orders are important, but are not urgent. **Focus:** Prioritization
5. **Ans: 2** Suspect hypokalemia and check the client's potassium level. Common ECG changes with hypokalemia include ST depression, inverted T waves, and prominent U waves. Clients with hypokalemia may also develop heart block. **Focus:** Prioritization
6. **Ans: 1** The client's potassium level is high (normal range is 3.5 to 5 mEq/L). Kayexalate removes potassium from the body through the gastrointestinal system. Spironolactone is a potassium-sparing diuretic that may cause the client's potassium level to go even higher. The beginning nursing student does not have the skill to assess ECG strips. **Focus:** Delegation, supervision
7. **Ans: 3** SIADH causes a relative sodium deficit due to excessive retention of water. **Focus:** Prioritization
8. **Ans: 1** Providing oral care is within the scope of practice of the nursing assistant. Monitoring and assessing clients, as well as administering IV fluids, require the additional education and skills of the RN. **Focus:** Assignment, delegation, supervision
9. **Ans: 2** A positive Chvostek sign (facial twitching of one side of the mouth, nose, and cheek in response to tapping the face just below and in front of the ear) is a neurologic manifestation of hypocalcemia. The LPN is experienced and possesses the skills to accurately measure vital signs. **Focus:** Prioritization
10. **Ans: 4** Clients with low calcium levels should be encouraged to eat dairy products, seafood, nuts, broccoli, and spinach, which are all good sources of dietary calcium. **Focus:** Prioritization
11. **Ans: 3** A musculoskeletal manifestation of low phosphorus levels is generalized muscle weakness, which may lead to acute muscle breakdown (rhabdomyolysis). Although the other statements are true, they do not answer the nursing assistant's question. **Focus:** Delegation, supervision
12. **Ans: 4** Although all of these laboratory values are outside of the normal range, the magnesium level is furthest from the normal values. With a magnesium level this low, the client is at risk for ECG changes and life-threatening ventricular dysrhythmias. **Focus:** Prioritization
13. **Ans: 2** The client with COPD, although ventilator dependent, is in the most stable condition of the clients in this group. Clients with acid-base imbalances often require frequent laboratory assessment and changes in therapy to correct their disorders. In addition, the client with diabetic ketoacidosis is a new admission and will require an in-depth admission assessment. All three of these clients need care from an experienced critical care nurse. **Focus:** Assignment
14. **Ans: 1** The blood gas component responsible for respiratory acidosis is carbon dioxide. Increasing the ventilator rate will blow off more carbon dioxide and decrease the acidosis. Changes in the oxygen setting may improve oxygenation but will not affect respiratory acidosis. **Focus:** Prioritization
15. **Ans: 2, 3** The nursing assistant's training and education includes how to measure vital signs and record intake and output. Performing fingerstick glucose checks and assessing clients requires additional education and skill, as possessed by licensed nurses. Some facilities may train experienced nursing assistants to perform fingerstick glucose checks and change their role descriptions to designate their new skills, but this task is beyond the normal scope of practice of a nursing assistant. **Focus:** Delegation, supervision

16. **Ans: 4** Risk factors for acid-base imbalances in the older adult include chronic renal disease and pulmonary disease. Occasional antacid use will not cause imbalances, although antacid abuse is a risk factor for metabolic alkalosis. **Focus:** Prioritization
17. **Ans: 1** A decreased respiratory rate indicates respiratory depression, which also puts the client at risk for respiratory acidosis. All of the other findings are important and should be reported to the RN, but the respiratory rate demands urgent attention. **Focus:** Delegation, supervision
18. **Ans: 2** The client is most likely hyperventilating and blowing off carbon dioxide. This decrease in carbon dioxide will lead to an increase in pH and cause a respiratory alkalosis. **Focus:** Prioritization, supervision
19. **Ans: 1** Prolonged nausea and vomiting can result in acid deficit that can lead to metabolic alkalosis. The other findings are important and need to be assessed, but are not related to acid-base imbalances. **Focus:** Prioritization, supervision
20. **Ans: 2** Nasogastric suctioning can result in a decrease in acid components and a metabolic alkalosis. The client's decrease in rate and depth of ventilation is an attempt to compensate by retaining carbon dioxide. The first response may be true, but it does not address all the components of the question. The third and fourth answers are inaccurate. **Focus:** Supervision, prioritization
21. **Ans: 1, 4, 5** HCTZ is a thiazide diuretic. It should not be taken at night because it will cause the client to awaken to urinate. This type of diuretic causes a loss of potassium, so you should teach the client about eating foods rich in potassium. Weight gain and increased edema should not occur while the client is taking this drug, so these should be reported to the prescriber. **Focus:** Prioritization
22. **Ans: 2** Potassium is lost when a client is taking HCTZ, and potassium level should be monitored regularly. **Focus:** Prioritization

Chapter 4: Immunologic Problems, pages 21-24

1. **Ans: 3** Giving epinephrine rapidly at the onset of an anaphylactic reaction may prevent or reverse cardiovascular collapse as well as airway narrowing caused by bronchospasm and inflammation. Oxygen use is also appropriate, but oxygen would be administered using a nonrebreather mask in order to achieve a fraction of inspired oxygen closer to 100%. Albuterol may also be administered to decrease airway narrowing but would not be the first therapy used for anaphylaxis. IV access will take longer to establish and should not be the first intervention. **Focus:** Prioritization
2. **Ans: 1** Supplying bleach solution to patients who are at risk for HIV infection can be done by staff members with health assistant education. Pretest and posttest counseling may be carried out by non-RN personnel with specialized training; however, an RN would be better prepared to answer the questions that are likely to be asked by at-risk individuals. Education and community assessment are RN-level skills. **Focus:** Delegation
3. **Ans: 2** Nystatin should be in contact with the oral and esophageal tissues as long as possible for maximum effect. The other actions are also inappropriate and should be discussed with the student but do not require action as quickly. HIV-positive patients do not require droplet/contact precautions or visitor restrictions to prevent opportunistic infections. Hot or spicy foods are not usually well tolerated by patients with oral or esophageal fungal infections. **Focus:** Prioritization
4. **Ans: 4** Pentamidine can cause fatal hypoglycemia, so the low blood glucose level indicates a need for a change in therapy. The low blood pressure suggests that the pentamidine infusion rate may need to be slowed. The other responses indicate a need for independent nursing actions (such as establishing a new IV site and encouraging oral intake) but are not associated with pentamidine infusion. **Focus:** Prioritization
5. **Ans: 2** Drug therapy for HIV infection requires taking multiple medications on a very consistent schedule. Failure to take the medications consistently can lead to mutations and the emergence of more virulent forms of the virus. Although the other data indicate the need for further assessments or interventions, they will not affect the decision to initiate antiretroviral therapy for this patient. **Focus:** Prioritization
6. **Ans: 3** The staff member who is most knowledgeable about the regulations regarding HIV prophylaxis and about obtaining a patient's HIV status and/or ordering patient HIV testing is the occupational health nurse. Performing unauthorized HIV testing or asking the patient yourself would be unethical. The charge nurse is not responsible for obtaining this information (unless the charge nurse is also in charge of occupational health). **Focus:** Prioritization
7. **Ans: 1** Patients with severe immunodeficiency may be unable to produce an immune response, so a negative TB skin test result does not completely rule out a TB diagnosis for this patient. The next steps in diagnosis are chest radiography and sputum culture. Teaching about isoniazid and follow-up TB testing may be required, depending on the radiographic findings and sputum culture results. **Focus:** Prioritization
8. **Ans: 2** Collection of data used to evaluate the therapeutic and adverse effects of medications is included in LPN/LVN education and scope of

practice. Assessment, planning, and teaching are more complex skills that require RN education. Assistance with hygiene and activities of daily living should be delegated to the nursing assistants. **Focus:** Delegation

9. **Ans: 3** To be most effective, cyclosporine must be mixed and administered in accordance with the manufacturer's instructions, so the RN who is likely to have the most experience with the medication should care for this patient or monitor the new graduate carefully during medication preparation and administration. The coronary care unit float nurse and the nurse who is new to the unit would not have experience with this medication. **Focus:** Assignment
10. **Ans: 4** Both naproxen (a nonsteroidal antiinflammatory drug [NSAID]) and prednisone (a corticosteroid) can cause gastrointestinal bleeding, and the stool appearance indicates that blood may be present in the stool. The health care provider should be notified so that actions such as testing a stool specimen for occult blood and administering medications like proton pump inhibitors can be prescribed. The other symptoms are common in patients with RA and will require further assessment or intervention but do not indicate that the patient is experiencing adverse effects from the medications. **Focus:** Prioritization
11. **Ans: 1** Nausea and vomiting are common adverse effects of interferon alfa-2a, but continued vomiting should be reported to the physician, because dehydration may occur. The medication may be given by either the subcutaneous or intramuscular route. Flulike symptoms such as a mild temperature elevation, headache, muscle aches, and anorexia are common after initiation of therapy but tend to decrease over time. **Focus:** Prioritization
12. **Ans: 3** Patients taking immunosuppressive medications are at increased risk for development of cancer. A nontender swelling or lump may signify that the patient has lymphoma. The other data indicate that the patient is experiencing common side effects of the immunosuppressive medications. **Focus:** Prioritization
13. **Ans: 1** Taking antiretroviral medications such as indinavir on a rigid time schedule is essential to treat HIV infection effectively and to avoid development of drug-resistant strains of the virus. The other medications should also be given within the time frame indicated in hospital policy (usually within 30 to 60 minutes of the scheduled time). **Focus:** Prioritization
14. **Ans: 4** Viral load testing measures the amount of HIV genetic material in the blood, so a decrease in viral load indicates that the HAART is effective. The lymphocyte count is used to assess the impact of HIV on immune function but will not directly measure the effectiveness of antiretroviral therapy. Rapid antibody testing and Western blot tests monitor for the presence of antibodies to HIV, so these tests will yield positive results after the patient is infected with HIV even if drug therapy is effective. **Focus:** Prioritization
15. **Ans: 1** Administration of oral medication is included in LPN/LVN education and scope of practice. Assessment, planning of care, and teaching are more complex RN-level interventions. **Focus:** Delegation
16. **Ans: 2** Methotrexate is teratogenic and should not be used by patients who are pregnant. The physician will need to discuss the use of contraception during the time the patient is taking methotrexate. The other patient information may require further patient assessment or teaching but does not indicate that methotrexate may be contraindicated for the patient. **Focus:** Prioritization
17. **Ans: 2** The varicella (chickenpox) vaccine is a live-virus vaccine and should not be administered to patients who are receiving immunosuppressive medications such as prednisone. The other medical orders are appropriate. Prednisone dose should be tapered gradually when patients have received long-term steroid therapy, but tapering is not necessary for short-term prednisone use. Measurement of CRP levels is not the most specific test for monitoring treatment, but the test is inexpensive and frequently used. High doses of NSAIDs such as ibuprofen are more likely to cause side effects like gastrointestinal bleeding but are useful in treating the joint pain associated with SLE exacerbations. **Focus:** Prioritization
18. **Ans: 3** Albuterol is the most rapidly acting of the medications listed. Corticosteroids are helpful in prevention of allergic reactions but are not rapidly acting. Cromolyn is used as a prophylactic medication to prevent asthma attacks but not to treat acute attacks. Aminophylline is not a first-line treatment for bronchospasm. **Focus:** Prioritization
19. **Ans: 1** A high number of patients with SLE develop nephropathy, so an increase in blood urea nitrogen level may indicate a need for a change in therapy or for further diagnostic testing such as a creatinine clearance test or renal biopsy. The other laboratory results are expected in patients with SLE. **Focus:** Prioritization
20. **Ans: 2** A high incidence of latex allergy in seen in individuals with allergic reactions to these fruits. More information and/or testing is needed to determine whether the new employee has a latex allergy, which might affect ability to provide direct patient care. The other findings are important to include in documenting the employee's health history but do not affect ability to provide patient care. **Focus:** Prioritization
21. **Ans: 1** Leukeran is an antineoplastic drug used to treat cancer. The medication used to treat methotrexate toxicity is leucovorin (Wellcovorin), a reduced form of folic acid. Leukeran and leucovorin are "look-alike

sound-alike" drugs that have been identified by the Institute for Safe Medication Practices as being at high risk for involvement in medication errors. The other orders may also need some clarification, because folic acid and vitamin B_{12} are usually given by the parenteral route when more rapid action is needed, and the IV rate may not be appropriate depending on the patient's cardiovascular status. However, the most important order to clarify is the Leukeran order, which is likely an error. **Focus:** Prioritization

22. **Ans: 3** LPN/LVN scope of practice includes care of patients with chronic and stable health problems, such as the patient with chronic graft-versus-host disease. Chemotherapy medications are considered high-alert medications and should be given by RNs who have received additional education in chemotherapy administration. Platelets and other blood products should be given by RNs. The 6-year-old patient has a history and clinical manifestations consistent with neutropenia and sepsis and should be assessed by an RN as quickly as possible. **Focus:** Assignment
23. **Ans: 4** Children who receive aspirin therapy are at risk for development of Reye syndrome if they contract viral illnesses such as varicella or influenza, so the lack of immunization is the greatest concern for this child. The other information also indicates a need for further investigation or intervention but does not place the child at risk for life-threatening complications. **Focus:** Prioritization
24. **Ans: 2** Because protease inhibitors decrease the metabolism of many drugs, including midazolam, serious toxicity can develop when protease inhibitors are given with other medications. Midazolam should not be given to this patient. The other patient data are consistent with the patient's diagnosis of panic attack and do not indicate an urgent need to communicate with the provider. **Focus:** Prioritization

Chapter 5: Infection Control, pages 25-28

1. **Ans: 3** Because SARS is a severe disease with a high mortality rate, the initial action should be to protect other clients and health care workers by placing the client in isolation. If an airborne-agent isolation (negative-pressure) room is not available in the ED, droplet precautions should be initiated until the client can be moved to a negative-pressure room. The other actions should also be taken rapidly but are not as important as preventing transmission of the disease. **Focus:** Prioritization
2. **Ans: 1** Because the respiratory manifestations associated with avian influenza are potentially life-threatening, the nurse's initial action should be to start oxygen therapy. The other interventions should be implemented after addressing the client's respiratory problems. **Focus:** Prioritization
3. **Ans: 3, 2, 4, 1, 5** This sequence will prevent contact of the contaminated gloves and gown with areas (such as your hair) that cannot be easily cleaned after client contact and stop transmission of microorganisms to you and your other clients. The correct method for donning and removal of PPE has been standardized by agencies such as the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration. **Focus:** Prioritization
4. **Ans: 2, 3, 4** Because herpes zoster (shingles) is spread through airborne means and by direct contact with the lesions, you should wear an N95 respirator or high-efficiency particulate air filter respirator, a gown, and gloves. Surgical face masks filter only large particles and will not provide protection from herpes zoster. Goggles and shoe covers are not needed for airborne or contact precautions. **Focus:** Prioritization
5. **Ans: 2** Varicella (chickenpox) is spread by the airborne means and could be rapidly transmitted to other clients in the ED. The child with the rash should be quickly isolated from the other ED clients through placement in a negative-pressure room. Droplet and/or contact precautions should be instituted for the clients with possible pertussis and MRSA infection, but this can be done after isolating the child with possible chickenpox. The client who has been exposed to TB does not place other clients at risk for infection because there are no symptoms of active TB. **Focus:** Prioritization
6. **Ans: 3** Several factors increase the risk for infection for this client: central lines are associated with a higher infection risk, the skin of the neck and chest have high numbers of microorganisms, and the line is nontunneled. Peripherally inserted IV lines such as PICC lines and midline catheters are associated with a lower incidence of infection. Implanted ports are placed under the skin and so are less likely to be associated with catheter infection than a nontunneled central IV line. **Focus:** Prioritization
7. **Ans: 3** LPN/LVN education and scope of practice include performing dressing changes and obtaining specimens for wound culture. Teaching, assessment, and planning of care are complex actions that should be carried out by the RN. **Focus:** Delegation
8. **Ans: 4** The client's age, history of antibiotic therapy, and watery stools suggest that he may have *Clostridium difficile* infection. The initial action should be to place him on contact precautions to prevent the spread of *C. difficile* to other clients. The other actions are also needed and should be taken after placing the client on contact precautions. **Focus:** Prioritization
9. **Ans: 2** To prevent contamination of staff or other clients by anthrax, decontamination of the client by removal and disposal of clothing and showering is the initial action in possible anthrax exposure. Assessment of the client for signs of infection should be performed

after decontamination. Notification of security personnel (and local and regional law enforcement agencies) is necessary in the case of possible bioterrorism, but this should occur after decontaminating and caring for the client. According to the CDC guidelines, antibiotics should be administered only if there are signs of infection or the contaminating substance tests positive for anthrax. **Focus:** Prioritization

10. **Ans: 3** All hospital personnel who care for the client are responsible for correct implementation of contact precautions. The other actions should be carried out by licensed nurses, whose education covers monitoring of laboratory results, client teaching, and methods of minimizing contamination when transporting infected clients. **Focus:** Delegation
11. **Ans: 3** The client's clinical manifestations suggest possible avian influenza ("bird flu"). If the client has traveled recently in Asia or the Middle East, where outbreaks of bird flu have occurred, you will need to institute airborne and contact precautions immediately. The other actions may also be appropriate but are not the initial action to take for this client, who may transmit the infection to other clients or staff members. **Focus:** Prioritization
12. **Ans: 4** Nursing assistants can follow agency policy to disinfect items that come in contact with intact skin (e.g., blood pressure cuffs) by cleaning with chemicals such as alcohol. Teaching and assessment for upper respiratory tract symptoms or use of immunosuppressants require more education and a broader scope of practice, and these tasks should be performed by licensed nurses. **Focus:** Delegation
13. **Ans: 1, 2** A gown and gloves should be used when coming in contact with linens that may be contaminated by the client's wound secretions. The other PPE items are not necessary, because transmission by splashes, droplets, or airborne means will not occur when the bed is changed. **Focus:** Prioritization
14. **Ans: 3** LPN/LVN scope of practice and education include administration of medications. Assessment of hydration status, client and family education, and assessment of client risk factors for diarrhea should be done by the RN. **Focus:** Delegation
15. **Ans: 2** Because the hands of health care workers are the most common means of transmission of infection from one client to another, the most effective method of preventing the spread of infection is to make supplies for hand hygiene readily available for staff to use. Wearing a gown to care for clients who are not on contact precautions is not necessary. Although some hospitals have started screening newly admitted clients for MRSA, there is no evidence that this decreases the spread of infection. Because administration of antibiotics to individuals who are colonized by bacteria may promote development of antibiotic resistance, antibiotic use should be restricted to clients who have clinical manifestations of infection. **Focus:** Prioritization
16. **Ans: 1** Because use of urinary catheters is the most common cause of hospital-acquired UTIs in the United States, the most effective way to reduce UTIs in the hospital setting is to avoid using retention catheters. For example, nurses are involved in developing policies that decrease the unnecessary use of catheters. The other actions also decrease risk for and/or detect UTIs, but avoidance of indwelling catheter use will be more effective. **Focus:** Prioritization
17. **Ans: 3** Clients with infections that require airborne precautions (such as TB) need to be in private rooms. Clients with infections that require contact precautions (such as those with *C. difficile* and VRE infections) should ideally be placed in private rooms; however, they can be placed in rooms with other clients with the same diagnosis. Standard precautions are required for the client with toxic shock syndrome. **Focus:** Prioritization
18. **Ans: 2** Current CDC evidence-based guidelines indicate that droplet precautions for clients with meningococcal meningitis can be discontinued when the client has received antibiotic therapy (with drugs that are effective against *Neisseria meningitidis*) for 24 hours. The other information may indicate that the client's condition is improving but does not indicate that droplet precautions should be discontinued. **Focus:** Prioritization
19. **Ans: 4** Clients who are neutropenic should be placed in positive-airflow rooms; placement of the child in a negative-airflow room will increase the likelihood of infection for this client. Although private rooms are preferred for clients who need droplet precautions, such as clients with RSV infection, they can be placed in rooms with other clients who are infected with the same microorganism. The use of an N95 respirator is not necessary for pertussis, and goggles are not needed for changing the linens of clients infected with *C. difficile;* however, these precautions do not increase risk to the clients. **Focus:** Prioritization
20. **Ans: 1, 3, 4** Because all staff who care for clients should be familiar with the various types of isolation, the nursing assistant will be able to stock the room and post the precautions on the client's door. Reminding visitors about previously taught information is a task that can be done by the nursing assistant, although the RN is responsible for the initial teaching. Client teaching and discussion of the reason for the protective isolation fall within the RN-level scope of practice. **Focus:** Delegation
21. **Ans: 4** The incidence of once-common infectious diseases such as measles, chickenpox, and mumps has been most effectively reduced by immunization of all school-aged children. The other actions are also helpful but will not have as great an impact as immunization. **Focus:** Prioritization

22. **Ans: 1** Administration of varicella-zoster immune globulin can prevent the development of varicella in high-risk clients and will typically be prescribed. Acyclovir therapy and hospitalization may be required if the child develops a varicella-zoster virus infection. Contact and airborne precautions will be implemented to prevent spread of infection to other children if the child develops varicella. **Focus:** Prioritization
23. **Ans: 1** Because clients with rubeola require implementation of airborne precautions, which include placement in a negative-airflow room, this child cannot be admitted to the pediatric unit. The other circumstances may require actions such as staff reassignments but would not prevent the admission of a client with rubeola. **Focus:** Prioritization

Chapter 6: Respiratory Problems, pages 29-34

1. **Ans: 1, 2, 4** The experienced LPN is capable of gathering data and making observations, including noting breath sounds and performing pulse oximetry. Administering medications, such as those delivered via MDIs, is within the scope of practice of the LPN. Independently completing the admission assessment, initiating the nursing care plan, and evaluating a patient's abilities require additional education and skills. These actions are within the scope of practice of the professional RN. **Focus:** Delegation, supervision
2. **Ans: 2** For patients with chronic emphysema, the stimulus to breath is a low serum oxygen level (the normal stimulus is a high carbon dioxide level). This patient's oxygen flow is too high and is causing a high serum oxygen level, which results in a decreased respiratory rate. If you do not intervene, the patient is at risk for respiratory arrest. Crackles, barrel chest, and assumption of a sitting position leaning over the night table are common in patients with chronic emphysema. **Focus:** Prioritization
3. **Ans: 1** When the oxygen flow rate is higher than 4 L/min, the mucous membranes can be dried out. The best treatment is to add humidification to the oxygen delivery system. Application of water-soluble jelly to the nares can also help decrease mucosal irritation. None of the other options will treat the problem. **Focus:** Prioritization
4. **Ans: 3** When tracheostomy care is performed, a sterile field is set up and sterile technique is used. Standard precautions such as washing hands must also be maintained but are not enough when performing tracheostomy care. The presence of a tracheostomy tube provides direct access to the lungs for organisms, so sterile technique is used to prevent infection. All of the other steps are correct and appropriate. **Focus:** Delegation, supervision
5. **Ans: 2, 3, 4, 5** The correct position for a patient with an anterior nosebleed is upright and leaning forward to prevent blood from entering the stomach and avoid aspiration. All of the other instructions are appropriate according to best practice for emergency care of a patient with an anterior nosebleed. **Focus:** Delegation, supervision, assignment
6. **Ans: 3** The nursing assistant can remind patients about actions that have already been taught by the nurse and are part of the patient's plan of care. Discussing and teaching require additional education and training. These actions are within the scope of practice of the RN. The RN can delegate administration of the medication to an LPN/LVN. **Focus:** Delegation, supervision
7. **Ans: 1, 2** The new RN is at an early point in her orientation. The most appropriate patients to assign to her are those in stable condition who require routine care. The patient with the lobectomy will require the care of an experienced nurse, who will perform frequent assessments and monitoring for postoperative complications. The patient admitted with newly diagnosed esophageal cancer will also benefit from care by an experienced nurse. This patient may have questions and needs a comprehensive admission assessment. As the new nurse advances through her orientation, you will want to work with her in providing care for these patients with more complex needs. **Focus:** Assignment, delegation, supervision
8. **Ans: 1, 2, 4, 5** Bedding should be washed in hot water to destroy dust mites. All of the other points are accurate and appropriate to a teaching plan for a patient with a new diagnosis of asthma. **Focus:** Prioritization
9. **Ans: 1, 3, 2, 5, 4, 6** Before each use, the cap is removed and the inhaler is shaken according to the instructions in the package insert. Next the patient should tilt the head back and breathe out completely. As the patient begins to breathe in deeply through the mouth, the canister should be pressed down to release one puff (dose) of the medication. The patient should continue to breathe in slowly over 3 to 5 seconds and then hold the breath for at least 10 seconds to allow the medication to reach deep into the lungs. The patient should wait at least 1 minute between puffs from the inhaler. **Focus:** Prioritization
10. **Ans: 1** Assisting patients with positioning and activities of daily living is within the educational preparation and scope of practice of a nursing assistant. Teaching, instructing, and assessing patients all require additional education and skills and are more appropriate to the scope of practice of licensed nurses. **Focus:** Delegation, supervision
11. **Ans: 1** Experienced LPNs/LVNs can use observation of patients to gather data regarding how well patients perform interventions that have already been taught. Assisting patients with activities of daily living is more appropriately delegated to a nursing

assistant. Planning and consulting require additional education and skills, appropriate to the RN's scope of practice. **Focus:** Delegation, supervision

12. **Ans: 4** A patient who did not have the pneumonia vaccination or flu shot is at increased risk for developing pneumonia or influenza. An elevated temperature indicates some form of infection, which may be respiratory in origin. All of the other vital sign values are slightly elevated but are not a cause for immediate concern. **Focus:** Delegation, supervision
13. **Ans: 2** The nursing assistant's training includes how to monitor and record intake and output. After the nurse has taught the patient about the importance of adequate nutritional intake for energy, the nursing assistant can remind and encourage the patient to take in adequate nutrition. Instructing patients and planning activities require more education and skill, and are appropriate to the RN's scope of practice. Monitoring the patient's cardiovascular response to activity is a complex process requiring additional education, training, and skill, and falls within the RN's scope of practice. **Focus:** Delegation, supervision
14. **Ans: 2** Continuous bubbling indicates an air leak that must be identified. With the physician's order you can apply a padded clamp to the drainage tubing close to the occlusive dressing. If the bubbling stops, the air leak may be at the chest tube insertion, which will require you to notify the physician. If the air bubbling does not stop when you apply the padded clamp, the air leak is between the clamp and the drainage system, and you must assess the system carefully to locate the leak. Chest tube drainage of 10 to 15 mL/hr is acceptable. Chest tube dressings are not changed daily but may be reinforced. The patient's complaints of pain need to be assessed and treated. This is important but is not as urgent as investigating a chest tube leak. **Focus:** Delegation, supervision
15. **Ans: 4** The patient with asthma did not achieve relief from shortness of breath after using the bronchodilator and is at risk for respiratory complications. This patient's needs are urgent. The other patients need to be assessed as soon as possible, but none of their situations is urgent. In COPD patients pulse oximetry oxygen saturations of more than 90% are acceptable. **Focus:** Prioritization
16. **Ans: 3** A nursing assistant can remind the patient to perform actions that are already part of the plan of care. Assisting the patient into the best position to facilitate coughing requires specialized knowledge and understanding that is beyond the scope of practice of the basic nursing assistant. However, an experienced nursing assistant could assist the patient with positioning after the nursing assistant and the patient had been taught the proper technique. The nursing assistant would still be under the supervision of the RN. Teaching patients about adequate fluid intake and techniques that facilitate coughing requires additional education and skill, and is within the scope of practice of the RN. **Focus:** Delegation, supervision
17. **Ans: 3** Many surgical patients are taught about coughing, deep breathing, and use of incentive spirometry preoperatively. To care for the patient with TB in isolation, the nurse must be fitted for a high-efficiency particulate air (HEPA) respirator mask. The bronchoscopy patient needs specialized and careful assessment and monitoring after the procedure, and the ventilator-dependent patient needs a nurse who is familiar with ventilator care. Both of these patients need experienced nurses. **Focus:** Assignment
18. **Ans: 2** Patients taking isoniazid must continue the drug for 6 months. The other three statements are accurate and indicate understanding of TB. Family members should be tested because of their repeated exposure to the patient. Covering the nose and mouth when sneezing or coughing, and placing tissues in plastic bags help prevent transmission of the causative organism. The dietary changes are recommended for patients with TB. **Focus:** Prioritization
19. **Ans: 1** Patients who have recently experienced trauma are at risk for deep vein thrombosis and pulmonary embolus. None of the other findings are risk factors for pulmonary embolus. Prolonged immobilization is also a risk factor for deep vein thrombosis and pulmonary embolus, but this period of bed rest was very short. **Focus:** Prioritization
20. **Ans: 4** An LPN who has been trained to auscultate lung sounds can gather data by routine assessment and observation, under supervision of an RN. Independently evaluating patients, assessing for symptoms of respiratory failure, and monitoring and interpreting laboratory values require additional education and skill, appropriate to the scope of practice of the RN. **Focus:** Delegation, supervision
21. **Ans: 1, 2, 3, 5** While a patient is receiving anticoagulation therapy, it is important to avoid trauma to the rectal tissue, which could cause bleeding (e.g., avoid rectal thermometers and enemas). All of the other instructions are appropriate to the care of a patient receiving anticoagulants. **Focus:** Delegation, supervision
22. **Ans: 1** A nonrebreather mask can deliver nearly 100% oxygen. When the patient's oxygenation status does not improve adequately in response to delivery of oxygen at this high concentration, refractory hypoxemia is present. Usually at this stage, the patient is working very hard to breathe and may go into respiratory arrest unless health care providers intervene by providing intubation and mechanical ventilation to decrease the patient's work of breathing. **Focus:** Prioritization

ANSWER KEY

23. **Ans: 3** The endotracheal tube should be marked at the level where it touches the incisor tooth or nares. This mark is used to verify that the tube has not shifted. The other three actions are appropriate after endotracheal tube placement. The priority at this time is to verify that the tube has been correctly placed. **Focus:** Delegation, supervision, prioritization
24. **Ans: 2** The nursing assistant's educational preparation includes measurement of vital signs, and an experienced nursing assistant would know how to check oxygen saturation by pulse oximetry. Assessing and observing the patient, as well as checking ventilator settings, require the additional education and skills of the RN. **Focus:** Delegation, supervision
25. **Ans: 4** Infections are always a threat for the patient receiving mechanical ventilation. The endotracheal tube bypasses the body's normal air-filtering mechanisms and provides a direct access route for bacteria or viruses to the lower parts of the respiratory system. **Focus:** Prioritization
26. **Ans: 3** Confusion in a patient this age is unusual and may be an indication of intracerebral bleeding associated with enoxaparin use. The right leg symptoms are consistent with a resolving deep vein thrombosis; the patient may need teaching about keeping the right leg elevated above the heart to reduce swelling and pain. The presence of ecchymoses may point to a need to do more patient teaching about avoiding injury while taking anticoagulants but does not indicate that the physician needs to be called. **Focus:** Prioritization
27. **Ans: 2** Manual ventilation of the patient will allow you to deliver an Fio_2 of 100% to the patient while you attempt to determine the cause of the high-pressure alarm. The patient may need reassurance, suctioning, and/or insertion of an oral airway, but the first step should be assessment of the reason for the high-pressure alarm and resolution of the hypoxemia. **Focus:** Prioritization
28. **Ans: 4** The patient's history and symptoms suggest the development of ARDS, which will require intubation and mechanical ventilation. The maximum oxygen delivery with a nasal cannula is an Fio_2 of 44%. This is achieved with the oxygen flow at 6 L/min, so increasing the flow to 10 L/min will not be helpful. Helping the patient to cough and deep breathe will not improve the lung stiffness that is causing his respiratory distress. Morphine sulfate will only decrease the respiratory drive and further contribute to his hypoxemia. **Focus:** Prioritization
29. **Ans: 3** Removal of large quantities of fluid from the pleural space can cause fluid to shift from the circulation into the pleural space, causing hypotension and tachycardia. The patient may need to receive IV fluids to correct this. The other data indicate that the patient needs ongoing monitoring and/or interventions but would not be unusual findings for a patient with this diagnosis or after this procedure. **Focus:** Prioritization
30. **Ans: 3** Research indicates that nursing actions such as maintaining the head of the bed at 30 to 45 degrees decrease the incidence of VAP. These actions are part of the standard of care for patients who require mechanical ventilation. The other actions are also appropriate for this patient but will not decrease the incidence of VAP. **Focus:** Prioritization
31. **Ans: 1** Medication safety guidelines indicate that use of a trailing zero is not appropriate when writing medication orders because the order can easily be mistaken for a larger dose, such as 10 mg. The order should be clarified before administration. The other orders are appropriate, based on the patient's diagnosis. **Focus:** Prioritization
32. **Ans: 1** Airway clearance techniques are critical for patients with cystic fibrosis and should take priority over the other activities. Although allowing more independent decision making is important for adolescents, the physiologic need for improved respiratory function takes precedence at this time. A private room may be desirable for the patient but is not necessary. With increased shortness of breath, it will be more important that the patient have frequent respiratory treatments than 8 hours of sleep. **Focus:** Prioritization
33. **Ans: 1** Frequent swallowing after tonsillectomy may indicate bleeding. You should inspect the back of the throat for evidence of bleeding. The other assessment results are not unusual in a 3-year-old after surgery. **Focus:** Prioritization
34. **Ans: 3** The most common complications after birth for infants with RDS is pneumothorax. Alveoli rupture and air leaks into the chest and compresses the lungs, which makes breathing difficult. **Focus:** Prioritization
35. **Ans: 2** Exosurf neonatal is a form of synthetic surfactant. An infant with RDS may be given two to four doses during the first 24 to 48 hours after birth. It improves respiratory status, and research has shown a significant decrease in the incidence of pneumothorax when it is administered. **Focus:** Prioritization

Chapter 7: Cardiovascular Problems, pages 35-40

1. **Ans: 2** Cardiac troponin levels are elevated 3 hours after the onset of acute coronary syndrome (unstable angina or myocardial infarction) and are very specific to cardiac muscle injury or infarction. Although levels of creatine kinase MB and myoglobin also increase with myocardial infarction, the increases occur later and/or are not as specific to myocardial damage as troponin levels. Elevated C-reactive protein levels are a risk factor for coronary artery disease but are not useful in detecting acute injury or infarction. **Focus:** Prioritization

2. **Ans: 4** Chest pain in a client undergoing a stress test indicates myocardial ischemia and is an indication to stop the testing to avoid ongoing ischemia, injury, or infarction. Moderate elevations in blood pressure and heart rate and slight decreases in oxygen saturation are a normal response to exercise and are expected during stress testing. **Focus:** Prioritization
3. **Ans: 1, 4, 6** Attaching cardiac monitor leads, obtaining an ECG, and administering oral medications are within the scope of practice of LPNs. An experienced ED LPN would be familiar with these activities. Anticoagulants and narcotics are high-alert medications that should be given by an RN. Obtaining a pertinent medical history requires RN-level education and scope of practice. **Focus:** Delegation
4. **Ans: 4** Research indicates that reducing sodium intake will lower blood pressure. Lifestyle management is appropriate initial therapy for this client with stage 1 hypertension and no cardiovascular disease or risk factors. Antihypertensive medications would not be prescribed unless lifestyle changes were attempted for several months without a decrease in blood pressure. This client's assessment data indicate that she is not overweight and does not drink alcohol excessively, so discussing changes in these risk factors would not be appropriate. **Focus:** Prioritization
5. **Ans: 3** A persistent and irritating cough (caused by accumulation of bradykinin) is a possible adverse effect of angiotensin-converting enzyme inhibitors such as enalapril and is a common reason for changing to another medication category such as the angiotensin II receptor blockers. The other assessment data indicate a need for more client teaching and ongoing monitoring but would not require a change in therapy. **Focus:** Prioritization
6. **Ans: 1, 2** The client's major modifiable risk factor is her ongoing smoking. The family history is significant, and she should be aware that this increases her cardiovascular risk. The goal when treating hypertension with medications is reduction of the blood pressure to under 140/90 mm Hg. There is no indication that stress is a risk factor for this client. The client's work involves moderate physical activity; although leisure exercise may further decrease her cardiac risk, this is not an immediate need for this client. **Focus:** Prioritization
7. **Ans: 2** An RN who worked on a medical-surgical unit would be familiar with left ventricular failure, the administration of IV medications, and ongoing monitoring for therapeutic and adverse effects of furosemide. The other clients need to be cared for by RNs who are more familiar with the care of clients who have acute coronary syndrome and with collaborative treatments such as coronary angioplasty and coronary artery stenting. **Focus:** Assignment
8. **Ans: 4** Because continuous chest pain lasting for more than 6 hours indicates that reversible myocardial injury has progressed to irreversible myocardial necrosis, fibrinolytic drugs are usually not given to clients with chest pain that has lasted for more than 6 hours (in some centers, 12 hours). The other information is also important to communicate but would not impact the decision about alteplase use. **Focus:** Prioritization
9. **Ans: 1** Administration of nitroglycerin and appropriate client monitoring for therapeutic and adverse effects are included in LPN/LVN education and scope of practice. Monitoring of blood pressure, pulse, and oxygen saturation should be delegated to the nursing assistant. Client teaching requires RN-level education and scope of practice. **Focus:** Delegation
10. **Ans: 3** The priority for a client with unstable angina or myocardial infarction is treatment of pain. It is important to remember to assess vital signs before administering sublingual nitroglycerin. The other activities also should be accomplished rapidly but are not as high a priority. **Focus:** Prioritization
11. **Ans: 3** The best option in this situation is to educate the client about the purpose of the docusate (to counteract the negative effects of immobility and narcotic use on peristalsis). Charting the medication as "refused" or telling the client that he should take the docusate simply because it was ordered are possible actions but are not as appropriate as client education. It is illegal to administer a medication to a client who is unwilling to take it, unless someone else has health care power of attorney and has authorized use of the medication. **Focus:** Prioritization
12. **Ans: 4** The goal in pain management for the client with an acute myocardial infarction is to completely eliminate the pain. Even pain rated at a level of 1 out of 10 should be treated with additional morphine sulfate (although possibly a lower dose). The other data indicate a need for ongoing assessment for the possible adverse effects of hypotension, respiratory depression, and tachycardia but do not require further action at this time. **Focus:** Prioritization
13. **Ans: 2** For behavior to change, the client must be aware of the need to make changes. This response acknowledges the client's statement and asks for further clarification. This will give you more information about the client's feelings, current diet, and activity levels and may increase the willingness to learn. The other responses (although possibly accurate) indicate an intention to teach whether the client is ready or not and are not likely to lead to changes in client lifestyle. **Focus:** Prioritization
14. **Ans: 3** Hyperkalemia is a common adverse effect of both angiotensin-converting enzyme inhibitors and potassium-sparing diuretics. The other laboratory values may be affected by these medications but are

not as likely or as potentially life threatening. **Focus:** Prioritization

15. **Ans: 1** The first priority for an ambulating client who is dizzy is to prevent falls, which could lead to serious injury. The other actions are also appropriate but are not as high a priority. **Focus:** Prioritization
16. **Ans: 1** Because TEE is performed after the throat is numbed using a topical anesthetic and possibly after IV sedation, it is important that the client be placed on NPO status for several hours before the test. The other actions also will need to be accomplished before the TEE but do not need to be implemented immediately. **Focus:** Prioritization
17. **Ans: 4** The most common complication after coronary arteriography is hemorrhage, and the earliest indication of hemorrhage is an increase in heart rate. The other data may also indicate a need for ongoing assessment, but the increase in heart rate is of most concern. **Focus:** Prioritization
18. **Ans: 1** Measurement of ankle and brachial blood pressures for ankle-brachial index calculation is within the nursing assistant's scope of practice. Calculation of the ankle-brachial index and any referrals or discussion with the client are the responsibility of the supervising RN. The other clients require more complex assessments or client teaching, which should be done by an experienced RN. **Focus:** Delegation
19. **Ans: 2** The new RN's education and hospital orientation would have included safe administration of IV medications. The preceptor will be responsible for supervision of the new graduate in assessments and client care. The other clients require more complex assessment or client teaching by an RN with experience in caring for clients with these diagnoses. **Focus:** Assignment
20. **Ans: 3** Premature ventricular contractions occurring in the setting of acute myocardial injury or infarction can lead to ventricular tachycardia and/or ventricular fibrillation (cardiac arrest), so rapid treatment is necessary. The other clients also have dysrhythmias that will require further assessment, but these are not as immediately life threatening as the premature ventricular contractions in the setting of myocardial infarction. **Focus:** Prioritization
21. **Ans: 1** The only effective treatment for ventricular fibrillation is defibrillation. If defibrillation is unsuccessful in converting the client's rhythm into a perfusing rhythm, CPR should be initiated. Administration of medications and intubation are later interventions. Determination of which of these interventions will be used first depends on other factors, such as whether IV access is available. **Focus:** Prioritization
22. **Ans: 4** When therapy with carvedilol is started for clients with heart failure, it is expected that the heart failure symptoms will initially become worse for a few weeks, so the increased fatigue, activity intolerance, weight gain, and crackles at the lung bases do not indicate a need to discontinue the medication at this time. However, the slow heart rate does require further follow-up, because bradycardia may progress to more serious dysrhythmias such as heart block. **Focus:** Prioritization
23. **Ans: 2** The client's symptoms indicate acute hypoxia, so immediate further assessments (such as assessment of oxygen saturation, neurologic status, and breath sounds) are indicated. The other clients also should be assessed soon, because they are likely to require nursing actions such as medication administration and teaching, but they are not as acutely ill as the dyspneic client. **Focus:** Prioritization
24. **Ans: 2** LPN/LVN education and scope of practice include data collection such as listening to lung sounds and checking for peripheral edema when caring for stable clients. Weighing the residents should be delegated to nursing assistants. Reviewing medications with residents and planning appropriate activity levels are nursing actions that require RN-level education and scope of practice. **Focus:** Delegation
25. **Ans: 3** The client's visual disturbances may be a sign of digoxin toxicity. The nurse should notify the physician and obtain an order for measurement of digoxin level. An irregularly irregular pulse is expected with atrial fibrillation; there are no contraindications to taking digoxin with food; and crackles that clear with coughing are indicative of atelectasis, not worsening of heart failure. **Focus:** Prioritization
26. **Ans: 2, 4, 3, 1** The primary goal is to decrease the cardiac ischemia that may be causing the client's tachycardia. This would be most rapidly accomplished by decreasing the workload of the heart and administering supplemental oxygen. Changes in blood pressure indicate the impact of the tachycardia on cardiac output and tissue perfusion. Finally, the physician should be notified about the client's response to activity, because changes in therapy may be indicated. **Focus:** Prioritization
27. **Ans: 3** The client's history and symptoms indicate that acute arterial occlusion has occurred. Because it is important to return blood flow to the foot rapidly, the physician should be notified immediately so that interventions such as balloon angioplasty or surgery can be initiated. Changing the position of the foot and improving blood oxygen saturation will not improve oxygen delivery to the foot. Telling the client that embolization is a common complication of endocarditis will not reassure a client who is experiencing acute pain. **Focus:** Prioritization
28. **Ans: 4** Assisting with hygiene is included in the role and education of nursing assistants. Assessments and teaching are appropriate activities for licensed nursing staff members. **Focus:** Delegation

29. **Ans: 1** Elevated blood pressure in the immediate postoperative period puts stress on the graft suture line and could lead to graft rupture and/or hemorrhage, so it is important to lower the blood pressure quickly. The other data also indicate the need for ongoing assessments and possible interventions but do not pose an immediate threat to the client's hemodynamic stability. **Focus:** Prioritization
30. **Ans: 3** Development of plans for client care or teaching requires RN-level education and is the responsibility of the RN. Wound care, medication administration, assisting with ambulation, and reinforcing previously taught information are activities that can be delegated to other nursing personnel under the supervision of the RN. **Focus:** Delegation
31. **Ans: 4** Anticoagulant medications are high-alert medications and require special safeguards, such as double-checking medications by two nurses before administration. Although the other medications require the usual medication safety procedures, double-checking is not needed. **Focus:** Prioritization
32. **Ans: 4.** Circumoral cyanosis indicates a drop in the partial pressure of oxygen that may precipitate seizures and loss of consciousness. The nurse should rapidly place the child in a knee-chest position, administer oxygen, and take steps to calm the child. The other assessment data are expected in a child with congenital heart defects like tetralogy of Fallot. **Focus:** Prioritization
33. **Ans: 3** Crackles throughout both lungs indicate that the child has severe left ventricular failure as a complication of endocarditis. Hypoxemia is likely, so the child needs rapid assessment of oxygen saturation, initiation of supplemental oxygen delivery, and administration of medications such as diuretics. The other children should also be assessed as quickly as possible, but they are not experiencing life-threatening complications of their medical diagnoses. **Focus:** Prioritization
34. **Ans: 1** This client requires the least complex assessments and interventions of the four clients. Safe administration of oral medications such as digoxin would have been included in the orientation of the new RN graduate. The conditions of the other clients are more complex, and they require assessments and/or interventions (such as teaching) that should be carried out by an RN with more experience. **Focus:** Assignment

Chapter 8: Hematologic Problems, pages 41-44

1. **Ans: 4** An elevation in white blood cell count may indicate that the patient has an infection, which would likely require rescheduling of the surgical procedure. The other values are slightly abnormal, but would not be likely to cause postoperative problems for knee arthroscopy. **Focus:** Prioritization
2. **Ans: 3** Normal saline, an isotonic solution, should be used when priming the IV line to avoid causing hemolysis of RBCs. Ideally, blood products should be infused as soon as possible after they are obtained; however, a 20-minute delay would not be unsafe. Large-gauge IV catheters are preferable for blood administration; if a smaller catheter must be used, normal saline may be used to dilute the RBCs. Although the new RN should avoid increasing patient anxiety by indicating that a serious transfusion reaction may occur, this action is not as high a concern as use of an inappropriate fluid for priming the IV tubing. **Focus:** Prioritization
3. **Ans: 2** Hypoxia and deoxygenation of the RBCs are the most common cause of sickling, so administration of oxygen is the priority intervention here. Pain control and hydration are also important interventions for this patient and should be accomplished rapidly. Vaccination may help prevent future sickling episodes by decreasing the risk of infection, but it will not help with the current sickling crisis. **Focus:** Prioritization
4. **Ans: 1** An experienced nursing assistant would have been taught how to obtain a stool specimen for the Hemoccult slide test, because this is a common screening test for hospitalized patients. Having the patient sign an informed consent form should be done by the physician who will be performing the colonoscopy. Administering medications and checking for allergies are within the scope of practice of licensed nursing staff. **Focus:** Delegation
5. **Ans: 3** A nurse who works in the PACU will be familiar with the monitoring needed for a patient who has just returned from a procedure like a colonoscopy, which requires conscious sedation. Care of the other patients requires staff with more experience with various types of hematologic disorders and would be better to assign to nursing personnel who regularly work on the medical-surgical unit. **Focus:** Assignment
6. **Ans: 1** Patients with pancytopenia are at higher risk for infection. The patient with digoxin toxicity presents the least risk of infecting the new patient. Viral pneumonia, shingles, and cellulitis are infectious processes. **Focus:** Prioritization
7. **Ans: 2** The joint pain that occurs in sickle cell crisis is caused by obstruction of blood flow by the sickled red blood cells. Cold packs will further decrease blood flow to the patient's knees and increase sickling. The appropriate therapy for this patient is application of moist heat to the joints to cause vasodilation and improve circulation. Genetic counseling may be provided to patients with sickle cell disease but is not appropriate to suggest to a 10-year-old. Although infection control is important in preventing and treating sickle cell crisis, there is no need to restrict all visitors or to check the temperature every 2 hours. **Focus:** Prioritization

8. **Ans: 3** Because aspirin will decrease platelet aggregation, patients with thrombocytopenia should not use aspirin routinely. Patient teaching about this should be included in the care plan. Bruising is consistent with the patient's admission problem of thrombocytopenia. Soft, dark brown stools indicate that there is no frank blood in the bowel movements. Although the patient's decreased appetite requires further assessment by the nurse, this is a common complication of chemotherapy. **Focus:** Prioritization
9. **Ans: 2** When a hemophiliac patient is at high risk for bleeding, the priority intervention is to maximize the availability of clotting factors. The other orders also should be implemented rapidly but do not have as high a priority as administration of clotting factors. **Focus:** Prioritization
10. **Ans: 1** Patients taking warfarin are advised to avoid making sudden dietary changes, because changing the oral intake of foods high in vitamin K (such as green leafy vegetables and some fruits) will have an impact on the effectiveness of the medication. The other statements suggest that further teaching may be indicated, but more assessment for teaching needs is required first. **Focus:** Prioritization
11. **Ans: 3** Because the decrease in oxygen saturation will have the greatest immediate effect on all body systems, improvement in oxygenation should be the priority goal of care. The other data also indicate the need for rapid intervention, but improvement of oxygenation is the most urgent need. **Focus:** Prioritization
12. **Ans: 3** More assessment about what the patient means is needed before any interventions can be planned or implemented. All of the other statements indicate an assumption that the patient is afraid of dying of Hodgkin disease, which may not be the case. **Focus:** Prioritization
13. **Ans: 4** Any temperature elevation in a neutropenic patient may indicate the presence of a life-threatening infection, so actions such as drawing blood for culture and administering antibiotics should be initiated quickly. The other patients need to be assessed as soon as possible but are not critically ill. **Focus:** Prioritization
14. **Ans: 2** Nursing assistant education covers routine nursing skills such as assessment of vital signs. Evaluation, baseline assessment of patient abilities, and nutrition planning are activities appropriate to RN practice. **Focus:** Delegation
15. **Ans: 3** The patient's symptoms indicate that a transfusion reaction may be occurring, so the first action should be to stop the transfusion. Chills are an indication of a febrile reaction, so warming the patient may not be appropriate. Checking the patient's temperature and administering oxygen are also appropriate actions if a transfusion reaction is suspected; however, stopping the transfusion is the priority. **Focus:** Prioritization
16. **Ans: 1** LPNs/LVNs should be assigned to care for stable patients. Subcutaneous administration of epoetin is within the LPN/LVN scope of practice. Blood transfusions should be administered by RNs, because evaluation for and management of transfusion reactions require RN-level education and scope of practice. The other patients will require teaching about phlebotomy and bone marrow aspiration that should be implemented by the RN. **Focus:** Assignment
17. **Ans: 4** The leg numbness may indicate spinal cord compression, which should be evaluated and treated immediately by the physician to prevent further loss of function. Chronic bone pain, hyperuricemia, and the presence of Bence Jones proteins in the urine all are typical of multiple myeloma and do require assessment and/or treatment; the loss of motor or sensory function is an emergency. **Focus:** Prioritization
18. **Ans: 2** Because the spleen has an important role in the phagocytosis of microorganisms, the patient is at higher risk for severe infection after a splenectomy. Medical therapy, such as antibiotic administration, is usually indicated for any symptoms of infection. The other information also indicates the need for more assessment and intervention, but prevention and treatment of infection are the highest priorities for this patient. **Focus:** Prioritization
19. **Ans: 3** Infusion of IV fluids is a common intervention that can be implemented by RNs who do not have experience in caring for patients who are severely immunosuppressed. Administration of cyclosporine, assessment for subtle indications of infection, and patient teaching are more complex tasks that should be done by RN staff members who have experience caring for immunosuppressed patients. **Focus:** Delegation
20. **Ans: 3** Because many aspects of nursing care need to be modified to prevent infection when a patient has a low absolute neutrophil count, care should be provided by the staff member with the most experience with neutropenic patients. The other staff members have the education required to care for this patient but are not as clinically experienced. When LPN/LVN staff members are given acute care patient assignments, they must work under the supervision of an RN. The LPN in this case would report to the RN assigned to the patient. **Focus:** Assignment
21. **Ans: 4** A patient with neutropenia is at increased risk for infection, so the LTC charge nurse needs to know about the neutropenia to make decisions about the patient's room assignment and to plan care. The other information also will impact planning for patient care, but the charge nurse needs the information about neutropenia before the patient is transferred. **Focus:** Prioritization

22. **Ans: 1** Fatal hyperkalemia may be caused by tumor lysis syndrome, a potentially serious consequence of chemotherapy in acute leukemia. The other symptoms also indicate a need for further assessment or interventions but are not as critical as the elevated potassium level. **Focus:** Prioritization
23. **Ans: 2** A nontender swelling in this area (or near any lymph node) may indicate that the patient has developed lymphoma, a possible adverse effect of immunosuppressive therapy. The patient should receive further evaluation immediately. The other symptoms may also indicate side effects of cyclosporine (gingival hyperplasia, nausea, paresthesia), but do not indicate the need for immediate action. **Focus:** Prioritization
24. **Ans: 4** Skin care is included in nursing assistant education and job description. Assessment and patient teaching are more complex tasks that should be delegated to registered nurses. Because the patient's clothes need to be carefully chosen to prevent irritation or damage to the skin, the RN should assist the patient with this. **Focus:** Delegation
25. **Ans: 1** The newly admitted patient should be assessed first, because the baseline assessment and plan of care need to be completed. The other patients also need assessments or interventions but do not need immediate nursing care. **Focus:** Prioritization
26. **Ans: 1** Because decreased responsiveness in a 1-year-old with a clotting disorder may indicate intracerebral bleeding, this patient should be assessed immediately. The other patients also require assessments or interventions but are not at immediate risk for life-threatening or disabling complications. **Focus:** Prioritization
27. **Ans: 2** The low hemoglobin level suggests that the child may have active bleeding, and rapid actions such as diagnostic testing and transfusions are indicated. The other laboratory data are expected in a child with idiopathic thrombocytopenic purpura. **Focus:** Prioritization
28. **Ans: 3** Methotrexate is a high-alert drug, and extra precautions, such as double-checking with another nurse, should be taken when administering this medication. Although many pediatric units have a policy requiring that all medication administration to children be double-checked, the other medications listed are not on the high-alert list published by the Institute for Safe Medication Practices. **Focus:** Prioritization

Chapter 9: Neurologic Problems, pages 45-50

1. **Ans: 1** The priority for interdisciplinary care for the client experiencing a migraine headache is pain management. All of the other nursing diagnoses are accurate, but none of them is urgent like the issue of pain, which is often incapacitating. **Focus:** Prioritization
2. **Ans: 1, 2, 3, 4, 5** Medications such as estrogen supplements may actually trigger a migraine headache attack. All of the other statements are accurate. **Focus:** Prioritization
3. **Ans: 3** Measurement of vital signs is within the education and scope of practice of a nursing assistant. The nurse should perform neurologic checks and document the seizure. Clients with seizures should not be restrained; however, the nurse may guide the client's movements if necessary. **Focus:** Delegation, supervision
4. **Ans: 2** The LPN can set up the equipment for oxygen and suctioning. The RN should perform the complete initial assessment. Controversy exists as to whether padded side rails actually provide safety, and their use may embarrass the client and family. Tongue blades should not be at the bedside and should never be inserted into the client's mouth after a seizure begins. **Focus:** Delegation, supervision
5. **Ans: 4** A client with a seizure disorder should not take over-the-counter medications without consulting with the physician first. The other three statements are appropriate teaching points for clients with seizure disorders and their families. **Focus:** Delegation, supervision
6. **Ans: 3** The nursing assistant should help the client with morning care as needed, but the goal is to keep this client as independent and mobile as possible. The client should be encouraged to perform as much morning care as possible. Assisting the client in ambulating, reminding the client not to look at his feet (to prevent falls), and encouraging the client to feed himself are all appropriate to the goal of maintaining independence. **Focus:** Delegation, supervision
7. **Ans: 1** Exercises are used to strengthen the back, relieve pressure on compressed nerves, and protect the back from reinjury. Ice, heat, and firm mattresses are appropriate intervention for back pain. People with chronic back pain should avoid wearing high-heeled shoes at all times. **Focus:** Prioritization
8. **Ans: 2** These signs and symptoms are characteristic of autonomic dysreflexia, a neurologic emergency that must be promptly treated to prevent a hypertensive stroke. The cause of this syndrome is noxious stimuli, most often a distended bladder or constipation, so checking for poor catheter drainage, bladder distention, and fecal impaction is the first action that should be taken. Adjusting the room temperature may be helpful, because too cool a temperature in the room may contribute to the problem. Acetaminophen will not decrease the autonomic dysreflexia that is causing the client's headache. Notification of the physician may be necessary if nursing actions do not resolve symptoms. **Focus:** Prioritization

9. **Ans: 2** The new RN graduate who is on orientation to the unit should be assigned to care for clients with stable, noncomplex conditions, such as the client with stroke. The task of helping the client with Parkinson disease to bathe is best delegated to a nursing assistant. The client being transferred to the nursing home and the new admitted client with SCI should be assigned to experienced nurses. **Focus:** Assignment
10. **Ans: 4** The first priority for the client with an SCI is assessing respiratory patterns and ensuring an adequate airway. A client with a high cervical injury is at risk for respiratory compromise, because the spinal nerves (C3 though C5) innervate the phrenic nerve, which controls the diaphragm. The other assessments are also necessary but are not as high a priority. **Focus:** Prioritization
11. **Ans: 2** The nursing assistant's training and education covers measuring and recording client's vital signs. The nursing assistant may help with turning and repositioning the client and may remind the client to cough and deep breathe but does not teach the client how to perform these actions. Assessing and monitoring clients require additional education and are appropriate to the scope of practice of professional nurses. **Focus:** Delegation, supervision
12. **Ans: 1, 2, 4, 5** All of the strategies except straight catheterization may stimulate voiding in clients with SCI. Intermittent bladder catheterization can be used to empty the client's bladder, but it will not stimulate voiding. **Focus:** Prioritization
13. **Ans: 1, 3, 4** Checking and observing for signs of pressure or infection is within the scope of practice of the LPN/LVN. The LPN/LVN also has the appropriate skills for cleaning the halo insertion sites with hydrogen peroxide. Neurologic examination requires additional education and skill appropriate to the professional RN. **Focus:** Delegation, supervision
14. **Ans: 3** The client's statement indicates impairment of adjustment to the limitations of the injury and the need for additional counseling, teaching, and support. The other three nursing diagnoses may be appropriate for a client with SCI but are not related to the client's statement. **Focus:** Prioritization
15. **Ans: 2** The traveling nurse is relatively new to neurologic nursing and should be assigned clients whose condition is stable and not complex. The newly diagnosed client will need a lot of teaching and support. The client with respiratory distress will need frequent assessments and may need to be transferred to the ICU. The client with C4-level SCI is at risk for respiratory arrest. All three of these clients should be assigned to nurses experienced in neurologic nursing care. **Focus:** Assignment
16. **Ans: 4** At this time, based on the client's statement, the priority is Self-Care Deficit related to fatigue after physical therapy. The other three nursing diagnoses are appropriate to a patent with MS but are not related to the client's statement. **Focus:** Prioritization
17. **Ans: 4** The priority intervention for a client with GBS is maintaining adequate respiratory function. Clients with GBS are at risk for respiratory failure, which requires urgent intervention. The other findings are important and should be reported to the nurse, but they are not life threatening. **Focus:** Prioritization, delegation, supervision
18. **Ans: 2** The changes that the nursing assistant is reporting are characteristic of myasthenic crisis, which often follows some type of infection. The client is at risk for inadequate respiratory function. In addition to notifying the physician, the nurse should carefully monitor the client's respiratory status. The client may need intubation and mechanical ventilation. **Focus:** Prioritization
19. **Ans: 3** Alteplase is a clot buster. In a client who has experienced hemorrhagic stroke, there is already bleeding into the brain. A drug like alteplase can worsen the bleeding. The other statements about the use of alteplase are accurate but are not pertinent to this client's diagnosis. **Focus:** Prioritization
20. **Ans: 1** Clients with right cerebral hemisphere stroke often manifest neglect syndrome. They lean to the left and, when asked, respond that they believe they are sitting up straight. They often neglect the left side of their bodies and ignore food on the left side of their food trays. The nurse needs to remind the student of this phenomenon and discuss the appropriate interventions. **Focus:** Delegation, supervision
21. **Ans: 1, 2, 3** An experienced nursing assistant would know how to reposition the client and how to reapply compression boots, and would remind the client to perform activities the client has been taught to perform. Assessing for redness and swelling (signs of deep venous thrombosis) requires additional education and skill, appropriate to the professional nurse. **Focus:** Delegation, supervision
22. **Ans: 1** Positioning the client in a sitting position decreases the risk of aspiration. The nursing assistant is not trained to assess gag or swallowing reflexes. The client should not be rushed during feeding. A client who needs suctioning performed between bites of food is not handling secretions and is at risk for aspiration. Such a client should be assessed further before feeding. **Focus:** Delegation, supervision
23. **Ans: 2** Bacterial meningitis is a medical emergency, and antibiotics are administered even before the diagnosis is confirmed (after specimens have been collected for culture). The other interventions will also help to reduce central nervous system stimulation and irritation and should be implemented as soon as possible but are not as important as starting antibiotic therapy. **Focus:** Prioritization

24. **Ans: 1** Meningococcal meningitis is spread through contact with respiratory secretions, so use of a mask and gown is required to prevent transmission of the infection to staff members or other clients. The other actions may not be appropriate but do not require intervention as rapidly. The presence of a family member at the bedside may decrease client confusion and agitation. Clients with hyperthermia frequently complain of feeling chilled, but warming the client is not an appropriate intervention. Checking the pupils' response to light is appropriate but is not needed every 30 minutes and is uncomfortable for a client with photophobia. **Focus:** Prioritization
25. **Ans: 1, 2** Any nursing staff member who is involved in caring for the client should observe for the onset and duration of any seizures (although more detailed assessment of seizure activity should be done by the RN). Administration of medications is included in LPN/LVN education and scope of practice. Teaching, discharge planning, and assessment for adverse effects of new medications are complex activities that require RN-level education and scope of practice. **Focus:** Delegation
26. **Ans: 1** The priority action during a generalized tonic-clonic seizure is to protect the airway by turning the client to one side. Administration of lorazepam should be the next action, because it will act rapidly to control the seizure. Although oxygen may be useful during the postictal phase, the hypoxemia during tonic-clonic seizures is caused by apnea. Checking the level of consciousness is not appropriate during the seizure, because generalized tonic-clonic seizures are associated with a loss of consciousness. **Focus:** Prioritization
27. **Ans: 2** Leukopenia is a serious adverse effect of phenytoin therapy and would require discontinuation of the medication. The other data indicate a need for further assessment and/or client teaching but will not require a change in medical treatment for the seizures. **Focus:** Prioritization
28. **Ans: 4** Urinary tract infections (UTIs) are a frequent complication in clients with MS because of the effect of the disease on bladder function, and UTIs may lead to sepsis in these patients. The elevated temperature and flank pain suggest that this client may have pyelonephritis. The physician should be notified immediately so that intravenous antibiotic therapy can be started quickly. The other clients should be assessed as soon as possible, but their needs are not as urgent as those of this client. **Focus:** Prioritization
29. **Ans: 1, 3, 5** Nursing assistant education and scope of practice includes taking pulse and blood pressure measurements. In addition, nursing assistants can reinforce previous teaching or skills taught by the RN or personnel in other disciplines, such as speech or physical therapists. Evaluating client response to medications and developing and individualizing the plan of care require RN-level education and scope of practice. **Focus:** Delegation
30. **Ans: 1** LPN/LVN education and team leader responsibilities include checking for the therapeutic and adverse effects of medications. Changes in the residents' memory would be communicated to the RN supervisor, who is responsible for overseeing the plan of care for each resident. Assessment for changes in score on the Mini-Mental State Examination and development of the plan of care are RN responsibilities. Assisting residents with personal care and hygiene would be delegated to nursing assistants working at the long-term care facility. **Focus:** Delegation
31. **Ans: 2** The husband's statement about lack of sleep and anxiety about whether his wife is receiving the correct medications are behaviors that support this diagnosis. There is no evidence that the client's cardiac output is decreased. The husband's statements about how he monitors the client and his concern with medication administration indicate that the risk for ineffective therapeutic regimen management and falls are not priority diagnoses at this time. **Focus:** Prioritization
32. **Ans: 1** The inability to recognize family members is a new neurologic deficit for this client and indicates a possible increase in ICP. This change should be communicated to the physician immediately so that treatment can be initiated. The continuing headache also indicates that the ICP may be elevated but is not a new problem. The glucose elevation and weight gain are common adverse effects of dexamethasone that may require treatment but are not emergencies. **Focus:** Prioritization
33. **Ans: 2** The client's history and assessment data indicate that he may have a chronic subdural hematoma. The priority goal is to obtain a rapid diagnosis and send the client to surgery to have the hematoma evacuated. The other interventions also should be implemented as soon as possible, but the initial nursing activities should be directed toward diagnosis and treatment of any intracranial lesion. **Focus:** Prioritization
34. **Ans: 3** Of the clients listed, the client with bacterial meningitis is in the most stable condition. An RN from the medical unit would be familiar with administration of IV antibiotics. The other clients require assessments and care from RNs more experienced in caring for clients with neurologic diagnoses. **Focus:** Assignment
35. **Ans: 1, 4, 3, 2** The first action after a medication error should be to assess the client for adverse outcomes. You should evaluate this client for symptoms such as bradycardia and excessive salivation. These may indicate cholinergic crisis, a possible effect of excessive doses of anticholinesterase medications such as neostigmine. The physician should be rapidly

notified so that treatment with atropine can be ordered to counteract the effects of the neostigmine, if necessary. Determining the circumstances that led to the error will help decrease the risk for future errors and will be needed to complete the medication error report. **Focus:** Prioritization

36. **Ans: 1** For phenytoin, the dose for children is prescribed as 5 mg/kg in 2 or 3 divided doses; 300 mg is the maintenance dose for an adult. The other three orders are within the acceptable dosage ranges for children with seizures. **Focus:** Prioritization
37. **Ans: 2** Pupil dilation may indicate increased ICP and should be reported immediately to the surgeon. The other data are not unusual in a 3-year-old after surgery, although they indicate the need for ongoing assessments or interventions. **Focus:** Prioritization
38. **Ans: 4** The elevated temperature indicates possible infection and should be reported immediately to the physician so that treatment can be started. The other data are typical in an infant with this defect. **Focus:** Prioritization

Chapter 10: Visual and Auditory Problems, pages 51-54

1. **Ans: 3** If the client is wearing contact lenses, the lenses may be causing the symptoms, and removing them will prevent further eye irritation or damage. Policies on giving telephone advice vary among institutions, and knowledge of your facility policy is essential. The other options may be appropriate, but you should gather additional information before suggesting anything else. **Focus:** Prioritization
2. **Ans: 3** Most accidental eye injuries (90%) could be prevented by wearing protective eyewear for sports and hazardous work. Other options should be considered in the overall prevention of injuries, but these have less impact. **Focus:** Prioritization
3. **Ans: 1, 3, 5, 6** Providing postoperative and preoperative instructions, making home health referrals, and assessing for needs related to loss of vision should be done by an experienced nurse who can give specific details and specialized information about follow-up eye care and adjustment to loss. The principles of applying eye pad and shield and teaching the administration of eyedrops are basic procedures that should be familiar to all nurses. **Focus:** Assignment
4. **Ans: 6, 2, 5, 4, 3, 1** Have the client sit with the head tilted back. Pulling down the lower conjunctival sac creates a small pocket for the drops. Stabilizing the hand prevents accidentally poking the client's eye. Having the client look up prevents the drop from falling on the cornea and stimulating the blink reflex. When the client gently moves the eye, the medication is distributed. Pressing on the lacrimal duct prevents systemic absorption. **Focus:** Prioritization
5. **Ans: 2, 3, 4, 7** Administering medications, reviewing and demonstrating standard procedures, and performing standardized assessments with predictable outcomes in noncomplex cases are within the scope of the LPN/LVN. Assessing for systemic manifestations and behaviors, risk factors, and nutritional factors is the responsibility of the RN. **Focus:** Delegation
6. **Ans: 2** Despite the fact that the child is screaming, the mother must continue to irrigate the eyes for at least 20 minutes or until the emergency medical service arrives. Another adult, if present, should call the Poison Control Center and 911. **Focus:** Prioritization
7. **Ans: 1** Warm compresses will usually provide relief. If the problem persists, eyelid scrubs and antibiotic drops would be appropriate. The ophthalmologist could be consulted, but other providers such as the family physician or the nurse practitioner could give a prescription for antibiotics. **Focus:** Prioritization
8. **Ans: 4** A curtainlike shadow is a symptom of retinal detachment, which is an emergency situation. A change in color vision is a symptom of cataract. Crusty drainage is associated with conjunctivitis. Increased lacrimation is associated with many eye irritants, such as allergies, contact lenses, or foreign bodies. **Focus:** Prioritization
9. **Ans: 2, 5** Assisting the client in ambulating in the hall and obtaining supplies are within the scope of practice of the nursing assistant. Dealing with the client's emotional state, orienting the client to the room, and encouraging independence require formative evaluation to gauge readiness, and these activities should be the responsibility of the RN. Storing items and rearranging furniture are inappropriate actions, because the person needs be able to consistently locate objects in the immediate environment. **Focus:** Delegation
10. **Ans: 4** Pain may signal hemorrhage, infection, or increased ocular pressure. A scratchy sensation and loss of depth perception with the patch in place are not uncommon. Adequate vision may not return for 24 hours. **Focus:** Prioritization
11. **Ans: 3, 4, 5, 6** The client's symptoms are suggestive of angle-closure glaucoma. Immediate inventions include instillation of miotics, which open the trabecular network and facilitate aqueous outflow, and intravenous or oral administration of hyperosmotic agents to move fluid from the intracellular space to the extracellular space. Applying cool compresses and providing a dark, quiet space are appropriate comfort measures. Photodynamic therapy is a treatment for age-related macular degeneration. Use of mydriatics is contraindicated because dilation of the pupil will further block the outflow. **Focus:** Prioritization
12. **Ans: 4** All beta-adrenergic blockers are contraindicated in bradycardia. Alpha-adrenergic agents can cause tachycardia and hypertension. Carbonic

anhydrase inhibitors should not be given to clients with rheumatoid arthritis who are taking high dosages of aspirin. **Focus:** Prioritization

13. **Ans: 4** Clients with conversion disorders are experiencing symptoms, even though there is no identifiable organic cause; therefore, they should be assisted in learning ways to cope and live with the disability. Encouraging the expression of feelings is okay, but it is premature to expect the client to link the fight to her blindness. It is likely that the sudden onset of blindness will quickly resolve, and the client may also be physically able to see, but presenting facts would not be helpful at this time. **Focus:** Prioritization
14. **Ans: 1, 2, 3** Irrigating the ear, giving medication, and reminding the client about postoperative instructions that were given by an RN are within the scope of practice of the LPN/LVN. Counseling clients and families and assessing for meningitis signs in a client with labyrinthitis are the responsibilities of the RN. **Focus:** Delegation
15. **Ans: 1** Aspirin (acetylsalicylic acid) is potentially ototoxic. The prescribing physician should be notified so that the condition and the prescribed drug can be evaluated. The other drugs are not associated with hearing problems. **Focus:** Prioritization
16. **Ans: 2** This client has a hearing loss and is likely to benefit from a referral for a hearing aid or rehabilitation program. The other diagnoses are pertinent if the hearing loss continues to interfere with her quality of life. **Focus:** Prioritization
17. **Ans: 3** A bulging red or blue tympanic membrane is a possible sign of otitis media or perforation. The other signs are considered normal anatomy. **Focus:** Prioritization
18. **Ans: 3** The client reporting vertigo without hearing loss should be further assessed for nonvestibular causes, such as cardiovascular or metabolic. The other descriptions are more commonly associated with inner ear or labyrinthine causes. **Focus:** Prioritization
19. **Ans: 1. MD, 2. Nursing assistant, 3. LPN/LVN, 4. MD, 5. RN, 6. Physical therapist** The physician is responsible for determining the medical diagnosis and for explaining the outcomes and risks of surgical procedures. A physical therapist evaluates movement and the need for adaptive equipment and teaches ambulation techniques; however, the nursing assistant (under supervision) is able to help clients with routine ambulation and position changes. The LPN/LVN is qualified to give medications and works under the supervision of the RN. The RN should assess the client to identify situations associated with vertigo. **Focus:** Assignment
20. **Ans: 3** Heavy lifting should be strictly avoided for at least 3 weeks after stapedectomy. Water in the ear and air travel should be avoided for at least 1 week. Coughing and sneezing should be performed with the mouth open to prevent increased pressure in the ear. **Focus:** Prioritization
21. **Ans: 3** Vegetable or insect matter will swell if water is used for irrigation. Tightly wedged objects like beads are difficult to flush. If perforation is suspected or if the object is not easily removed, the nurse should not attempt irrigation or instillation. **Focus:** Prioritization

Chapter 11: Musculoskeletal Problems, pages 55-58

1. **Ans: 4** Assisting with activities of daily living is within the scope of the nursing assistant's practice. The other three interventions require additional educational preparation and are within the scope of practice of licensed nurses. **Focus:** Delegation, supervision
2. **Ans: 1, 2, 3, 5** The purpose of the teaching is to help the patient prevent falls. The hip protector can prevent hip fractures if the patient falls. Throw rugs and obstacles in the home increase the risk of falls. Patients who are tired are also more likely to fall. Exercise helps to strengthen muscles and improve coordination. **Focus:** Prioritization
3. **Ans: 2** Platybasia (basilar skull invagination) causes brainstem manifestations that threaten life. Patients with Paget disease are usually short and often have bowing of the long bones that results in asymmetric knees or elbow deformities. The skull is typically soft, thick, and enlarged. **Focus:** Prioritization
4. **Ans: 3** Application of heat, not ice, is the appropriate measure to help reduce the patient's pain. Ibuprofen is useful to manage mild to moderate pain. Exercise prescribed by the PT would be nonimpact in nature and provide strengthening for the patient. A diet rich in calcium promotes bone health. **Focus:** Delegation, supervision
5. **Ans: 4** The PACU nurse is very familiar with the assessment skills necessary to monitor a patient who just underwent surgery. For the other patients, nurses familiar with musculoskeletal system–related nursing care are needed to provide teaching and assessment, and prepare a report to the long-term care facility. **Focus:** Assignment
6. **Ans: 1** An elevated temperature indicates infection and inflammation. This patient needs intravenous antibiotic therapy. The other vital sign values are normal or high normal. **Focus:** Delegation, supervision
7. **Ans: Clear, Concise, Correct, Complete** Implementing the Four Cs of communication helps the nurse ensure that the nursing assistant understands what is being said; that the nursing assistant does not confuse the nurse's directions; that the directions comply with policies, procedures, job descriptions, and the law; and that the nursing assistant has all the

information necessary to complete the tasks assigned. **Focus:** Delegation, supervision

8. **Ans: 3** Placing a splint for the first time is appropriate to the scope of practice of physical therapists. Assessing and testing for paresthesia are not within the scope of practice of nursing assistants. Helping with activities of daily living is within the scope of practice of nursing assistants. **Focus:** Delegation, supervision
9. **Ans: 3** When a patient with CTS has a splint to immobilize the wrist, the wrist is placed either in the neutral position or in slight extension. The other interventions are correct and are within the scope of practice of a nursing assistant. Nursing assistants may remind patients about elements of their care plans such as avoiding heavy lifting. **Focus:** Delegation, supervision
10. **Ans: 1** Postoperative pain and numbness occur for a longer period of time with endoscopic carpal tunnel release than with the open procedure. Patients often need assistance postoperatively, even after they are discharged. The dressing from the endoscopic procedure is usually very small, and there should not be a lot of drainage. **Focus:** Prioritization
11. **Ans: 1, 2, 3, 5** Postoperatively, patients undergoing open carpal tunnel release surgery experience pain and numbness. Their discomfort may last for weeks to months. All of the other directions are appropriate for the postoperative care of this patient. It is important to monitor for drainage, tightness, and neurovascular changes. Raising the hand and wrist above the heart reduces the swelling from surgery, and this is often done for several days. **Focus:** Assignment, delegation, supervision
12. **Ans: 2** Hand movements, including heavy lifting, may be restricted for 4 to 6 weeks after surgery. Patients experience discomfort for weeks to months after surgery. The surgery is not always a cure. In some cases, CTS may recur months to years after surgery. **Focus:** Prioritization
13. **Ans: 1** Ibuprofen can cause abdominal discomfort or pain and ulceration of the gastrointestinal tract. In such cases, it should be taken with meals or milk. Removal of throw rugs helps prevent falls. Range-of-motion exercises and rest are important strategies for coping with osteoporosis. **Focus:** Prioritization
14. **Ans: 2** Fat embolism syndrome is a serious complication that often results from fractures of long bones. The earliest manifestation of this is altered mental status caused by a low arterial oxygen level. The nurse would want to know about and treat the pain, but it is not life threatening. The nurse would also want to know about the blood pressure and the patient's voiding; however, neither of these pieces of information is urgent to report. **Focus:** Prioritization, delegation, supervision
15. **Ans: 3** The patient with the tight cast is at risk for circulation impairment and peripheral nerve damage. Although all of the other patients' concerns are important and the nurse will want to see them as soon as possible, none of their complaints is urgent. **Focus:** Prioritization
16. **Ans: 3** When the weights are resting on the floor, they are not exerting pulling force to provide reduction and alignment or to prevent muscle spasm. The weights should always hang freely. Attending to the weights may reduce the patient's pain and spasm. With skeletal pins, a small amount of clear fluid drainage is expected. It is important to inspect the traction system after a patient changes position, because position changes may alter the traction. **Focus:** Delegation, supervision, prioritization
17. **Ans: 1** Moving from a lying position first to a sitting position and then to a standing position allows the patient to establish balance before standing. Administering pain medication before the patient begins exercising decreases pain with exercise. Explanations about the purpose of the exercise program and proper use of crutches are appropriate interventions with this patient. **Focus:** Delegation, supervision
18. **Ans: 2** Monitoring for sufficient tissue perfusion is the priority at this time. Phantom pain is a concern but is more common in patients with above-the-knee amputations. Early ambulation is a goal, but at this time the patient is more likely to be engaged in muscle-strengthening exercises. Elevation of the residual limb on a pillow is controversial, because it may promote knee flexion contracture. **Focus:** Delegation, supervision
19. **Ans: 1** Three theories are being researched with regard to phantom limb pain. The peripheral nervous system theory hold that sensations remain as a result of the severing of peripheral nerves during the amputation. The central nervous system theory states that phantom limb pain results from a loss of inhibitory signals that were generated through afferent impulses from the amputated limb. The psychologic theory helps predict and explain phantom limb pain because stress, anxiety, and depression often trigger or worsen a pain episode. **Focus:** Prioritization
20. **Ans: 4** The patient is indicating an interest in learning about prostheses. The experienced nurse can initiate discussion and begin educating the patient. Certainly the physician can also discuss prostheses with the patient, but the patient's wish to learn should receive a quick response. The nurse can then notify the physician about the patient's request. **Focus:** Delegation, supervision
21. **Ans: 1** Pressure and pain may be due to increased compartment pressure and can indicate the serious complication of acute compartment syndrome. This situation is urgent. If it is not treated, cyanosis,

tingling, numbness, paresis, and severe pain can occur. **Focus:** Prioritization

22. **Ans: 1** Doses of fluoxetine, a drug used to treat depression, that are greater than 20 mg should be given in two divided doses, not once a day. The other three orders are appropriate for a patient who underwent amputation 4 days earlier. **Focus:** Prioritization

Chapter 12: Gastrointestinal and Nutritional Problems, pages 59-62

1. **Ans: 2** The nursing assistant can reinforce dietary and fluid restrictions after the RN has explained the information to the client. It is also possible that the nursing assistant can administer the enema; however, special training is required, and policies may vary among institutions. Medication administration should be performed by licensed personnel. **Focus:** Delegation
2. **Ans: 4** A client with a fractured femur is at risk for fat embolism, so a fat emulsion should be used with caution. Vomiting may be a problem if the emulsion is infused too rapidly. TPN is commonly used in clients with GI obstruction, severe anorexia nervosa, and chronic diarrhea or vomiting. **Focus:** Prioritization
3. **Ans: 3, 5, 2, 1, 4, 6** The solution should not be cloudy or turbid. Prepare the equipment by priming the tubing and threading the pump. To prevent infection, use aseptic technique when inserting the connector into the injection cap and connecting the tubing to the central line. Set the pump at the prescribed rate. **Focus:** Prioritization
4. **Ans: 4** A boardlike abdomen with shoulder pain is a symptom of a perforation, which is the most lethal complication of peptic ulcer disease. A burning sensation is a typical complaint and can be controlled with medications. Projectile vomiting can signal an obstruction. Coffee-ground emesis is typical of slower bleeding, and the client will require diagnostic testing. **Focus:** Prioritization
5. **Ans: 2** Body dysmorphic disorder is a preoccupation with an imagined physical defect. Corrective surgery can exacerbate this disorder when the client continues to feel dissatisfied with the results. The other findings are criterion indicators for this treatment. **Focus:** Prioritization
6. **Ans: 4** Fluctuating level of consciousness and mood swings are associated more with acute delirium, which could be caused by many things, such as electrolyte imbalances, sepsis, or medications. Information about the client's baseline behavior is essential; however, based on your knowledge of pathophysiology, you know that flat affect and rambling and repetitive speech, memory impairments, and disorientation to time are behaviors typically associated with chronic dementia. Lack of motivation and early morning awakening are associated with depression. **Focus:** Prioritization
7. **Ans: 3** Reminding the client to follow through on advice given by the nurse is an appropriate task for the nursing assistant. The RN should take responsibility for teaching rationale, discussing strategies for the treatment plan, and assessing client concerns. **Focus:** Delegation
8. **Ans: 3** The health care team must always be vigilant for actual physical disease; however, the client most likely has somatoform disorder, which is a chronic and severe psychologic condition in which the client experiences physical symptoms but without apparent organic cause. Depression and anxiety are common among clients with somatoform disorders. Other options are appropriate; however, having emotional support from a consistent health care provider is often the most effective approach. **Focus:** Prioritization
9. **Ans: 4** Nausea and vomiting are common after chemotherapy. Administration of antiemetics and fluid monitoring can be done by an LPN/LVN. The RN should perform the preoperative teaching for the glossectomy client. Clients returning from surgery need extensive assessment. The client with anorexia is showing signs of hypokalemia and is at risk for cardiac dysrhythmias. **Focus:** Assignment
10. **Ans: 3** The LPN/LVN can assist in the planning of interventions, but the RN should take ultimate responsibility for planning or designing. Obtaining equipment should be delegated to a nursing assistant. A physical therapist should be contacted to set up specialized equipment. **Focus:** Delegation
11. **Ans: 4** Showing the student how to insert the suppository meets both the immediate client need and the student's learning need. The instructor can address the student's fears and long-term learning needs once he or she is aware of the incident. It is preferable that students express fears and learning needs. The other options will discourage the student's future disclosure of clinical limitations and need for additional training. **Focus:** Supervision, assignment
12. **Ans: 7, 3, 1, 5, 2, 8, 4, 6** Putting on a pair of clean gloves protects the hands from colostomy secretions. The warm should be warm (cold water can cause cramping) and the container should be hung at shoulder height (hanging the container too high or too low will alter the rate of flow). Lubricating the stoma and gently inserting the tubing tip will allow the water to flow into the stoma. A slow and steady flow prevents cramps and spillage. Providing adequate time allows for complete evacuation. Walking stimulates the bowel. Careful attention to the skin prevents breakdown. **Focus:** Prioritization
13. **Ans: 3** Disconnecting the tube from suction is an appropriate task to delegate. Suction should be reconnected by the nurse, so that correct pressure is checked.

If the nursing assistant is permitted to reconnect the tube, the RN is still responsible for checking that the pressure setting is correct. During removal of the tube, there is a potential for aspiration, so the nurse should perform this task. If the tube is dislodged, the nurse should recheck placement before it is secured. **Focus:** Delegation

14. **Ans: 3** The goal of bowel training is to establish a pattern that mimics normal defecation, and many people have the urge to defecate after a meal. If this is not successful, a suppository can be used to stimulate the urge. Use of incontinence briefs is embarrassing for the client, and they must be changed frequently to prevent skin breakdown. Routine use of rectal tubes is not recommended because of the potential for damage to the mucosa and sphincter tone. **Focus:** Prioritization
15. **Ans: 1** The immediate problem is controlling the diarrhea. Addressing this problem is a step toward correcting the nutritional imbalance and decreasing the diarrheal cramping. Self-care and compliance with the treatment plan are important long-term goals that can be addressed when the client is feeling better physically. **Focus:** Prioritization
16. **Ans: 3, 4, 1, 2, 6, 5** Immediate decontamination is appropriate, because time can affect viral load. The occupational health nurse will direct the employee in filing the correct forms, getting the appropriate laboratory tests, obtaining appropriate prophylaxis, and following up on results. **Focus:** Prioritization
17. **Ans: 2, 5, 3, 4, 1, 6** Stay calm and stay with the client. Any increase in intra-abdominal pressure will worsen the evisceration; placement of the client in a semi-Fowler position with knees flexed will decrease the strain on the wound site. (Note: If shock develops, the patient's head should be lowered.) Continuously monitor vital signs, particularly for a decrease in blood pressure or increase in pulse rate, while your colleague gathers supplies and notifies the physician. Covering the site protects tissue. Ultimately, the client will need emergency surgery. **Focus:** Prioritization
18. **Ans: 3** Right upper quadrant pain is a sign of hemorrhage or bile leak. Ability to void should return within 6 hours postoperatively. Right shoulder pain is related to unabsorbed carbon dioxide and will be resolved by placing the client in Sims position. Output that does not equal input after surgery for the first several hours is expected. **Focus:** Prioritization
19. **Ans: 1** The nursing assistant should use infection control precautions for the protection of self, employees, and other clients. Planning and monitoring are RN responsibilities. Although nursing assistants can report valuable information, they should not be responsible for detecting signs and symptoms that can be subtle or hard to detect, such as skin changes. **Focus:** Delegation
20. **Ans: 1** There is a potential for sudden rupture of fragile blood vessels with massive hemorrhage from straining that increases thoracic or abdominal pressure. The client could have fluid accumulation in the abdomen (ascites) that can be mild and hard to detect or severe enough to cause orthopnea. Dependent peripheral edema can also be observed but is less urgent. **Focus:** Prioritization
21. **Ans: 2** Assisting with procedures in clients in stable condition with predictable outcomes is within the educational preparation of the LPN/LVN. Teaching the client about self-care or pathophysiology and evaluating the outcome of interventions are responsibilities of the RN. **Focus:** Delegation
22. **Ans: 1** Distention and rigidity can signal hemorrhage or peritonitis. The physician may also decide that these symptoms require a medication to stimulate peristalsis. Absence of bowel sounds is expected within the first 24 to 48 hours. Nausea and vomiting are not uncommon and are usually self-limiting, and an "as needed" (prn) order for an antiemetic is usually part of the routine postoperative orders. The client's reason for pulling the tube should be assessed and the tube secured as necessary. **Focus:** Prioritization
23. **Ans: 2, 3** Both clients will need frequent pain assessments and medications. Clients with copious diarrhea or vomiting will frequently need enteric isolation. Cancer clients receiving chemotherapy are at risk for immunosuppression and are likely to need protective isolation. **Focus:** Assignment
24. **Ans: 3, 4, 6** Anyone who was involved in the direct care of the client should be invited to participate. The purpose of this root cause analysis is to review the event to identify behaviors, signs, or signals of risk for suicide. This information would be used to increase the staff's awareness to prevent future similar events. Inviting the wife and family is not appropriate, because the performance of the staff is internally reviewed to improve performance. The purpose is not to fix blame or to create a situation that engenders guilt for the wife or family (or the staff). Likewise, the purpose of the analysis is not to provide psychotherapy or support for the wife or family. (Referrals should be made for this.) **Focus:** Assignment
25. **Ans: 1, 3, 4, 5, 6** Strangulated intestinal obstruction is a surgical emergency. The NG tube is for decompression of the intestine. Abdominal radiography is the most useful diagnostic aid. IV fluids are needed to maintain fluid and electrolyte balance and allow IV delivery of medication. IV broad-spectrum antibiotics are usually ordered. Pain medications are likely to be withheld during the initial period to prevent masking of peritonitis or perforation. In addition, morphine slows gastric motility. A barium enema examination is not ordered if perforation is suspected. **Focus:** Prioritization

26. **Ans: 6, 2, 3, 5, 4, 1** A pair of clean gloves should be put on before touching the skin or pouch. The stoma should be assessed for a healthy pink color. Washing, rinsing, and drying the skin and applying a skin barrier help to protect the skin. A good fit prevents gastric contents from spilling onto the skin. **Focus:** Prioritization
27. **Ans: 2:** The shift report indicates that the client still has a disturbed body image; however, she is actively working on gaining weight and improving self-esteem, and has appropriate knowledge that she can use to maintain her health. **Focus:** Prioritization
28. **Ans: 2** Passage of brown stool indicates resolution of the intussusception. The other findings are part of the clinical presentation of this disorder. **Focus:** Prioritization
29. **Ans: 4:** Even though the caller reports that the child is "breathing okay," additional questions about possible airway obstruction are the priority (i.e., coughing, gagging, choking, drooling, refusing to eat or drink). GI symptoms should be assessed but are less urgent. The type of foreign body, in the absence of symptoms, may dictate a wait-and-see approach, in which case the parent would be directed to check the stools for passage of the foreign body. **Focus:** Prioritization
30. **Ans: 1** Hand washing is the most important aspect to emphasize. Addressing fecal incontinence and sharing of personal items may be recommended when the disease is in an infectious stage. Immunizations should be encouraged. **Focus:** Prioritization

Chapter 13: Diabetes and Other Endocrine Problems, pages 63-66

1. **Ans: 3** The higher the blood glucose level is over time, the more glycosylated the hemoglobin becomes. $HgbA_{1c}$ level is a good indicator of average blood glucose level over the previous 120 days. Fasting glucose and oral glucose tolerance tests are important diagnostic tools. Fingerstick blood glucose monitoring provides information that allows adjustment of the patient's therapeutic regimen. **Focus:** Prioritization
2. **Ans: 4** The nursing assistant's role includes reminding patients about interventions that are already part of the plan of care. Arranging for a consult with the dietitian is appropriate for the unit clerk. Teaching and assessing require additional education and should be carried out by licensed nurses. **Focus:** Delegation, supervision, assignment
3. **Ans: 1, 2, 5** Sensory alterations are the major cause of foot complications in diabetic patients, and patients should be taught to examine their feet on a daily basis. Properly fitted shoes protect the patient from foot complications. Broken skin increases the risk of infection. Cotton socks are recommended to absorb moisture. Patients, family, or health care providers may trim toenails. **Focus:** Prioritization
4. **Ans: 3** Profuse perspiration is a symptom of hypoglycemia, a complication of diabetes that requires urgent treatment. A glucose level of 185 mg/dL will need coverage with sliding-scale insulin, but this is not urgent. Numbness and tingling, as well as bunions, are related to the chronic nature of diabetes and are not urgent problems. **Focus:** Prioritization
5. **Ans: 1** Checking the bath water temperature is part of assisting with activities of daily living and is within the education and scope of practice of the nursing assistant. Discussing community resources, teaching, and assessing require a higher level of education and are appropriate to the scope of practice of licensed nurses. **Focus:** Delegation
6. **Ans: 1, 2, 5** When a diabetic patient is ill, glucose levels become elevated, and administration of insulin may be necessary. Teaching or reviewing the components of proper foot care is always a good idea with a diabetic patient. Bed rest is not necessary, and glucose level may be better controlled when a patient is more active. The Atkins diet suggests decreasing the consumption of carbohydrates and is not a good diet for diabetic patients. **Focus:** Prioritization
7. **Ans: 4** When a diabetic patient is ill or has surgery, glucose levels become elevated, and administration of insulin may be necessary. This is a temporary change that resolves with recovery from the illness or surgery. Option 3 is correct but does not explain why the patient may currently need insulin. The patient does not have type 1 diabetes, and fingerstick glucose checks are usually prescribed for before meals and at bedtime. **Focus:** Prioritization
8. **Ans: 1** The onset of action for rapid-acting insulin is within minutes, so it should be given only when the patient has food. Because of this, rapid-acting insulin is sometimes called "see food" insulin. Options 2, 3, and 4 are incorrect. Long-acting insulins mimic the action of the pancreas. Regular insulin is the only insulin that can be given IV. **Focus:** Assignment, supervision
9. **Ans: 1, 3, 5** Giving the patient extra sweetener, recording oral intake, and checking blood pressure are all within the scope of practice of the nursing assistant. Assessing shoe fit and patient teaching are not within the nursing assistant's scope of practice. **Focus:** Assignment
10. **Ans: 2** Rapid, deep respirations (Kussmaul respirations) are symptomatic of DKA. Hammer toe, as well as numbness and tingling, are chronic complications associated with diabetes. Decreased sensitivity and swelling (lipohypertrophy) occurs at a site of repeated

insulin injections, and treatment involves teaching the patient to rotate injections sites. **Focus:** Prioritization

11. **Ans: 1** The nurse should not leave the patient. The scope of the unit clerk's job includes calling and paging physicians. LPNs generally do not administer IV push medication. IV fluid administration is not within the scope of practice of nursing assistants. Patients with DKA already have a high glucose level and do not need orange juice. **Focus:** Delegation, supervision
12. **Ans: 2** The new nurse is still on orientation to the unit. Appropriate patient assignments at this time include patients whose conditions are stable and not complex. **Focus:** Assignment
13. **Ans: 2** The signs and symptoms the patient is exhibiting are consistent with hyperglycemia. The RN should not give the patient additional glucose. All of the other interventions are appropriate for this patient. The RN should also notify the physician at this time. **Focus:** Prioritization
14. **Ans: 3** The nursing assistant's scope of practice includes checking vital signs and assisting with morning care. A nursing assistant with special training can check the patient's glucose level before meals. It is generally not within the nursing assistant's scope of practice to administer medications, but this is within the scope of practice of the LPN/LVN. **Focus:** Assignment
15. **Ans: 4** Before orange juice or insulin is given, the patient's blood glucose level should be checked. Checking blood pressure is a good idea but is not the first action the nurse should take. **Focus:** Prioritization
16. **Ans: 3** Exophthalmos (abnormal protrusion of the eyes) is characteristic of patients with hyperthyroidism due to Graves disease. Periorbital edema, bradycardia, and hoarse voice are all characteristics of patients with hypothyroidism. **Focus:** Prioritization
17. **Ans: 1** The cardiac problems associated with hyperthyroidism include tachycardia, increased systolic blood pressure, and decreased diastolic blood pressure. Patients with hyperthyroidism also may have increased body temperature related to increased metabolic rate. **Focus:** Delegation, supervision
18. **Ans: 2** Monitoring vital signs and recording their values are within the education and scope of practice of nursing assistants. An experienced nursing assistant should have been taught how to monitor the apical pulse. However, a nurse should observe the nursing assistant to be sure that the nursing assistant has mastered this skill. Instructing and teaching patients, as well as performing venipuncture to obtain laboratory samples, are more suited to the education and scope of practice of licensed nurses. In some facilities, an experienced nursing assistant may perform venipuncture, but only after special training. **Focus:** Delegation, supervision, assignment
19. **Ans: 3** Although patients with hypothyroidism often have cardiac problems that include bradycardia, a heart rate of 48 beats/min may have significant implications for cardiac output and hemodynamic stability. Patients with Graves disease usually have a rapid heart rate, but 94 beats/min is within normal limits. The diabetic patient may need sliding-scale insulin dosing. This is important but not urgent. Patients with Cushing disease frequently have dependent edema. **Focus:** Prioritization
20. **Ans: 1** Patients with hypofunction of the adrenal gland often have hypotension and should be instructed to change positions slowly. Once a patient has been so instructed, it is appropriate for the nursing assistant to remind the patient of those instructions. Assessing, teaching, and planning nursing care require more education and should be done by licensed nurses. **Focus:** Delegation, supervision
21. **Ans: 4** The presence of crackles in the patient's lungs indicate excess fluid volume due to excess water and sodium reabsorption and may be a symptom of pulmonary edema, which must be treated rapidly. Striae (stretch marks), weight gain, and dependent edema are common findings in patients with Cushing disease. These findings should be monitored but do not require urgent action. **Focus:** Prioritization
22. **Ans: 4** Monitoring vital signs is within the education and scope of practice for nursing assistants. The nurse should be sure to instruct the nursing assistant that blood pressure measurements are to be taken with the cuff on the same arm each time. Revising the care plan and instructing and assessing patients are beyond the scope of nursing assistants and fall within the purview of licensed nurses. **Focus:** Assignment
23. **Ans: 2** Palpating the abdomen can cause the sudden release of catecholamines and severe hypertension. **Focus:** Delegation, supervision
24. **Ans: 1** Rapid weight gain and edema are signs of excessive drug therapy, and the dosage of the drug would need to be adjusted. Hypertension, hyperkalemia, and hyperglycemia are common in patients with adrenal hypofunction. **Focus:** Prioritization
25. **Ans: 1** The presence of glucose in nasal drainage indicates that the fluid is cerebrospinal fluid (CSF) and suggests a CSF leak. Packing is normally inserted in the nares after the surgical incision is closed. Urine output of 40 to 50 mL/hr is adequate, and patients may experience thirst postoperatively. When patients are thirsty, nursing staff should encourage fluid intake. **Focus:** Prioritization
26. **Ans: 2** The 83-year-old has no complicating factors at the moment. Providing care for patients in stable and uncomplicated condition falls within the LPN/LVN's educational preparation and scope of practice, with the care always being provided under the supervision and direction of an RN. The nurse should assess the patient

who has just undergone surgery and the newly admitted patient. The patient who is preparing for discharge after myocardial infarction may need some complex teaching. **Focus:** Delegation, supervision, assignment

27. **Ans: 1** The parathyroid glands are located on the back of the thyroid gland. The parathyroids are important in maintaining calcium and phosphorus balance. The nurse should be attentive to all patient laboratory values, but calcium and phosphorus levels are important to monitor after thyroidectomy because abnormal values could be the result of removal of the parathyroid glands during the thyroidectomy. **Focus:** Prioritization
28. **Ans: 4** A patient with permanent diabetes insipidus requires lifelong vasopressin therapy. All of the other statements are appropriate to the home care of this patient. **Focus:** Prioritization
29. **Ans: 1, 2, 4, 5** A patient with Cushing disease experiences body changes affecting body image and is at risk for bruising, infection, and hypertension. Such a patient usually gains weight. **Focus:** Prioritization
30. **Ans: 1** A patient with Addison disease is at risk for anemia. The nurse should expect this patient's sodium level to decrease, and potassium and calcium levels to increase. **Focus:** Prioritization

Chapter 14: Integumentary Problems, pages 67-70

1. **Ans: 3** An LPN/LVN who is experienced in working with postoperative clients will know how to monitor for pain, bleeding, or swelling and will notify the supervising RN. Client teaching requires more education and a broader scope of practice and is appropriate for RN staff members. **Focus:** Delegation
2. **Ans: 4** LPN/LVN education and scope of practice includes sterile and nonsterile wound care. LPNs/LVNs do function as wound care nurses in some LTC facilities, but the choice of dressing type and assessment for risk factors are more complex skills that are appropriate to the RN level of practice. Assisting the client to change position is a task included in nursing assistant education and would be more appropriate to delegate to a nursing assistant. **Focus:** Delegation
3. **Ans: 2** Facial burns are frequently associated with airway inflammation and swelling, so this client requires the most immediate assessment. The other clients also require rapid assessment or interventions, but not as urgently as the client with facial burns. **Focus:** Prioritization
4. **Ans: 3, 4, 2, 1, 5** Pain medication should be administered before changing the dressing, because changing dressings for partial-thickness burns is painful, especially if the dressing change involves removal of eschar. The wound should be débrided before obtaining wound specimens for culture to avoid including bacteria that are skin contaminants rather than causes of the wound infection. The antibacterial cream should be applied to the area after débridement to gain the maximum effect. Finally, the wound should be covered with a sterile dressing. **Focus:** Prioritization
5. **Ans: 3** A nurse from the oncology unit would be familiar with dressing changes and sterile technique. The charge RN in the burn unit would work closely with the float RN to provide partners to assist in providing care and to answer any questions. Admission assessment and development of the initial care plan, discharge teaching, and splint positioning in burn clients all require expertise in caring for clients with burns. These clients should be assigned to RNs who regularly work on the burn unit. **Focus:** Assignment
6. **Ans: 4** Irregular borders and a black or variegated color are characteristics associated with malignant skin lesions. Striae and toenail thickening or yellowing are common in elderly individuals. Silver scaling is associated with psoriasis, which may need treatment but is not as urgent a concern as the appearance of the mole. **Focus:** Prioritization
7. **Ans: 1** A blue color or cyanosis may indicate that the client has significant problems with circulation or ventilation. More detailed assessments are needed immediately. The other data may also indicate health problems in major body systems, but potential respiratory or circulatory abnormalities are the priority. **Focus:** Prioritization
8. **Ans: 1** Because isotretinoin is associated with a high incidence of birth defects, it is important that the client stop using the medication at least a month before attempting to become pregnant. Nausea and poor night vision are possible adverse effects of isotretinoin that would require further assessment but are not as urgent as discussing the fetal risks associated with this medication. The client's concern about whether treatment is effective should be addressed, but this is a lower-priority intervention. **Focus:** Prioritization
9. **Ans: 3** Scheduling an appointment for the client is within the legal scope of practice and training for the medical assistant role. Client teaching, assessment for positive skin reactions to the test, and monitoring for serious allergic reactions are appropriate to the education and practice role of licensed nursing staff. **Focus:** Delegation
10. **Ans: 1** Systemic use of tetracycline is associated with severe photosensitivity reactions to ultraviolet light. All individuals should be taught about the potential risks of overexposure to sunlight or other ultraviolet light, but the client taking tetracycline is at the most immediate risk for severe adverse effects. **Focus:** Prioritization
11. **Ans: 3** Although it is not appropriate for the nursing assistant to plan or implement initial client or family teaching, reinforcement of previous teaching is an

important function of the nursing assistant (who is likely to be in the home on a daily basis). Teaching about medication use, nutritional assessment and planning, and evaluation for improvement are included in the RN scope of practice. **Focus:** Delegation

12. **Ans: 1** Medication administration is included in LPN/LVN education and scope of practice. Bathing and cleaning clients require the least education and would be better delegated to a nursing assistant. Assessment and evaluation of outcomes of care are more complex skills best performed by RNs. **Focus:** Delegation
13. **Ans: 2** The highest priority diagnoses for this client are Acute Pain and Impaired Nutrition. The Acute Pain diagnosis takes precedence, because the client's acute oral pain will need to be controlled to increase the ability to eat and to improve nutrition. The assessment data do not indicate that the client's lack of understanding about how the virus is contracted contributed to the infection. (The most frequent cause of oral herpes infection in immunocompromised clients is reactivation of previously acquired herpes simplex virus.) Disturbed body image is a major concern for the client but is not as high a priority as the need for pain control and improved nutrition. **Focus:** Prioritization
14. **Ans: 4** Wheals are frequently associated with allergic reactions, so asking about exposure to new medications is the most appropriate question for this client. The other questions would be useful in assessing the skin health history but do not directly relate to the client's symptoms. **Focus:** Prioritization
15. **Ans: 2** With chemical injuries, it is important to remove the chemical from contact with the skin to prevent ongoing damage. The other actions also should be accomplished rapidly; however, rinsing the chemical off is the priority for this client. **Focus:** Prioritization
16. **Ans: 3** This client's vital signs indicate that the life-threatening complications of sepsis and septic shock may be developing. The other clients also need rapid assessment and/or nursing interventions, but their symptoms do not indicate that they need care as urgently as the febrile and hypotensive client. **Focus:** Prioritization
17. **Ans: 4** Because aspirin affects platelet aggregation, the client is at increased risk for postprocedure bleeding, and the surgeon may need to reschedule the procedure. The other information is also pertinent but will not affect the scheduling of the procedure. **Focus:** Prioritization
18. **Ans: 3** A new graduate would be familiar with the procedure for a sterile dressing change, especially after working for 3 weeks on the unit. Clients whose care requires more complex skills such as admission assessments, preprocedure teaching, and discharge teaching should be assigned to more experienced RN staff members. **Focus:** Assignment
19. **Ans: 3** Epigastric pain may indicate that the client is developing peptic ulcers, which require collaborative interventions such as the use of antacids, histamine 2 receptor blockers (e.g., famotidine [Pepcid]), or proton pump inhibitors (e.g., esomeprazole [Nexium]). The elevation in blood glucose level, increased appetite, and slight elevation in blood pressure may be related to prednisone use but are not clinically significant when steroids are used for limited periods and do not require treatment. **Focus:** Prioritization
20. **Ans: 2** Dairy products inhibit the absorption of tetracycline, so this action would decrease the effectiveness of the antibiotic. The other activities are not appropriate but would not cause as much potential harm as the administration of tetracycline with milk. Anaerobic bacteria would not be likely to grow in a superficial wound. The herpes zoster vaccine is recommended for patients who are 60 years or older. Pressure garments may be used after graft wounds heal and during the rehabilitation period after a burn injury, but this should be discussed when the client is ready for rehabilitation, not when the client is admitted. **Focus:** Prioritization
21. **Ans: 3** Oral sedation agents such as the benzodiazepines are considered high-alert medications when ordered for children, and extra precautions should be taken before administration. Many facilities require that all medications administered to pediatric clients be double-checked before administration, but the midazolam is the most important to double-check with another nurse. **Focus:** Prioritization

Chapter 15: Renal and Urinary Problems, pages 71-74

1. **Ans: 4** Providing the equipment that the patient needs to collect the urine sample is within the scope of practice of a nursing assistant. Teaching, planning, and assessing all require additional education and skill, which is appropriate to the scope of practice of professional nurses. **Focus:** Delegation, supervision
2. **Ans: 3** The presence of 100,000 bacterial colonies per milliliter of urine or the presence of many white blood cells (WBCs) and red blood cells (RBCs) indicates urinary tract infection. The WBC count is within normal limits and the hematocrit is a little low, which may need follow-up. Neither of these results indicates infection. **Focus:** Prioritization
3. **Ans: 1** The patient with cystitis who is taking oral antibiotics is in stable condition with predictable outcomes, and caring for this patient is therefore appropriate to the scope of practice of an LPN/LVN under the supervision of an RN. The patient with a new order for lithotripsy will need teaching about the procedure, which should be accomplished by the RN. The patient in need of bladder training will need the RN to plan this

intervention. The patient with flank pain needs careful and skilled assessment by the RN. **Focus:** Assignment

4. **Ans: 2** Prostate disease increases the risk of urinary tract infections in men because of urinary retention. The wife's urinary tract infection should not affect the patient. The times of the catheter usage and kidney stone removal are too distant to cause this urinary tract infection. **Focus:** Prioritization
5. **Ans: 4** A cystoscopy is needed to accurately diagnose interstitial cystitis. Urinalysis may show WBCs and RBCs, but no bacteria. The patient will probably need a urinalysis upon admission, but daily samples do not need to be obtained. Intake and output may be assessed but results will not contribute to the diagnosis. Cystitis does not usually affect urine electrolyte levels. **Focus:** Prioritization
6. **Ans: 3** For uncomplicated cystitis, a 3-day course of antibiotics is an effective treatment, and research has shown that patients are more likely to adhere to shorter antibiotic courses. Seven-day courses of antibiotics are appropriate for complicated cystitis, and 10- to 14-day courses are prescribed for uncomplicated pyelonephritis. This patient is being discharged and should not be at risk for a nosocomial infection. **Focus:** Prioritization, supervision, evidence-based practice
7. **Ans: 4** Women should avoid irritating substances such as bubble bath, nylon underwear, and scented toilet tissue to prevent urinary tract infections. Adequate fluid intake, consumption of cranberry juice, and regular voiding are all good strategies for preventing urinary tract infections. **Focus:** Delegation, supervision, prioritization
8. **Ans: 3** A patient with urge incontinence can be taught to control the bladder as long as the patient is alert, aware, and able to resist the urge to urinate by starting a schedule for voiding, then increasing the intervals between voids. Patients with functional incontinence related to mental status changes or loss of cognitive function will not be able to follow a bladder-training program. A better treatment for a patient with stress incontinence is exercises such as pelvic floor (Kegel) exercises to strengthen the pelvic floor muscles. **Focus:** Prioritization
9. **Ans: 1** Oxybutynin is an anticholinergic agent, and these drugs often cause an extremely dry mouth. The maximum dosage is 20 mg/day. Oxybutynin should be taken between meals, because food interferes with absorption of the drug. **Focus:** Prioritization
10. **Ans: 4** Teaching about bladder emptying, self-catheterization, and medications requires additional knowledge and training and is appropriate to the scope of practice of the RN. The LPN can reinforce information that has already been taught to the patient. **Focus:** Delegation, supervision
11. **Ans: 1** When patients with urolithiasis pass stones they can be in excruciating pain for up to 24 to 36 hours. All of the other nursing diagnoses for this patient are accurate; however, at this time, pain is the urgent concern for the patient. **Focus:** Prioritization
12. **Ans: 3** Bruising is to be expected after lithotripsy. It may be quite extensive and take several weeks to resolve. All of the other statements are accurate for a patient after lithotripsy. **Focus:** Prioritization
13. **Ans: 3, 4** Both these patients will need frequent assessments and medications. The patient receiving chemotherapy and the patient who has just undergone surgery should not be exposed to any patient with infections. **Focus:** Assignment
14. **Ans: 4** Administering oral medications appropriately is covered in the educational program for LPNs/LVNs and is within their scope of practice. Teaching and assessing the patient require additional education and skill and are appropriate to the scope of practice of RNs. **Focus:** Delegation, supervision
15. **Ans: 1, 5, 3, 2, 7, 4, 6, 8** Before checking postvoid residual, you should ask the patient to void, and then position him. Next you should open the catheterization kit and put on sterile gloves, position the patient's penis, clean the meatus, then lubricate and insert the catheter. All urine must be drained from the bladder to assess the amount of postvoid residual the patient has. Finally, the catheter is removed, the penis cleaned, and the urine measured. **Focus:** Prioritization
16. **Ans: 1** The underlying pathophysiology of nephrotic syndrome involves increased glomerular permeability, which allows larger molecules to pass through the membrane into the urine and be removed from the blood. This process causes massive loss of protein, edema formation, and decreased serum albumin levels. Key features include hypertension and renal insufficiency (decreased urine output) related to concurrent renal vein thrombosis, which may be a cause or an effect of nephrotic syndrome. Flank pain is seen in patients with acute pyelonephritis. **Focus:** Prioritization
17. **Ans: 2** Chemotherapy has limited effectiveness against renal cell carcinoma. This form of cancer is usually treated surgically by nephrectomy. **Focus:** Supervision, prioritization
18. **Ans: 1, 2, 3, 5** A patient with only one kidney should avoid all contact sports and high-risk activities to protect the remaining kidney from injury and preserve renal function. All of the other points are key to preventing renal trauma. **Focus:** Prioritization
19. **Ans: 1, 2, 4, 6** Administration of oral medications is appropriate to the scope of practice for an LPN/LVN or RN. Assessment of breath sounds requires additional education and skill development and is most appropriately within the scope of practice of an RN, but it may be part of the observations of an experienced and competent LPN/LVN. All other actions are within the educational preparation and scope of practice of a nursing assistant. **Focus:** Delegation, supervision

20. **Ans: 1** During the oliguric phase of acute renal failure, a patient's urine output is greatly reduced. Fluid boluses and diuretics do not work well. This phase usually lasts from 8 to 15 days. Although there are frequent omissions in recording intake and output, this is probably not the cause of the patient's decreased urine output. Retention of sodium and water is the rationale for giving furosemide, not the reason that it is ineffective. Nitrogenous wastes build up as a result of the kidneys' inability to perform their elimination function. **Focus:** Prioritization, supervision
21. **Ans: 2** A nurse from the surgical intensive care unit will be thoroughly familiar with the care of patients who have just undergone surgery. The patient scheduled for lithotripsy may need education about the procedure. The newly admitted patient needs an in-depth admission assessment, and the patient with chronic renal failure needs teaching about peritoneal dialysis. All of these interventions would best be accomplished by an experienced nurse with expertise in the care of patients with renal problems. **Focus:** Assignment
22. **Ans: 1** Gentamicin can be a highly nephrotoxic substance. You would monitor creatinine and blood urea nitrogen levels for elevations indicating possible nephrotoxicity. All of the other measures are important but are not specific to gentamicin therapy. **Focus:** Prioritization
23. **Ans: 2** Patients with acute renal failure usually go though a diuretic phase 2 to 6 weeks after the onset of the oliguric phase. The diuresis can result in an output of up to 10 L/day of dilute urine. During this phase it is important to monitor for electrolyte and fluid imbalances. This is followed by the recovery phase. A patient with acute renal failure caused by hypovolemia would receive IV fluids to correct the problem; however, this would not necessarily lead to the onset of diuresis. **Focus:** Supervision
24. **Ans: 1** CAVH is a continuous renal replacement therapy that is prescribed for patients with renal failure who are critically ill and do not tolerate the rapid shifts in fluids and electrolytes that are associated with hemodialysis. A teaching plan is not urgent at this time. A patient must have a mean arterial pressure of at least 60 mm Hg for CAVH to be of use. The physician should be notified about this. It is a priority, but not the highest priority. When a patient urgently needs a procedure, morning care does not take priority and may be deferred until later in the day. **Focus:** Prioritization
25. **Ans: 3** Theories about bed-wetting relate it to immature bladder and deep sleep patterns. Although it is true that most children stop bed-wetting by the time they start school, this does not answer the mother's question. Many boys wet the bed until after the age of 5. The fourth response is not accurate, because often bed-wetting is not within the control of a 5-year-old child. **Focus:** Prioritization
26. **Ans: 1** Reminding the child about something that has already been taught is within the scope of practice of a nursing assistant. An LPN/LVN could administer the oral medication. Teaching and discussion of other strategies for dealing with bed-wetting require additional education and are more appropriate to the scope of practice of the professional RN. **Focus:** Assignment, delegation

Chapter 16: Reproductive Problems, pages 75-78

1. **Ans: 3** A palpable bladder and restlessness are indicators of bladder distention, which would require action (such as insertion of a catheter) to empty the bladder. The other data would be consistent with the client's diagnosis of BPH. More detailed assessment may be indicated, but no immediate action is required. **Focus:** Prioritization
2. **Ans: 4** Irregularly shaped and nontender lumps are consistent with a diagnosis of breast cancer, so this client needs immediate referral for diagnostic tests such as mammography or ultrasound. The other information is not unusual and does not indicate the need for immediate action. **Focus:** Prioritization
3. **Ans: 1** An LPN/LVN working in a PACU would be expected to check dressings for bleeding and alert RN staff members if bleeding occurs. The other tasks are more appropriate for nursing staff with RN-level education and licensure. **Focus:** Delegation
4. **Ans: 2** Positioning the client's arm is a task that a nursing assistant who works on a surgical unit would be able to do. Client teaching and assessment are RN-level skills. The RN should reinforce dressings as necessary, because this requires assessment of the surgical site and possible communication with the physician. **Focus:** Delegation
5. **Ans: 4** The bladder spasms may indicate that blood clots are obstructing the catheter, which would indicate the need for irrigation of the catheter with 30 to 50 mL of saline using a piston syringe. The other data would all be normal after a TURP, but the client may need some teaching about the usual post-TURP symptoms and care. **Focus:** Prioritization
6. **Ans: 4** Because tamsulosin blocks alpha receptors in the peripheral arterial system, the most significant side effects are orthostatic hypotension and dizziness. To avoid falls, it is important that the client change position slowly. The other information is also accurate and may be included in client teaching but is not as important as decreasing the risk for falls. **Focus:** Prioritization

7. **Ans: 2** Hemorrhage is a major complication after TURP and should be reported to the surgeon immediately. The other assessment data also indicate a need for nursing action, but not as urgently. **Focus:** Prioritization
8. **Ans: 1** Reinforcement of previous teaching is an expected role of the LPN/LVN. Planning and implementing client initial teaching and documentation of a client's discharge assessment should be performed by experienced RN staff members. **Focus:** Delegation
9. **Ans: 4** It is important to assess oxygenation, because the client's calf tenderness and shortness of breath suggest a possible deep vein thrombosis and pulmonary embolus, serious complications of TURP. The other activities are appropriate but are not as high a priority as ensuring that oxygenation is adequate. **Focus:** Prioritization
10. **Ans: 1** This client has symptoms of testicular torsion, an emergency that needs immediate assessment and intervention, because it can lead to testicular ischemia and necrosis within a few hours. The other clients also have symptoms of acute problems (primary syphilis, acute bacterial prostatitis, and prostatic hyperplasia and urinary retention), which also need rapid assessment and intervention, but these are not as urgent as the possible testicular torsion. **Focus:** Prioritization
11. **Ans: 2, 1, 3, 4** Bladder spasms after a TURP are usually caused by the presence of clots that obstruct the catheter, so irrigation should be the first action taken. Administration of analgesics may help to reduce spasm. Administration of a bolus of IV fluids is commonly used in the immediately postoperative period to help maintain fluid intake and increase urinary flow. Oral fluid intake should be encouraged once you are sure that the client is not nauseated and has adequate bowel tone. **Focus:** Prioritization
12. **Ans: 3** Sildenafil is a potent vasodilator and has caused cardiac arrest in clients who were also taking nitrates such as nitroglycerin. The other client data indicate the need for further assessment and/or teaching, but it is essential for the client who uses nitrates to avoid concurrent use of sildenafil. **Focus:** Prioritization
13. **Ans: 2** Administration of narcotics and the associated client monitoring are included in LPN/LVN education and scope of practice. Assessments and teaching are more complex skills that require RN-level education and are best accomplished by an RN with experience in caring for clients with this diagnosis. **Focus:** Delegation
14. **Ans: 3** An RN from the ED would be experienced in assessment and management of pain. Because of their diagnoses and treatments, the other clients should be assigned to RNs who are experienced in caring for clients with cancer. **Focus:** Assignment
15. **Ans: 4, 3, 2, 1** The bilateral orchiectomy client needs immediate assessment, because confusion may be an indicator of serious postoperative complications such as hemorrhage, infection, or pulmonary embolism. The client who had a perineal prostatectomy should be assessed next, because pain medication may be needed to allow him to perform essential postoperative activities such as deep breathing, coughing, and ambulating. The vaginal hysterectomy client's anxiety needs further assessment next. Although the breast implant client has questions about care of the drains at the surgical site, there is nothing in the report indicating that these need to be addressed immediately. **Focus:** Prioritization
16. **Ans: 3** Although infection occurs only rarely as a complication of transrectal prostate biopsy, it is important that the client receive teaching about checking his temperature and calling the physician if there is any fever or other signs of systemic infection. The client should understand that the test results will not be available immediately but that he will be notified about the results. Transient rectal bleeding may occur after the biopsy, but bleeding that lasts for more than a few hours indicates that there may have been rectal trauma. **Focus:** Prioritization
17. **Ans: 4** Cramping or aching abdominal pain is common after dilation and curettage; however, sharp, continuous pain may indicate uterine perforation, which would require rapid intervention by the surgeon. The other data indicate a need for ongoing assessment or interventions. Transient blood pressure elevation may occur due to the stress response after surgery. Bleeding following the procedure is expected but should decrease over the first 2 hours. And although the oxygen saturation is not at an unsafe level, interventions to improve the saturation should be carried out. **Focus:** Prioritization
18. **Ans: 2, 4, 5** Assisting with catheter care, ambulation, and hygiene is included in home health aide education and would be expected activities for this staff member. Client assessments are the responsibility of RN members of the home health care team. **Focus:** Delegation
19. **Ans: 1** Because the most likely source of the bacteria causing the toxic shock syndrome is the client's tampon, it is essential to remove it first. The other actions should be implemented in the following order: obtain blood culture samples (best done before initiating antibiotic therapy to ensure accurate culture and sensitivity results), infuse nafcillin (rapid initiation of antibiotic therapy will decrease bacterial release of toxins), and administer acetaminophen (fever reduction may be necessary, but treating the infection has the highest priority). **Focus:** Prioritization
20. **Ans: 2** Right calf swelling and tenderness indicate the possible presence of deep vein thrombosis. This

will change the plan of care, because the client should be placed on bed rest, whereas the usual plan is to ambulate the client as soon as possible after surgery. The other data indicate the need for common postoperative nursing actions such as having the client cough, assessing her pain, and increasing her fluid intake. **Focus:** Prioritization

21. **Ans: 3** Clients with intracavitary implants are kept in bed during the treatment to avoid dislodgement of the implant. The other actions may also require you to intervene by providing guidance to the student. Minimal time should be spent close to clients who are receiving internal irradiation. Asking the client about her reaction to losing childbearing abilities may be inappropriate at this time. Clients are frequently placed on low-residue diets to decrease bowel distention while implants are in place. **Focus:** Prioritization
22. **Ans: 1** The client has symptoms of a urinary tract infection. Inserting a straight catheter will enable you to obtain an uncontaminated urine specimen for culture and sensitivity testing before the antibiotic is started. In addition, the client is probably not emptying her bladder fully because of the painful urination. The antibiotic therapy should be initiated as rapidly as possible once the urine specimen is obtained. Administration of acetaminophen is the lowest priority, because the client's temperature is not dangerously elevated. **Focus:** Prioritization
23. **Ans: 2** After an A and P repair, it is essential that the bladder be empty to avoid putting pressure on the suture lines. The abdominal firmness and tenderness indicate that the client's bladder is distended. The physician should be notified and an order for catheterization obtained. The other data also indicate a need for further assessment of her cardiac status and actions such as having the client cough and deep breathe, but these are not such immediate concerns. **Focus:** Prioritization
24. **Ans: 3** The client should be positioned in a semi-Fowler position to minimize the risk of abscess development higher in the abdomen. The other actions also require correction, but not as rapidly. Tampon use is not contraindicated after an episode of PID, although some sources recommend not using tampons during the acute infection. Heat application to the abdomen and pelvis is used for pain relief. Intercourse is safe a few weeks after effective treatment for PID. **Focus:** Prioritization
25. **Ans: 2** "Red man" syndrome occurs when vancomycin is infused too quickly. Because the client needs the medication to treat PID, the vancomycin should not be discontinued. Antihistamines may help decrease the flushing, but vancomycin should be administered over at least 60 minutes. Although the client's temperature will be monitored, a temperature elevation is not the most likely cause of the client's flushing. **Focus:** Prioritization
26. **Ans: 4** Wound dehiscence or evisceration may cause shock, so the first action should be to assess the client's blood pressure and heart rate. The next action should be to ensure that the abdominal contents remain moist by covering the wound and loops of intestine with dressings soaked with sterile normal saline. The physician should be notified. The nurse should not attempt to replace any eviscerated organs back into the abdominal cavity. **Focus:** Prioritization
27. **Ans: 3** LPN/LVN education includes vital sign monitoring; an experienced LPN/LVN would report changes in vital signs to the RN. The paracentesis tray could be obtained by a nursing assistant or unit clerk. Client admission assessment and teaching require RN-level education and experience, although part of the data gathering may be done by an LPN/LVN. **Focus:** Delegation
28. **Ans: 4** The current national guidelines, supported by nonrandomized screening trials and observational data, call for first-degree relatives of clients with the BRCA gene to be screened with both annual mammography and magnetic resonance imaging (MRI). Although annual mammography, breast self-examination, and clinical breast examination by a physician or nurse practitioner may help to detect cancer, the best option for this client is annual mammography and MRI. **Focus:** Prioritization
29. **Ans: 1** Because *Chlamydia trachomatis* infection is the most prevalent sexually transmitted disease in the United States, the research-based guidelines released by the American Academy of Family Practitioners state that *Chlamydia* screening is strongly recommended for all sexually active females age 25 or younger. Screening for the other STDs may also be considered, but is recommended only if other risk factors or evidence of disease is present. **Focus:** Prioritization

Chapter 17: Obstetrics and Maternity, pages 79-82

1. **Ans: 4** The incidence of congenital anomalies is three times higher in the offspring of diabetic women. Good glycemic control during preconception and early pregnancy significantly reduces this risk and would be the highest priority message to this patient at this point. The other responses are correct but are not of greatest importance at this time. **Focus:** Prioritization
2. **Ans: 1** A nursing assistant can check the blood pressure of this patient and report it to the RN. The RN would include this information in her full assessment of the patient, who may be showing signs of preeclampsia. The other tasks listed require nursing assessment, analysis, and planning, and should be performed by the RN. **Focus:** Delegation

3. **Ans: 2** A multiparous patient in active labor with an urge to have a bowel movement will probably give birth imminently. She needs to be the first assessed, the provider must be notified immediately, and she must be moved to a safe location for the birth. She should not be allowed up to the bathroom at this time. The other patients all have needs requiring prompt assessment, but the imminent birth takes priority. Vaginal bleeding after intercourse could be due to cervical irritation or a vaginal infection, or could have a more serious cause such as placenta previa. This patient should be the next one assessed. **Focus:** Prioritization
4. **Ans: 1, 3, 4** Magnesium sulfate toxicity can cause fatal cardiovascular events and/or respiratory depression or arrest, so monitoring of respiratory rate is of utmost importance. The drug is excreted by the kidneys, and therefore monitoring for adequate urine output is essential. Deep tendon reflexes disappear when serum magnesium is reaching a toxic level. Vaginal bleeding is not associated with magnesium sulfate use. Calf pain can be a sign of a deep vein thrombosis but is also not commonly associated with magnesium sulfate therapy. **Focus:** Prioritization
5. **Ans: 2** It is recommended to avoid artificial nipples and pacifiers while establishing breast feeding unless medically indicated. Improper latch and position are common causes of nipple soreness and can be corrected with assessment and assistance to the mother. **Focus:** Prioritization
6. **Ans: 2** The positive group B streptococci result requires immediate action. The provider must be notified and orders obtained for prompt antibiotic prophylaxis during labor to reduce the risk of mother-to-newborn transmission of group B streptococci. The other data are not as significant in the care of the patient at this moment. **Focus:** Prioritization
7. **Ans: 1** An RN in a prenatal clinic can safely give telephone advice regarding nausea, vomiting, and pedal edema, which can be considered normal in pregnancy. She would assess the complaint, give the patient evidence-based advice, and define the circumstances under which the patient should call back. Vaginal itching at 20 weeks could be a yeast infection. Depending on clinic protocols, the RN could, after phone assessment, safely recommend an over-the-counter medication or arrange an office visit for the patient. Leaking vaginal fluid at 34 weeks requires immediate attention, however, because it could indicate premature rupture of membranes with the risk of premature birth. **Focus:** Prioritization
8. **Ans: 4** The RN must follow through on her findings of a nonreassuring fetal heart rate. Where patient safety is concerned, she is obligated to pursue an appropriate response. Documenting the conversation with the provider and discussing it with a colleague are appropriate but do nothing to address the immediate safety concern and possible need for intervention at this time. The RN must persist until she is satisfied that the safety concern has been addressed appropriately. **Focus:** Prioritization
9. **Ans: 1** The cause of variable fetal heart decelerations is compression of the umbilical cord, which can often be corrected by a change in maternal position. **Focus:** Prioritization
10. **Ans: 1, 3, 5** Late fetal heart rate decelerations can be an ominous sign of fetal hypoxemia, especially if repetitive and accompanied by decreased variability. Notification of the provider is indicated. Turning off the oxytocin and administering oxygen to the mother are recommended nursing actions to improve fetal oxygenation. It is also recommended to increase the IV rate to improve hydration, correct hypovolemia, and increase blood flow to the uterus. Putting the woman in a lateral position can increase blood flow to the uterus and increase oxygenation to the fetus. **Focus:** Prioritization
11. **Ans: 3** The care of a vegetarian woman who is pregnant should begin with assessment of her diet, because vegetarian practices vary widely. The RN must first assess exactly what the woman's diet consists of and then determine any deficiencies. The reason for the diet is less important than what the diet actually contains. It is probable that the woman will need a vitamin B_{12} supplement, but the assessment comes first. Vegetarian diets can be completely adequate in protein, and therefore protein supplementation is not routinely recommended. **Focus:** Prioritization
12. **Ans: 1, 3, 5** An experienced nursing assistant could remove the Foley catheter if the assistant has been taught to do this. The nursing assistant could also measure the vital signs of the patient and assist her to ambulate. The RN would be responsible for evaluating the amount of urine output through the catheter and the normality of the vital sign values. The nursing assistant should be given parameter limits for vital signs and told to report values outside these limits to the RN. Assisting in breast feeding for a first-time mother is a very important nursing function, because the RN needs to give consistent, evidence-based advice to enhance success at breast feeding. A common complaint of postpartum patients is inconsistent help with and advice on breast feeding. The RN should also be the one to check the amount of lochia, because the evaluation requires nursing judgment. **Focus:** Delegation
13. **Ans: 1** Fundal pressure should never be applied in a case of shoulder dystocia, because it may worsen the problem by impacting the fetal shoulder even more firmly into the symphysis pubis. This issue of patient safety would require the supervising RN to intervene immediately. The other responses are appropriate actions in a case of shoulder dystocia. **Focus:** Assignment

14. **Ans: 1, 3, 4** It is recommended that a newborn be placed on the back in a crib with a firm mattress with no toys and a minimum of blankets as a safety measure for prevention of sudden infant death syndrome. A newborn discharged before 72 hours of life should be seen by an RN or MD within 2 days of discharge. Breast-feeding women should breast-feed at all feedings, especially in these early weeks of establishing breast feeding. A more appropriate response would be for the father to help with household chores to allow breast feeding to be established successfully. A flu shot in flu season is a recommended intervention for a new mother. **Focus:** Prioritization
15. **Ans: 1, 4** Patient 1 is in the latent phase of labor with her first child; she typically will cope well at this point and will have many hours before labor becomes more active. Patient 4 would most likely be managed expectantly at this point and require observation and assessment for labor or signs of infection. Patient 2 can be expected to deliver soon and so requires intensive nursing care. Patient 3 is in the first hour of recovery and therefore requires frequent assessments, newborn assessments, and help with initiation of breast feeding if this is her chosen feeding method. Patient 5 could be in premature labor and require administration of tocolytic medications to stop contractions or preparation for a preterm delivery if dilation is advanced. **Focus:** Assignment
16. **Ans: 3** The first two answer choices are appropriate nursing actions, but do nothing to stop the immediate bleeding. Putting the baby to the breast does release oxytocin, which causes uterine contraction, but it will be slower to do so than fundal massage, which helps the uterus to contract firmly and thus reduces bleeding. This would be the priority nursing action, because it directly addresses the problem. **Focus:** Prioritization
17. **Ans: 2, 4, 5** Autopsy should be discussed, but not at the very moments after birth. The infant should not be placed on the maternal abdomen until the nurse assesses the parents' wishes of when and how to view the infant. Staying with the parents at this moment and offering physical and emotional support is appropriate. It is also appropriate to prepare the infant in a way that demonstrates care and respect for the baby and to offer the parents the opportunity to view and/or hold the infant as they desire. The RN must ask the parents if there are cultural or religious rituals they would like for their child to ensure that they feel their infant has been treated properly with respect to their religion or culture. **Focus:** Prioritization
18. **Ans: 3** Slight redness in the left calf could be suggestive of thrombophlebitis and requires further investigation. The other findings are within normal limits. **Focus:** prioritization
19. **Ans: 2, 4** Insertion of a Foley catheter is indicated, because the woman will usually be unable to void due to the effect of the anesthetic in the bladder area. Positioning the patient on her side enhances blood flow and helps to prevent hypotension. Changing maternal position encourages progress in labor. In management of the second stage of labor when epidural anesthesia is used, laboring down as opposed to immediately pushing without the urge to push is advocated. It is not recommended to routinely discontinue an epidural anesthetic at complete dilation. A continuous epidural infusion provides pain relief throughout labor and birth. **Focus:** Prioritization
20. **Ans: 2, 3** The patient may be experiencing supine hypotension caused by the pressure of the uterus on the vena cava and the effects of epidural medication. Maternal hypotension can cause uteroplacental insufficiency leading to fetal hypoxia. Placing the woman in lateral position can relieve the pressure on the vena cava. The anesthesiologist should be notified and may need to treat the patient with ephedrine to correct the hypotension. IV fluids are increased per protocol when supine hypotension occurs. **Focus:** Prioritization
21. **Ans: 3** The RN remains an important part of the labor and birth in this scenario. Even with a good support team present, the RN needs to observe and assess the patient's comfort and safety as part of essential nursing care during labor. The RN's expertise allows the RN to make helpful suggestions to the support persons and patient. The patient should be encouraged to utilize positions and activity that are most comfortable to her. It is appropriate to let the patient and support persons know of all pain control options, but it would not be appropriate to continually offer pain medication to a patient who has chosen natural childbirth. **Focus:** Prioritization
22. **Ans: 3** Painless vaginal bleeding can be a symptom of placenta previa. A digital vaginal examination is contraindicated until ultrasound can be performed to rule out placenta previa. If a digital examination is performed when placenta previa is present, it can cause increased bleeding. The other statements reflect appropriate assessment of an incoming patient with vaginal bleeding. **Focus:** Assignment
23. **Ans: 1** Administration of antiviral medications to the pregnant woman and the newborn, cesarean birth, and avoidance of breast feeding have reduced the incidence of perinatal transmission of HIV from approximately 26% to 1% to 2%. Pregnancy is not known to accelerate HIV disease in the mother. The most important nursing action is to engage the mother in prenatal care and educate her as to the great benefits of medication for HIV during pregnancy. **Focus:** Prioritization
24. **Ans: 3** When a patient discloses fear of hurting herself or her baby, the RN must have the woman

immediately evaluated before allowing her to leave. Merely informing the patient about community resources is not sufficient. The baby blues are typically milder and occur 1 to 2 weeks postpartum. Once the woman has been evaluated, the provider can prescribe antidepressants that can be safely used while breast feeding. **Focus:** Prioritization

25. **Ans: 2** There is no evidence that exercise should be avoided in the first trimester of pregnancy in a healthy woman without medical or obstetrical complications. The American College of Obstetricians and Gynecologists recommends 30 minutes or more of exercise on most if not all days of the week for pregnant women. Exercise in which injury is more likely to occur should be avoided. **Focus:** Prioritization

Chapter 18: Emergencies and Disasters, pages 83-88

1. **Ans: 3** Triage requires at least one experienced RN. Pairing an experienced RN with an inexperienced RN provides opportunities for mentoring. Advanced practice nurses are qualified to perform triage; however, their services are usually required in other areas of the ED. An LPN/LVN is not qualified to perform the initial client assessment or decision making. Pairing an experienced RN with a nursing assistant is the second best option, because the assistant can measure vital signs and assist in transporting. **Focus:** Assignment
2. **Ans: 2, 1, 4, 3** An irritable infant with fever and petechiae should be further assessed for other signs of meningitis. The client with the head wound needs additional history taking and assessment for intracranial pressure. The client with moderate abdominal pain is in discomfort, but her condition is not unstable at this point. For the ankle injury, medical evaluation could be delayed up to 24 to 48 hours if necessary, but the client should receive the appropriate first aid. **Focus:** Prioritization
3. **Ans: 3** A brief neurologic assessment to determine level of consciousness and pupil reaction is part of the primary survey. Measurement of vital signs, assessment of the abdomen, and checking of pulse oximetry readings are considered part of the secondary survey. **Focus:** Prioritization
4. **Ans: 3** The priority goal is to increase myocardial oxygenation. The other actions are also appropriate and should be performed immediately. **Focus:** Prioritization
5. **Ans: 1** The nursing assistant can help with the removal of outer clothing, which allows the heat to dissipate from the child's skin. Advising and explaining are teaching functions that are the responsibility of the RN. Tepid baths are not usually given because of the potential for rebound and shivering. **Focus:** Delegation
6. **Ans: 4** The homeless person has symptoms of heat stroke, a medical emergency, which increases the risk for brain damage. The elderly client is at risk for heat syncope and should be educated to rest in a cool area and avoid future similar situations. The runner is having heat cramps, which can be managed with rest and fluids. The housewife is experiencing heat exhaustion, and management includes administration of fluids (IV or oral) and cooling measures. **Focus:** Prioritization
7. **Ans: 2, 4, 1, 3, 5** Establish unresponsiveness first. (The client may have fallen and sustained a minor injury.) If the client is unresponsive, get help and activate the code team. Performing the chin lift or jaw thrust maneuver opens the airway. The nurse is then responsible for starting CPR. CPR should not be interrupted until the client recovers or it is determined that all heroic efforts have been exhausted. A crash cart should be at the site when the code team arrives; however, basic CPR can be effectively performed until the team is present. **Focus:** Prioritization
8. **Ans: 1** Nursing assistants are trained in basic cardiac life support and can perform chest compressions. The use of the bag valve mask requires practice, and usually a respiratory therapist will perform this function. The nurse or the respiratory therapist should provide assistance as needed during intubation. The defibrillator pads are clearly marked; however, placement should be done by the RN or physician because of the potential for skin damage and electrical arcing. **Focus:** Delegation
9. **Ans: 3** The client is hyperventilating secondary to anxiety, and breathing into a paper bag will allow rebreathing of carbon dioxide. Also, encouraging slow breathing will help. Other treatments such as oxygen administration and medication may be needed if other causes are identified. **Focus:** Prioritization
10. **Ans: 3** The fast-track clinic deals with clients in relatively stable condition. The triage, trauma, and pediatric medicine areas should be staffed with experienced nurses who know the hospital routines and policies and can rapidly locate equipment. **Focus:** Assignment
11. **Ans: 1** Iron is a toxic substance that can lead to massive hemorrhage, coma, shock, and hepatic failure. Deferoxamine is an antidote that can be used for severe cases of iron poisoning. The other information needs additional investigation but will not change the immediate diagnostic testing or treatment plan. **Focus:** Prioritization
12. **Ans: 3** An LPN/LVN is able to listen and provide emotional support for clients. The other tasks are the responsibility of an RN or, if available, a sexual assault nurse examiner who has received training in assessing, collecting, and safeguarding evidence, and caring for assault victims. **Focus:** Delegation

13. **Ans: 3, 2, 4, 1, 5** The client should be removed from the cold environment first, then the rewarming process can be initiated. It will be painful, so pain medication should be given before immersing the feet in warm water. The client should be monitored for compartment syndrome every hour after initial treatment. **Focus:** Prioritization
14. **Ans: 3** The only correct intervention is option 3. The digits should be gently cleansed with normal saline, wrapped in sterile gauze moistened with saline, and placed in a plastic bag or container. The container is then placed on ice. **Focus:** Delegation
15. **Ans: 1** Safety is a priority for this client, and she should not return to a place where violence could recur. The other options are important for the long-term management of this case. **Focus:** Prioritization
16. **Ans: 3** Parental refusal is an absolute contraindication; therefore the physician must be notified. Tetanus status can be addressed later. The RN can reestablish the IV access and provide information about conscious sedation; if the parent is still not satisfied, the physician can give more information. **Focus:** Prioritization
17. **Ans: 4** The client has symptoms of alcohol abuse and there is a risk for Wernicke syndrome, which is caused by a thiamine deficiency. Multiple drug abuse is not uncommon; however, there is currently nothing to suggest an opiate overdose that requires naloxone. Additional information or the results of the blood alcohol testing are part of the total treatment plan but should not delay the immediate treatment. **Focus:** Prioritization
18. **Ans: 3** Postmortem care requires some turning, cleaning, lifting, and so on, and the nursing assistant is able to assist with these duties. The RN should take responsibility for the other tasks to help the family begin the grieving process. In cases of questionable death, belongings may be retained for evidence, so the chain of custody would have to be maintained. **Focus:** Delegation
19. **Ans: 5, 3, 4, 2, 1** Checking end-tidal carbon dioxide levels is the most accurate way of immediately verifying placement. Auscultating and confirming equal bilateral breath sounds should be performed in rapid succession. If the sounds are not equal or if the sounds are heard over the midepigastric area, tube placement must be corrected immediately. Securing the tube can be performed after these assessments are performed. Finally radiographic study will verify and document correct placement. **Focus:** Prioritization
20. **Ans: 2** An impaled object may be providing a tamponade effect, and removal can precipitate sudden hemodynamic decompensation. Additional history, including a more definitive description of the blood loss, depth of penetration, and medical history, should be obtained. Other information, such as the dirt on the stick or history of diabetes, is important in the overall treatment plan, but can be addressed later. **Focus:** Prioritization
21. **Ans: 1** The client demonstrates neurologic hyperreactivity and is on the verge of a seizure. Client safety is the priority. The client needs medications such as chlordiazepoxide (Librium) to decrease neurologic irritability and phenytoin (Dilantin) for seizures. Thiamine and haloperidol (Haldol) may also be ordered to address the other problems. The other diagnoses are pertinent but less urgent. **Focus:** Prioritization
22. **Ans: 2** The stinger will continue to release venom into the skin, so prompt removal of the stinger is advised. Cool compresses and antihistamines can follow. The caller should be further advised about symptoms that require 911 assistance. **Focus:** Prioritization
23. **Ans: 1** Cats' mouths contain a virulent organism, *Pasteurella multocida,* that can lead to septic arthritis or bacteremia. There is also a risk for tendon damage due to deep puncture wounds. These wounds are usually not sutured. A tetanus shot can be given before discharge. **Focus:** Prioritization
24. **Ans: 4, 5, 2, 3, 1, 6** The client with a pulsating mass has an abdominal aneurysm that may rupture, and he may decompensate suddenly. The woman with lower left quadrant pain is at risk for ectopic pregnancy, which is a life-threatening condition. The 11-year-old boy needs evaluation to rule out appendicitis. The woman with vomiting needs evaluation for gallbladder problems, which appear to be worsening. The 35-year-old man has food poisoning, which is usually self-limiting. The woman with midepigastric pain may have an ulcer, but follow-up diagnostic testing and teaching of lifestyle modification can be scheduled with the primary care provider. **Focus:** Prioritization
25. **Ans: 4** At least one representative from each group should be included, because all employees are potential targets for violence in the ED. **Focus:** Assignment
26. **Ans: 1** A deviated trachea is a symptom of tension pneumothorax, which will result in respiratory arrest if not corrected. All of the other symptoms need to be addressed, but are of lower priority. **Focus:** Prioritization
27. **Ans: 3, 2, 4, 1, 5, 6, 7** For a trauma client with multiple injuries, many interventions will occur simultaneously as team members assist in the resuscitation. Performing techniques to open the airway such as chin lift or jaw thrust can occur simultaneously with assessing for spontaneous respirations. However, airway and oxygenation are the priority. Starting IV lines for fluid resuscitation is part of supporting circulation. (Emergency medical service personnel will usually establish at least one IV line in the field.) Nursing assistants can be directed to measure vital signs and remove clothing. Insertion of a Foley catheter is necessary for close monitoring of output. **Focus:** Prioritization

28. **Ans: 1** In preparing for disasters, the RN should be aware of the emergency response plan. The plan gives guidance that includes the roles of team members, responsibilities, and mechanisms of reporting. Signs and symptoms of exposure to many agents will mimic common complaints, such as flulike symptoms. Discussions with colleagues and supervisors may help the individual nurse to sort through ethical dilemmas related to potential danger to self. **Focus:** Prioritization
29. **Ans: 3, 4, 2, 5, 1** The first priority is to protect personnel, unaffected clients, bystanders, and the facility. Personal protective gear should be donned before exposure to victims. Decontamination of victims in a separate area is followed by triage and treatment. The incident should be reported according to protocol as information about the number of persons involved, history, and signs and symptoms becomes available. **Focus:** Prioritization
30. **Ans: 4** Any of these persons may need or benefit from psychiatric counseling. Obviously, there will be variations in previous coping skills and support systems; however, a person who experienced a threat to his or her own life is at the greatest risk for psychiatric problems following a disaster incident. **Focus:** Prioritization
31. **Ans: 2, 3, 4, 5, 7** These would be appropriate for disaster triage. The other items are important and would be addressed when the staff has time and resources to collect the additional information. (Note: During nondisaster situations, it would be appropriate to include all items.) **Focus:** Prioritization
32. **Ans: 6, 2, 4, 3, 5, 1** Treat the 12-year-old with asthma first by initiating an albuterol treatment. This action is quick to initiate, and the child or parent can be instructed to hold the apparatus while you attend to other clients. The firefighter is in greater respiratory distress than the 12-year-old; however, managing a strong combative client is difficult and time consuming (i.e., the 12-year-old could die if you spend too much time trying to control the firefighter). Attend to the teenager with a crush injury next. Anxiety and tachycardia may be caused by pain or stress; however, the swelling suggests hemorrhage. Next attend to the woman with burns on the forearms by providing dressings and pain management. The child with burns over more than 70% of the anterior body should be given comfort measures; however, the prognosis is very poor. The prognosis for the client in cardiac arrest is also very poor, and the CPR efforts have been prolonged. **Focus:** Prioritization
33. **Ans: 1, 3, 4, 5** Children have proportionately larger heads that predispose them to head injuries. Hypoxemia is more likely because of their higher oxygen demand. Liver and spleen injuries are more likely because the thoracic cage of children offers less protection. Hypothermia is more likely because of children's thinner skin and proportionately larger body surface area. They have strong hearts; therefore pulse rate will increase to compensate, but other arrhythmias are less likely to occur. Children have relatively flexible bones compared with those of adults. The most likely spinal injury in children is injury to the cervical area. **Focus:** Prioritization
34. **Ans: 2** Decontamination in a specified area is the priority. Performing assessments and moving others delays decontamination and does not protect the total environment. Personnel should don personal protective equipment before assisting with decontamination or assessing the clients. The clients must undergo decontamination before entering cold or clean areas. **Focus:** Prioritization

PART 3

Case Study 1: Chest Pressure, Indigestion, Nausea, and Vomiting, pages 89-90

1. **Ans: 4** Monitoring and recording intake and output are within the scope of practice of a nursing assistant. Initiating telemetry, performing venipuncture, and obtaining ECGs require additional education and training. Attaching ECG leads may be done by unlicensed assistive personnel (UAPs) in some facilities, as may venipuncture and ECG recording. However, the UAPs performing these tasks would require additional specialized training. These actions are generally considered to be within the scope of practice of licensed nurses. **Focus:** Delegation
2. **Ans: 3** Cardiac monitoring is the highest priority, because the client's heart rate is rapid and irregular and the client is experiencing chest pressure. The client is at risk for life-threatening dysrhythmias such as frequent PVCs. Measuring vital signs every 2 hours, checking levels of cardiac markers, and recording a 12-lead ECG every 6 hours are important, but cardiac monitoring takes precedence for the reasons stated earlier. **Focus:** Prioritization
3. **Ans: 1** With frequent PVCs, the client is at risk for life-threatening dysrhythmias such as ventricular tachycardia or ventricular fibrillation. Amiodarone is an antidysrhythmic drug used to control ventricular dysrhythmias. Nitroglycerin and morphine can be given for chest pain relief. Atenolol is a beta-blocker, which can be used to control heart rate and decrease blood pressure. **Focus:** Prioritization
4. **Ans: 2** A troponin T level of more than 0.20 ng/mL is an elevated level and indicates myocardial injury or infarction. Although the other laboratory values are all abnormal, none of them is life threatening. **Focus:** Prioritization

5. **Ans: 1** Morphine sulfate has been ordered to relieve the chest discomfort that is common in the setting of acute myocardial infarction. Relief from the chest pain is the highest priority at this time. Ranitidine is a histamine 2 blocker used to prevent gastric ulcers. Scheduling an echocardiogram or drawing blood for coagulation studies, although important, will not help relieve chest discomfort. **Focus:** Prioritization
6. **Ans: 1, 2, 6** Measuring vital signs, recording intake and output, and assisting clients with activities of daily living are all within the scope of practice of the nursing assistant. Administration of IV drugs, venipuncture for laboratory tests, and assessment are beyond the scope of practice of nursing assistants. **Focus:** Delegation, supervision, assignment
7. **Ans: 4** Measuring and recording vital sign values are within the scope of practice of the nursing assistant. When a nursing assistant makes a mistake, it is best to communicate specifically, stressing the importance of recording the vital sign values after they have been obtained. Supervision should be done in a supportive rather than confrontational manner. Notification of the nurse manager is not appropriate at this time. Reprimanding the nursing assistant in front of others also is not appropriate. **Focus:** Delegation, supervision
8. **Ans: 2** Chest pain can be an indicator of additional myocardial muscle damage. Additional episodes of chest pain significantly affect the client's plan of care. Small increases in heart rate and blood pressure after activity are to be expected. **Focus:** Prioritization, delegation, supervision
9. **Ans: 1** HCTZ is a thiazide diuretic used to correct edema and lower blood pressure. A side effect of HCTZ is loss of potassium, and clients may require potassium supplementation. Captopril is an angiotensin-converting enzyme inhibitor and will lower blood pressure. It is never appropriate to take twice the dose of this drug. **Focus:** Prioritization
10. **Ans: 1, 3, 4, 5, 6** All of these interventions are within the scope of practice of an experienced LPN/LVN. You would be sure to instruct the LPN when to notify you or the physician of any abnormal findings. Preparing a teaching plan requires additional education and is more suited to the RN. Taking vital signs and reminding the patient about bedrest could also be delegated to a nursing assistant. **Focus:** Delegation, supervision
11. **Ans: 3** The dressing should be left in place for at least the first day after the client is discharged to prevent dislodging the clot. Heavy lifting and exercise should be avoided for several days. A small hematoma or bruise is expected and is not abnormal. It is not necessary to keep the affected extremity straight after the patient is off bed rest. **Focus:** Prioritization

Case Study 2: Dyspnea and Shortness of Breath, pages 91-92

1. **Ans: 2** The patient's major problems at this time relate to airway and breathing. The patient's anxiety is most likely directly related to his breathing difficulty. An acid-base imbalance may result from the patient's breathing problem, but this is not the highest priority at the moment. **Focus:** Prioritization
2. **Ans: 1** Baseline arterial blood gas results are important in planning the care of this patient. The unit clerk can schedule the pulmonary function tests and chest radiography. The albuterol therapy is a routine order. **Focus:** Prioritization
3. **Ans: 3** The pH is on the low side of normal and the $Paco_2$ is elevated, which indicates an underlying respiratory acidosis. The HCO_3^- level is elevated, which indicates compensation. Both the Pao_2 and the oxygen saturation levels are low, which points to hypoxemia. These blood gas results are typically expected when a patient has a chronic respiratory problem such as COPD. **Focus:** Prioritization, knowledge
4. **Ans: 1, 3, 6** The patient's major problem at this time is impaired gas exchange with hypoxemia. Strategies to compensate include administration of low-flow oxygen as well as interventions to improve gas exchange, such as having the patient cough and deep breath and perform incentive spirometry. These strategies may improve the patient's condition and prevent the need to initiate a code and/or transfer to the ICU. A saline lock is a good idea, but giving the patient too much fluid may worsen his condition by producing a fluid overload. **Focus:** Prioritization
5. **Ans: 4** Increasing oxygen flow for a patient based on a physician's order is within the scope of practice of LPNs/LVNs. Nursing assistants may measure vital signs. Arterial draws for laboratory tests are not within the LPN/LVN's scope of practice. Hand-held nebulizers are usually operated by respiratory therapists. **Focus:** Delegation, supervision
6. **Ans: 1, 4, 6** Assisting patients with activities of daily living such as toileting are within the scope of practice of nursing assistants. Once licensed nurses or respiratory therapists have taught the patient to use incentive spirometry, the nursing assistant can play a role in reminding the patient to perform it. Nursing assistants can participate in encouraging patients to drink adequate fluids. Assessing and teaching are not within the scope of practice of nursing assistants. Performing pulse oximetry could be appropriate for experienced nursing assistants once they have been taught how to use the pulse oximetry device to gather additional data. **Focus:** Delegation, supervision, assignment
7. **Ans: 3** Barrel chest and clubbed fingers are signs of chronic COPD. The patient had a productive cough on admission to the hospital. Bilateral crackles are a

new finding and indicate fluid-filled alveoli and pulmonary edema. Fluid in the alveoli affects gas exchange and can result in worsening arterial blood gas concentrations. **Focus:** Prioritization

8. **Ans: 1** Furosemide is a loop diuretic. The uses of this drug include treatment of pulmonary edema. Intake and output records and daily weights are important in documenting the effectiveness of the medication. A side effect of this drug is hypokalemia, and some patients are also prescribed a potassium supplement when taking this medication. **Focus:** Prioritization
9. **Ans: 3** The patient's temperature was elevated on admission. Further elevation indicates ongoing infection. The physician needs to be notified and an appropriate treatment plan started. All of the other pieces of information are important, but are not urgent. The patient's incontinence is not new. **Focus:** Supervision, prioritization
10. **Ans: 4** The heart rate and blood pressure are slightly increased from admission and the respiratory rate is slightly decreased. The continued elevation in temperature indicates a probable respiratory tract infection that needs to be recognized and treated. **Focus:** Prioritization
11. **Ans: 2** Discharge planning and IV administration of antibiotics are more appropriate to the scope of practice of the RN. However, in some states LPNs/LVNs with special training may administer IV antibiotics. Check the regulations in your state. Administering oral medications is appropriate to delegate to LPNs/LVNs. Although the LPN could weigh the patient, this intervention is appropriate to the scope of practice of nursing assistants. **Focus:** Delegation, supervision
12. **Ans: 4** The patient is demonstrating improper use of the MDI by taking 2 puffs in rapid succession, which can lead to incorrect dosage and ineffective action of the albuterol. Teaching is the first priority. As you work with this patient, you may determine that he would benefit from the use of a spacer. Sitting up in a chair may also be useful, but these interventions are not the first priority. Notifying the physician that the patient needs to continue with nebulizer treatments is not within your scope of practice and does not address the problem, which is that the patient does not know how to properly use his MDI. **Focus:** Prioritization

Case Study 3: Multiple Clients on a Medical-Surgical Unit, pages 93-94

1. **Ans: 1, 3, 4, 6** It is important to recognize that the RN continues to be accountable for the care of all clients by this team. Appropriate client assignments for the LPN include clients whose conditions are stable and not complex. Ms. J is currently experiencing chest pain, and Ms. B is a complex new admission. **Focus:** Assignment, delegation, supervision
2. **Ans: 2** Although it is important that the nurse see all of these clients, Ms. J's assessment takes priority. Her chest pain may indicate coronary artery blockage and acute heart attack. None of the other clients' needs is life-threatening. **Focus:** Prioritization
3. **Ans: 3** Cardiac catheterization is usually accomplished by inserting a large-bore needle into the femoral vein and/or artery. Clients are routinely restricted to bed rest for 4 to 6 hours after the procedure to prevent hemorrhage. Family members are usually permitted to visit as soon as the client returns to the room. **Focus:** Prioritization
4. **Ans: 4, 1, 2, 1, 2, 1, 2, 1, 4, 3** The ECG should be completed first because the physician has ordered it during episodes of chest pain. Nitroglycerin is usually tried before morphine to relieve the chest pain. Hypotension is a side effect of nitroglycerin. Blood pressure and heart rate are monitored whenever nitroglycerin is administered. **Focus:** Prioritization
5. **Ans: 4** Assessment and teaching are more appropriate to the educational preparation of licensed nursing staff. The nursing assistant could perform pulse oximetry after undergoing orientation and being taught to use the device. Monitoring and recording intake and output are within the educational scope of nursing assistants. **Focus:** Assignment, Delegation, supervision
6. **Ans: 1** A temperature elevation to 102° F is an indicator of an infectious process. The other criterion parameters should be based on abnormalities from each client's baseline. **Focus:** Delegation, supervision
7. **Ans: 3** Acute chest pain can indicate myocardial ischemia, coronary artery blockage, and/or myocardial damage. The nursing assistant's question should be answered with the most accurate response. Although the unit may have protocols that the nursing assistant should be familiar with, option 4 is not the most accurate response. **Focus:** Prioritization
8. **Ans: 2** Assisting clients with activities of daily living such as feeding are most appropriate to the scope of practice of nursing assistants. **Focus:** Delegation, supervision, assignment
9. **Ans: 3** The nurse should gather more information before notifying the physician. Pulse oximetry assessment provides information about the client's oxygenation status. Clients with COPD usually receive low-dose oxygen because their stimulus for breathing is low oxygen level. Coughing and deep breathing help mobilize secretions. **Focus:** Prioritization
10. **Ans: 1** This client's temperature elevation is most likely due to an infection. The physician must be notified to modify the client's plan of care. Administering acetaminophen and removing extra blankets may decrease the client's temperature, but they will not treat the infection. **Focus:** Prioritization

11. **Ans: 1** The client's temperature elevation indicates an infectious process. For elderly clients with bladder infections, changes in level of consciousness are frequently a sign. **Focus:** Prioritization
12. **Ans: 2** Assisting clients with activities of daily living is appropriate to the educational preparation and scope of practice of nursing assistants. Teaching, assessing, and administering medications fall within the scope of practice for licensed nurses. **Focus:** Delegation, supervision
13. **Ans: 2** A common side effect of beta-adrenergic agonists such as albuterol is increased heart rate. Drugs such as albuterol are commonly prescribed for clients with chronic obstructive pulmonary disease (COPD) to use as needed to dilate the airways when experiencing shortness of breath. Although the other factors are important and may be related to the client's COPD, they may not have contributed to the increase in heart rate. **Focus:** Prioritization
14. **Ans: 4** Standards of practice for the use of restraints require that nurses attempt alternative strategies before asking that a client be restrained. A physician's order is required for continued use of restraints but can be gotten after the fact if the client's actions endanger his or her well-being. **Focus:** Prioritization, delegation, supervision
15. **Ans: 3** The nursing assistant is new to the unit and may need assistance or instruction regarding the completion of this assignment. **Focus:** Delegation, supervision, assignment
16. **Ans: Right task, Right person, Right circumstance, Right direction and communication, Right supervision** According to the National Council of State Boards of Nursing, the Five Rights are essential for the process of delegation. The right task is assigned to the right person in the right circumstances. The RN then offers the right direction and communication, and right supervision. **Focus:** Delegation, supervision, assignment

Case Study 4: Shortness of Breath, Edema, and Decreased Urine Output, pages 95-96

1. **Ans: 2** All of these findings are important, but only the presence of crackles in both lungs is urgent, because it signifies fluid-filled alveoli and interruption of adequate gas exchange and oxygenation, possibly pulmonary edema. The patient's peripheral edema is not new. The faint pulses are most likely due to the presence of peripheral edema. The dry and peeling skin is a result of chronic diabetes and merits careful monitoring to prevent infection. **Focus:** Prioritization
2. **Ans: 3** Teaching, instructing, and assessing are all functions that require additional education and preparation. These interventions fall within the scope of the professional nurse. Providing the patient with ice for the urine collection and reminding the patient to collect her urine fit the scope of practice of the nursing assistant. **Focus:** Delegation, supervision
3. **Ans: 1** A patient with a serum potassium level of 7 to 8 mmol/L or higher is at risk for electrocardiographic changes and fatal dysrhythmias. The physician should be notified immediately about this potassium level. Although the serum creatinine and blood urea nitrogen levels are quite high, these levels are commonly reached before patients experience symptoms of CKD. The serum calcium level is low, but not life threatening. Keep in mind that there is an inverse relationship between calcium and phosphorus, so when calcium is low, expect phosphorus to be high. **Focus:** Prioritization
4. **Ans: 4** Kayexalate removes potassium from the body by exchanging sodium for potassium in the large intestine. Diuretics such as furosemide generally do not work well in chronic renal failure. The patient may need a calcium supplement and subcutaneous epoetin alfa; however, these drugs do nothing to decrease potassium levels. **Focus:** Prioritization
5. **Ans: 1** Insertion of a urinary catheter is within the scope of practice of LPNs/LVNs, and the LPN/LVN must be under the supervision of an RN. Planning care, teaching respiratory care techniques, and discussing options such as renal replacement therapies all generally require additional education and training. In many acute care hospitals, LPNs/LVNs auscultate breath sounds as a part of their observations, and RNs follow up with overall assessment and synthesis of data. These latter interventions are more appropriate to the scope of practice of the RN. **Focus:** Delegation, supervision
6. **Ans: 2** Checking vital signs usually includes measuring oral body temperature. Because the patient just finished drinking fluids, an oral temperature measurement would be inaccurate at this time. All of the other actions are appropriate and within the scope of practice of a nursing assistant. **Focus:** Delegation, supervision
7. **Ans: 1, 2, 3, 5** The usual fluid restriction for patients with chronic renal failure is 500 to 700 mL plus urine output. All of the other actions are appropriate for a patient with fluid overload. **Focus:** Prioritization
8. **Ans: 2** Even after beginning HD, patients are still required to restrict fluid intake. In addition, patients on HD have nutritional restrictions (e.g., protein, potassium, phosphorus, sodium restriction). All of the other patient statements indicate appropriate understanding of teaching about HD. **Focus:** Prioritization
9. **Ans: 3** Temporary dialysis lines are to be used only for HD. As supervising nurse, you should stop the new nurse before the temporary HD system is interrupted.

Breaking into the system increases the risk for complications such as infection. The blood pressure should always be assessed on the nondialysis arm. Postoperative patients should always be monitored for bleeding. Oxycodone, when ordered by the physician, is an appropriate analgesic for moderate to moderately severe pain. **Focus:** Delegation, supervision

10. **Ans: 3** Changes in level of consciousness during or after HD can signal dialysis disequilibrium syndrome, a life-threatening situation that requires early recognition and treatment with anticonvulsants. Decreases in weight and blood pressure are to be expected as a result of dialysis therapy. A small amount of drainage is common after HD. **Focus:** Prioritization
11. **Ans: 1** Measuring vital signs and weighing the patient are within the education and scope of practice of the nursing assistant. The nursing assistant could remind the patient to request assistance when getting out of bed after the RN has instructed to patient to do so. Assessing the HD access site for bleeding, bruit, and thrill require additional education and skill and are appropriately performed by a licensed nurse. **Focus:** Delegation, supervision
12. **Ans: 4** Epoetin alfa is used to treat anemia and is given two to three times a week. It is given by either the intravenous or subcutaneous route. Most commonly epoetin alfa is given subcutaneously. All of the other statements about CKD patient medications are accurate. **Focus:** Delegation, supervision

Case Study 5: Diabetic Ketoacidosis, pages 97-98

1. **Ans: 1, 2, 5, 6, 7** Onset of symptoms and the amount of fluid loss help to determine acuity. Pain assessment of the abdomen should be performed to obtain a baseline; his pain is probably associated with diabetic ketoacidosis (DKA), but infection or trauma could also be factors. The physician should know if Mr. D had insulin today. Information about allergies should be obtained for all clients regardless of the presenting complaint. Knowing the reason Mr. D did not go to see the physician and knowing his last blood glucose reading do not alter your priority actions at this point. **Focus:** Prioritization
2. **Ans: 5** Mr. D should be taken to a treatment room where evaluation and treatment can begin immediately. Paging the ED physician to come to the triage area is not necessary unless the client becomes unresponsive in the triage area. Calling the parents is not necessary because Mr. D is old enough to provide consent himself. (If Mr. D were underage, the treatment would not be delayed if the parents were unavailable in an emergency situation.) Calling the primary care physician is usually done by the ED physician after the preliminary workup is completed. (Policies for calling private physicians vary among institutions.) Teaching about hyperglycemia is important, but treatment is the priority. **Focus:** Prioritization
3. **Ans: 3** Mr. D is severely dehydrated and is at risk for hypovolemic shock. Although he is demonstrating Kussmaul respirations, this breathing pattern is the body's attempt to compensate for the acidosis. Anxiety and noncompliance are also relevant, but can be addressed after Mr. D's condition is stabilized. **Focus:** Prioritization
4. **Ans: 1, 2, 3, 5** Checking vital signs, bagging up belongings, and measuring and recording output are within the scope of duties for the nursing assistant. Checking blood glucose level is accomplished with a fingerstick, and nursing assistants, particularly in specialty areas like the ED, will frequently have been trained to do this task, but this may vary from state to state and facility to facility. Information should not be released by the nursing assistant because of confidentiality issues. The RN should decide how to convey information to friends and family. **Focus:** Delegation
5. **Ans: 3, 6** Subcutaneous insulin is not absorbed fast enough and is inappropriate for emergency situations. (IV insulin would be appropriate.) The client is likely to be on orders for nothing by mouth until the vomiting subsides. **Focus:** Prioritization
6. **Ans: 1** Normal saline (0.9% sodium chloride) is the first fluid used to correct dehydration in most adults with DKA. Half-strength saline (0.45% sodium chloride) can be used for children or adults at risk for volume overload. Potassium supplements are added within 1 to 2 hours after starting insulin. Solutions of dextrose 5% are added to the therapy once the blood glucose level approaches 250 mg/dL. **Focus:** Prioritization
7. **Ans: 2** Initially in clients with DKA, serum potassium level is expected to be within normal limits or elevated; regardless of the laboratory value, however, there is an overall potassium deficit. After therapy, hypokalemia is expected as the potassium shifts back into the cells; therefore, if potassium level is initially low, it will be even lower after therapy. **Focus:** Prioritization
8. **Ans: 2** Her calculations are incorrect. The pump should be set at 7 mL/hr.
   $145/2.2 = 70$ kg
   70 kg$/x$ units : 1 kg$/0.1$ units $= 7$ units
   100 units$/100$ mL $= 1$ unit$/1$ mL : 7 units$/x$ mL $= 7$ mL
   Calling the physician is inappropriate; the nurse is responsible for calculating the pump settings. Insulin is a high-alert drug, and calculations must always be double-checked. When discrepancies are discovered, the source of error must be determined and corrected. **Focus:** Prioritization, supervision

ANSWER KEY

9. **Ans: 3** Acknowledging and reflecting underlying feelings is therapeutic. Options 1 and 4 give unsolicited advice, and option 2 is a platitude that is not supported by firsthand knowledge of the mother-son relationship. **Focus:** Prioritization
10. **Ans: 1** First, the situation should be assessed to determine if a HIPAA (Health Insurance Portability and Accountability Act) violation has occurred. Client information should be released only to facilitate continuity of care (i.e., in a shift report) and only to those who are directly involved in the care. If HIPAA rules were violated, the incident would be reported to the nurse manager for potential complaints related to the assistant's actions and so that the assistant could receive the proper remediation. Giving positive feedback for sincere efforts to assist clients and families is appropriate, but guidelines must be recognized and followed. **Focus:** Supervision
11. **Ans: 2** Before potassium is administered, it is important to know that the kidneys are functioning. The other information is important but has less relevance to the potassium infusion. **Focus:** Prioritization
12. **Ans: 2** Ask the secretary to correct the omission by calling the admissions office right away. In this case, client care is more urgent than filing a complaint or determining why the secretary made the omission. If you have a good relationship with the ICU nurses, they will probably take the report; however, you retain responsibility for the client's care until the admission procedure and transfer are completed. **Focus:** Supervision
13. **Ans: 2** Ventricular dysrhythmias suggest hypokalemia, which is a significant cause of death in clients with DKA. One P wave should normally precede every QRS complex. Frequent QRS complexes will be present in tachycardia. An artifact is usually caused by loose leads or client movement. **Focus:** Prioritization
14. **Ans: 1, 4, 5, 6, 7** Other signs and symptoms of hypokalemia include paralytic ileus, nausea and vomiting, abdominal distention, confusion, and irritability. Seizures, hallucinations, and cold, clammy skin are more associated with hypoglycemia. **Focus:** Prioritization
15. **Ans: 1, 4, 5, 6** The nursing assistant can direct family and visitors to appropriate waiting areas, obtain equipment, and measure vitals signs. An RN or MD should accompany Mr. D to the ICU; the nursing assistant can help, but should not independently transport clients to the ICU. The unit secretary usually prepares the papers, but the RN is responsible for ensuring that everything is in order. In specialty areas such as the ED, nursing assistants may receive additional training to connect clients' cardiac leads to the cardiac monitor; however, the RN is responsible for assessing the cardiac rhythm. **Focus:** Delegation

Case Study 6: Home Health, pages 99-102

1. **Ans: 1, 4, 5, 6** Ms. A's dyspnea and increased use of oxygen require rapid assessment. Mr. I's sample for a CBC must be drawn when the bone marrow is most suppressed to accurately assess the impact of chemotherapy on bone marrow function. Ms. R should be seen as soon as possible after discharge to determine the plan of care. Mr. W needs to receive the scheduled dose of risperidone. Mr. D and Ms. F do not have urgent needs, and these visits can be rescheduled for the following day. **Focus:** Prioritization
2. **Ans: 1** Ms. A's increased shortness of breath indicates a need for rapid assessment. In addition, high oxygen flow rates can suppress respiratory drive in patients with COPD, so Ms. A should be seen as soon as possible. The other patients can be scheduled according to criteria such as location or patient preference about visit time. **Focus:** Prioritization
3. **Ans: 4** In the home health setting, the patient is in control of health management, so enlisting the patient's cooperation for the visit is essential. In this response, the nurse indicates that the patient has a choice about whether the visit is scheduled for today but educates the patient about why it is important that the visit occur as soon as possible. Because the initial visit requires a multidimensional assessment, it is usually quite lengthy. The patient's comments do not indicate a lack of need or desire for home health services. **Focus:** Prioritization
4. **Ans: 2** The patient has symptoms and risk factors which could indicate that her oxygen saturation is either excessively high or too low, so checking oxygen saturation is the first action that should be taken. The other actions may also be appropriate, but assessment of oxygen saturation will determine which action should occur next. **Focus:** Prioritization
5. **Ans: 1** The goal for oxygen saturation for a patient with COPD is usually about 90% to 92%, because high oxygen levels can lead to increases in the partial pressure of carbon dioxide ($Paco_2$). The next step is to notify the physician, who may want to admit the patient to the hospital or order arterial blood gas analysis. It will be important to discuss appropriate home oxygen use with the patient and her husband, but not until the immediate situation is resolved. **Focus:** Prioritization
6. **Ans: 3** Although the risperidone is scheduled for today, because the medication is absorbed gradually, rescheduling the dose for tomorrow will not have an adverse impact on control of the patient's schizophrenia. The other patients have more urgent needs and should receive visits today. **Focus:** Prioritization
7. **Ans: 2** The chest pressure indicates that Ms. R is experiencing myocardial ischemia and requires immediate assessment and intervention (such as administration

of sublingual nitroglycerin). The shortness of breath requires further investigation and may be related to the chest pressure and myocardial ischemia. The other responses also indicate the need for further assessment and interventions, such as teaching, but do not require immediate action. **Focus:** Prioritization

8. **Ans: 3** Because the patient still has chest discomfort, administration of another nitroglycerin tablet is the first action to take. Completing the admission assessment, having her rest, and notifying the physician about her chest pain are also appropriate actions, but administration of another nitroglycerin tablet and resolution of the chest pressures are the priorities. **Focus:** Prioritization
9. **Ans: 4, 5, 6** Home health aide education and scope of practice include assisting with personal hygiene and obtaining routine data such as vital sign values and daily weights. It is the RN's responsibility to evaluate these data and plan individualized care using the data. The other assessments and interventions require more education and broader scope of practice. **Focus:** Delegation
10. **Ans: 2** The focus in home health nursing is empowering the patient and family members by teaching self-care. Ms. R's condition is not so unstable that she needs to be reassessed today, because her chest pain did resolve after she took two nitroglycerin tablets, she has taken her medications, and her daughter will be available and has been educated about how to manage if Ms. R's condition deteriorates. The patient's symptoms of chest pressure, crackles, and edema do indicate a need for reassessment the next day. Although the home health aide will visit, home health aide education and role do not include evaluating the patient's response to the ordered therapies and planning changes in care based on the evaluation. **Focus:** Prioritization
11. **Ans: 2** Because Mr. I is in the nadir period following his chemotherapy, he is at high risk for infection. Avoidance of any cross-contamination from Mr. D's leg infection is essential. **Focus:** Prioritization
12. **Ans: 4** The initial assessment and development of the plan of care, including interventions such as oxygen therapy, are the responsibility of RN staff members. The RN with the most experience in caring for patients with emphysema is the on-call part-time RN. Some patient care activities are assigned to staff members from other disciplines, such as LPNs/LVNs and respiratory therapists, after the plan of care is developed by the RN. **Focus:** Assignment
13. **Ans: 3** Immunosuppression decreases the patient's ability to mount a fever in response to infection, so that even a minor increase in temperature (especially in combination with symptoms such as lethargy and confusion) can be an indicator of a serious infection, including sepsis. The decreased right-sided breath sounds are consistent with the patient's diagnosis of lung cancer. The poor appetite and dry oral mucous membranes also require assessment and intervention, but infection is one of the most serious complications of chemotherapy. **Focus:** Prioritization
14. **Ans: 4** Mr. I's immunosuppression, fever, and possible sepsis diagnosis indicate that he should be assessed immediately once he arrives in the ED, so that he will avoid exposure to other ED patients. In addition, the appropriate treatment for sepsis is rapid initiation of intravenous antibiotics (after appropriate culture results are obtained). The other information will also be helpful, but will not ensure that Mr. I is assessed and treated rapidly in the ED. **Focus:** Prioritization
15. **Ans: Elevated temperatures, blood glucose levels, and blood pressures** The elevated temperatures and blood glucose levels suggest a possible infectious process and should be reported to the health care provider so that interventions can be quickly implemented to prevent complications such as sepsis, diabetic ketoacidosis, or hyperglycemic hyperosmolar nonketotic coma. The blood pressures should also be reported, because current national guidelines indicate that blood pressure for diabetic patients should be maintained at a level of less than 130/80 to decrease cardiovascular risk. The pulse, respiratory rate, and weight do not indicate a need for a change in the patient's treatment. **Focus:** Prioritization
16. **Ans: 2, 3, 5, 6, 8, 9** The assessment of Mr. D suggests that he has an acute lower respiratory tract infection such as pneumonia. The appropriate collaborative interventions for this include sputum culture and antibiotic therapy. Blood cultures are frequently ordered for patients with pneumonia, because sepsis is a possible complication. There are no data to suggest the need for urine or wound cultures. Daily oximetry is appropriate. Incentive spirometry and an increase in fluid intake will both help loosen secretions. Because the patient is alert and is not hypoxemic or acutely dyspneic, he does not appear to require hospitalization at this time. You will want to reassess him the next day. **Focus:** Prioritization

Case Study 7: Spinal Cord Injury, pages 103-104

1. **Ans: 2** The priority at this time, with an SCI at the C4-C5 level, is airway and respiratory status. The cervical spine nerves (C3 to C5) innervate the phrenic nerve, which controls the diaphragm. Careful and frequent assessments are necessary, and endotracheal intubation may be required to prevent respiratory arrest. The other three concerns are appropriate, but are not urgent like airway and respiratory status. **Focus:** Prioritization

2. **Ans: 2, 4** The experienced nursing assistant can make sure that the oxygen flow setting is correct and that the cannula is in place once instructed by the RN. The experienced nursing assistant would also know how to measure oxygen saturation by pulse oximetry. The nurse retains responsibility for ensuring that the client's oxygen flow rate is correct and for interpretation of oxygen saturation measurements. Assessments, including auscultation, and client teaching require additional education, training, and skill, and are appropriate to the scope of practice of the professional RN. **Focus:** Delegation, supervision
3. **Ans: 3** The nurse should notify the physician immediately. The client's symptoms indicate the strong possibility of impending respiratory arrest. This client probably needs endotracheal intubation and mechanical ventilation. **Focus:** Prioritization
4. **Ans: 1** The traction weights must be hanging freely at all times to maintain the cervical traction and prevent further injury. All of the other actions are appropriate for the care of a client with cervical tongs. **Focus:** Prioritization
5. **Ans: 1, 4** A nursing student can administer medications and simple treatments such as cervical tong pin care. The nursing student should be mentored by the nurse when monitoring traction during client repositioning and performing neurologic assessments. **Focus:** Delegation, supervision
6. **Ans: 1** An experienced nursing assistant has been taught how to reposition clients while maintaining proper body alignment. The nurse remains responsible for ensuring that this action is performed correctly. Inspecting a client's skin and administering medications requires additional education and skill, and are appropriately performed by licensed nurses. Performing range-of-motion exercises also requires additional education and skill and is appropriate to the scope of practice of licensed nurses and physical therapists. However, some nursing assistants are given extra training and are able to perform range-of-motion exercises for clients. The skill level and job descriptions of nursing assistant team members should be checked to determine their ability to perform range-of-motion exercises. **Focus:** Delegation, supervision
7. **Ans: 3** Mr. M has a level C4-C5 spinal injury. The best way to assess motor functions in a client with injury at this level is to apply downward pressure while the client shrugs his shoulders upward. Testing plantar flexion assesses S1-level injuries. Application of resistance when the client lifts the legs assesses injuries at the L2 to L4 level. Having a client grasp and form a fist assesses C8-level injuries. **Focus:** Prioritization
8. **Ans: 3** The client should be encouraged to perform as much self-care as he is able, and the nursing assistant should help with care the client is unable to complete. The client's wife should also be taught to encourage the client to do as much as possible for himself. **Focus:** Prioritization, delegation
9. **Ans: 1, 2, 3, 4, 5, 6** Clients should be taught to drink 2000 to 2500 mL of fluid each day to prevent urinary tract infections and calculus formation. They may be taught to decrease the amount of fluid intake after 6 to 7 PM to decrease the need to void, or to self-catheterize in the middle of the night. The other points are appropriate for a bladder training program. **Focus:** Prioritization
10. **Ans: 2** The first, third, and fourth statements are reasonable client goals for rehabilitation. The second statement probably represents an unrealistic expectation, and the client needs additional teaching about setting realistic goals for rehabilitation. **Focus:** Prioritization

Case Study 8: Multiple Patients with Adrenal Gland Disorders, pages 105-106

1. **Ans: 3** These signs and symptoms indicate adrenal crisis (addisonian crisis), or acute adrenocortical insufficiency—a life-threatening event in which the need for cortisol and aldosterone is greater than the available supply. The other actions are important and will likely be implemented rapidly, because a common cause of acute adrenal gland hypofunction is hemorrhage, but the physician must be notified immediately. **Focus:** Prioritization
2. **Ans: 1** The patient is hypotensive and most likely hypovolemic. Because the patient already has an IV line, the IV fluids should be begun first to address the primary problem. The second IV line and typing and cross matching need to be accomplished rapidly, and the blood sample may be drawn at the same time the second IV line is inserted. The patient needs cortisol replacement, but with nausea and vomiting present, the oral route is not the best route. **Focus:** Prioritization
3. **Ans: 2, 3, 4** The patient is experiencing nausea and vomiting, so oral fluids are not appropriate at this time. The nursing assistant can take frequent vital sign measurements, record intake and output, and weigh the patient. The nurse should instruct the nursing assistant about what variations in vital signs must be reported. **Focus:** Delegation, supervision
4. **Ans: 1** The manifestations the patient has developed are classic signs of hypoglycemia, a complication of adrenal gland hypofunction. The nurse should check the patient's glucose level. If it is low, the patient should receive some form of glucose, most likely dextrose 50% IV. **Focus:** Prioritization
5. **Ans: 4** A patient with hypercortisolism is immunosuppressed because excess cortisol reduces the number of circulating lymphocytes and inhibits production of

cytokines and inflammatory chemicals such as histamine. These patients are at greater risk for infection. **Focus:** Prioritization

6. **Ans: 1** Women with hypercortisolism may report a history of cessation of menses. Increased androgen production can interrupt the normal hormone feedback mechanism for the ovary, which decreases the production of estrogens and progesterone and results in oligomenorrhea (scant or infrequent menses). **Focus:** Prioritization
7. **Ans: 1, 3, 4, 6** A patient with Cushing disease typically has paperlike thin skin and weight gain as a result of an increase in total body fat caused by slow turnover of plasma fatty acids. Weight loss is to be expected in a patient with hypocortisolism (e.g., Addison disease). The other findings are typical of a patient with Cushing disease. **Focus:** Supervision, prioritization
8. **Ans: 3, 4** The educational preparation of the LPN/LVN includes fingerstick glucose monitoring and administration of subcutaneous medications. Assessing cardiac rhythms and reviewing laboratory results require additional education and skill, and are appropriate to the RN's scope of practice. **Focus:** Delegation, supervision
9. **Ans: 1, 3** The nursing assistant can provide articles for self-care and reinforce what the RN has already taught the patient. The nursing assistant can also remind the patient about changing positions. Instructing and assessing are within the scope of practice of the professional nurse. **Focus:** Delegation, supervision
10. **Ans: 1, 3, 4, 5, 6** Cortisol replacement drugs should be taken with meals or snacks, because the patient can develop gastrointestinal irritation when the drugs (cortisone, hydrocortisone [Cortef], prednisone [Deltasone], fludrocortisone [Florinef]) are taken on an empty stomach. All of the other teaching points are appropriate. **Focus:** Prioritization
11. **Ans: 1** When a patient with possible pheochromocytoma is assessed, the abdomen should not be palpated, because this action could cause a sudden release of catecholamines and severe hypertension. None of the other assessments should have an adverse effect on this patient. **Focus:** Prioritization
12. **Ans: 3** During the 3- to 4-day VMA testing period, medications usually withheld include aspirin and antihypertensive agents. Beta-blockers are avoided because these drugs may cause a rebound rise in blood pressure. All of the other instructions are appropriate for this diagnostic test. **Focus:** Delegation, supervision
13. **Ans: 2** The nursing assistant should remind the patient about elements of the care regimen that the nurse has already taught the patient. Assessing, instructing, and identifying stressful situations that may trigger a hypertensive crisis require additional education and skill appropriate to the scope of practice of the professional RN. **Focus:** Delegation, supervision
14. **Ans: 1, 4** The new nurse graduate who has just completed orientation should be assigned patients whose conditions are relatively stable and not complex. The new graduate should be familiar with the adrenal surgery after completing her orientation and should be able to provide the teaching the patient needs. The patient with a low potassium level will need some form of potassium supplementation, which the new nurse should be able to administer. The patient in addisonian crisis should be assigned to an experienced nurse. The fearful, anxious patient would also benefit from being cared for by an experienced nurse. **Focus:** Assignment

Case Study 9: Multiple Clients with Gastrointestinal Problems, pages 107-110

1. **Ans: 6** Mr. R has several prognostic factors that increase the risk for death: age older than 50 years, increased WBC and blood glucose level. Shock can occur secondary to bleeding; release of kinins, which causes vasodilation; or release of enzymes into the circulation. **Focus:** Prioritization
2. **Ans: 1, 2, 4** Ms. H, Ms. D, and Mr. A are in the most stable condition and represent the least complex cases according to the shift report. Mr. R's confusion and belligerence will make pain management especially difficult. Because of his pancreatitis, his laboratory results and symptoms of worsening should be closely monitored. Ms. T is at risk for electrolyte imbalances, especially hypokalemia. She needs repetitive perineal hygiene and skin assessment. TPN and central line management requires additional skill. Mr. K is in stable condition, but because of the family dynamics his care should be handled by an experienced nurse. **Focus:** Assignment
3. **Ans: 1, 2, 3, 4** Measuring vital signs, performing hygienic care, and transporting are within the scope of the nursing assistant's duties. The nursing assistant should not remove the dressing. If the dressing needs to be removed, the nurse should remove it, conduct the wound assessment, clean the area, and redress as needed. **Focus:** Delegation
4. **Ans: 3, 4, 5** The nursing assistant can report on changes in vital sign values; giving parameters for notification is better than asking for general reports on any changes. The nursing assistant can report that a client is having pain but is not expected to assess that pain. All staff should be aware of when registered inpatients come and go on the unit and should keep each other advised. (Note: Clients should also be encouraged to tell someone if they are going off

the unit.) Judging response to treatment and evaluating drainage are responsibilities of the RN. **Focus:** Delegation

5. **Ans: 2** When the shift report is incomplete, you can ask for any type of additional information. However, vital sign values and orders for medications can be obtained from the records if the off-going shift neglects to give that information. A current pain report can and should be obtained directly from the client. The physician's plan for procedures and diagnostic testing is frequently communicated verbally to the nursing staff, but the physician's written notes may be pending, especially if it is an emergency admission or if the physician is trying to complete morning rounds. **Focus:** Prioritization
6. **Ans: 3** Giving written information about gallbladder disease and options will help Ms. H to prepare any questions she might have for the physician. If diagnostic results are pending, calling the physician is premature. Describing the surgical procedure is inappropriate because there is more than one type of procedure, and the one to be used is still undetermined. Explaining postoperative care would be appropriate once the need for cholecystectomy has been verified by the physician. **Focus:** Prioritization
7. **Ans: 5** In the provision of routine care, clients who need extra time should be left until last, so that care for others is not delayed. Mr. K will require more time and assistance because of age and weakness. Also you will have to determine which medications can be crushed for delivery via PEG tube. Dealing with Mr. K's family is also more time consuming. **Focus:** Prioritization
8. **Ans: 1, 2, 3, 6** Remind the student of several things: The flat palmar surface of the hand is better than the fingertips when palpating for distention. If the wall suction is activated, it will interfere with auscultating for bowel sounds. Asking about pain first will guide the physical assessment steps. And the skin on the anterior chest under the clavicle is a better place to check for turgor than the lower abdomen, especially if abdominal distention is present. Checking the drainage and inspecting for peristaltic waves or distention are correct actions. **Focus:** Supervision
9. **Ans: 3** With continuous NG suction, there is a loss of sodium and potassium. Also, the loss of acid via suctioning will result in an increase in blood pH or metabolic alkalosis. Full assessment of laboratory data is always important when a change in status is noted, but the other values are less relevant to this client's NG therapy. **Focus:** Prioritization
10. **Ans: 4** Stopping the diarrhea is a priority for Ms. T. Chronic, frequent diarrhea is demoralizing, and fluid and electrolyte losses cause weakness. If the bowel is allowed to rest, the cramping will stop. The other options also provide accurate information, but the potential resolution of the most disturbing symptom will encourage her to continue. **Focus:** Prioritization
11. **Ans: 3** Sulfasalazine is potentially nephrotoxic. The other adverse effects are also possible, but are less serious. **Focus:** Prioritization
12. **Ans: 2** Explaining the physiologic reason to the nursing assistant helps the assistant to understand that rest is part of the therapy. Following physician's orders is important, but it is an inadequate explanation. Depression does not justify bed rest. Using large words to explain common concepts should be avoided, regardless of the audience. **Focus:** Supervision
13. **Ans: 1** If Mr. A is homeless, he will need instructions for adapting the dressing change procedures because of inconsistent access to hot water, soap, and adequate bathroom facilities. The social worker can be contacted for assistance with financial issues related to medication or transportation. Simplify written material and verbally reinforce it and/or instruct Mr. A to have a friend read the information to him. **Focus:** Prioritization
14. **Ans: 3** Washing the hands is the first basic step for dressing change. Helping Mr. A identify other ways to maintain asepsis would be more useful than stressing strict sterile technique. **Focus:** Prioritization
15. **Ans: 2** Bowel sounds should resume in 24 hours; this signals GI system readiness. The client's subjective reports of hunger (or lack of hunger) should not dictate initiation of feedings. The pharmacy may label the formula according to the prescriber's order but will not determine the feeding schedule. **Focus:** Prioritization
16. **Ans: 1, 3, 4, 5** Elderly clients are especially at risk for hyperglycemia, aspiration, diarrhea, and fluid overload. Hypotension is not a direct complication of enteral feedings. **Focus:** Prioritization, knowledge
17. **Ans: 4, 1, 3, 2** Use therapeutic communication skills with Mr. R to convince him to return to his room. Assess his mental status related to decision making; he is at risk for injury and self-harm. Assess Ms. H's vomiting and give an antiemetic if appropriate. Assess what Mr. K's family needs from the physician and page the physician if appropriate. Remind Mr. A that he will be notified as soon as possible about the discharge. (Tip: Early in the shift, advise clients that discharge requires several steps [i.e., physician's order; follow-up paperwork; consultation with the case manager, social services office, physical therapy department, etc.]. This information will help them to understand the need to wait and will reduce impatient inquiries.) **Focus:** Prioritization
18. **Ans: 4** Helping her to prioritize will build skill and confidence. She feels upset, but she has not made any errors that have compromised client care. Sending her off the unit further delays care, leaves her without support, and hinders opportunities to problem solve.

Asking the nursing assistant to help her or helping her with select tasks is the second best choice because it demonstrates team support. Taking over one of her clients is not necessary unless care and safety are compromised. **Focus:** Supervision

19. **Ans: 1, 2, 3, 4** The low calcium level and the falling hematocrit and Po_2, in combination with the elevated WBC and his age, are indicators of a high mortality risk. High level of pain is not a prognostic factor, but severe unrelieved pain should always be reported. Blood type will not affect the physician's decisions about therapy. **Focus:** Prioritization
20. **Ans: 3, 5, 4, 1, 6, 7, 2** Stay with the client and have a colleague gather equipment. (Note: If oxygen tubing and mask are available in the room, start oxygen delivery immediately and check oxygen saturation.) Restart the IV infusion so that emergency fluids or drugs can be given. Check the blood glucose level to rule out a hypoglycemic reaction. Continuously monitor vital signs. If at all possible reinsert the NG tube; however, this is not a lifesaving priority. **Focus:** Prioritization
21. **Ans: 3** Mr. R has sufficient severe problems to warrant intensive care. The physician is responsible for the decision to transfer Mr. R; however, the nurse must recognize and advocate for clients who are decompensating. Ordering laboratory and other diagnostic testing may be warranted, and reestablishing NG suction is important, but ultimately the client should be transferred to the ICU. Surgery is unlikely until aggressive medical management measures are exhausted. **Focus:** Prioritization
22. **Ans: 4** If the client meets the criteria for admission to a medical-surgical unit, nutritional restoration is the primary concern. Concurrently, the health care team will assist the client to achieve success in the other areas. **Focus:** Prioritization
23. **Ans: 2** The oral route is the least intrusive. In addition, the client and family can participate in determining the food plan and food choices. The nasogastric and intravenous routes are options for clients who are in life-threatening situations. Rapid feeding via these routes increases the likelihood of refeeding syndrome. Hypodermoclysis is a subcutaneous method of delivering fluids or medications and is an unlikely choice for this client. **Focus:** Prioritization
24. **Ans: 1** The nursing assistant should be instructed to observe the amount of food eaten and ensure that the client is not throwing the food out. After meals, observation is necessary to ensure that the client does not induce vomiting. Ritualistic behaviors can be subtle or difficult to define. Observation for these behaviors cannot be delegated. Requests for special foods could be delaying tactics or attempts to manipulate the staff. The nursing assistant should not be responsible for deciding if food requests are appropriate. Daily weighings may not be ordered. In addition, repeatedly telling the client that she is underweight is counterproductive, because she does not believe she is underweight. **Focus:** Delegation
25. **Ans: 4** Reminding the client of a previous contractual agreement and her responsibility in meeting treatment goals is the best response. (For certain clients, allowing limited times for exercise may be part of the contract in the early phase, if the client has been compulsively exercising.) Avoid opening opportunities for manipulation by allowing "a few more minutes" of exercise. Exploration of the purpose that exercise serves should be carried out by a psychotherapist. Power struggles over food should be avoided. Privileges may be forfeited if the behavior persists, but the response would be improved by stating specifically what privileges will be lost. **Focus:** Prioritization
26. **Ans: 1** Refeeding syndrome occurs when aggressive and rapid feeding results in fluid retention and heart failure. Levels of electrolytes, especially phosphorus, should be monitored, and the client should be observed for signs of fluid overload. Monitoring for bowel sounds, nausea, and distention do not apply specifically to refeeding syndrome but are appropriate for any client with nutritional issues or those receiving enteral feedings. Observing for purging and water ingestion do not apply specifically to refeeding syndrome but would be generally appropriate for a client with an eating disorder. Pallor and decreased perfusion are not related to refeeding syndrome. **Focus:** Prioritization
27. **Ans: 1, 3, 5, 6, 7** Transferring Mr. R to the ICU is a priority because his condition is unstable. Documentation must be completed, and totaling IV fluids is part of the complete documentation. Briefly assessing clients is a safety measure; client decompensation during shift change is not uncommon. Thanking ancillary staff is a team-building measure. Asking the nursing assistant to measure vital signs for all the clients is unnecessary. If select clients are in unstable condition, or if there is a reason that the vital signs may have changed since the last routine reading, then remeasuring vital signs is appropriate. Asking the ED to hold the client until the next shift will displease the ED staff, but admission should be deferred to the oncoming shift unless there is adequate time to assess the client immediately on arrival and review the orders. (Note: Admitting a new client can take 30 minutes or more depending on the complexity of the orders, the acuity of the client's condition, and the facility's admission forms.) Talking to Ms. C about self-esteem should not occur at the end of the shift. This is a complex issue that requires time, patience, and continuous reinforcement. **Focus:** Prioritization

Case Study 10: Multiple Patients with Pain, pages 111-114

1. **Ans: 6, 3, 2, 1, 5** Mr. A's respiratory status (i.e., rate, rhythm, pulse oximetry reading) should be quickly checked. Mr. O should be checked for shock symptoms, mental status changes, and escalating pain. Mr. L and Ms. R are both in relatively stable condition but need quick pain assessments and reassurance that their needs will be met. Ms. J and her family should be approached last, because they need time and patience, and caregivers should not appear rushed. Mr. H is currently in the OR. **Focus:** Prioritization
2. **Ans: 1, 2, 4** Ms. R and Mr. L have conditions that require pain medication but are less physiologically complex. Mr. H will be just out of surgery later in the shift, but hernia repairs are routine and reasonably predictable; this is a good postoperative case for a new RN. Mr. O will require careful assessment for slowly developing complications such as hemorrhage or peritonitis. Ms. J and her family will need support through anticipated grief and loss and complex decision making for hospice and end-of-life issues. Mr. A's respiratory status must be carefully monitored, and he has complex pain and care issues. **Focus:** Assignment
3. **Ans: 4** Acknowledge loss and encourage the patient to talk about the past. During this discussion you and she might find activities that could be adapted to her current situation. Try to avoid giving false reassurance, changing the subject, or switching the focus from her needs to your concerns. **Focus:** Prioritization
4. **Ans: 3** The shower is preferred, because arthritis patients can have trouble getting in and out of the bathtub. An RN should suggest relaxation techniques and evaluate outcomes of therapies. **Focus:** Assignment
5. **Ans: 2** Encourage staff members to deal directly with each other to define and resolve problems. If staff cannot resolve the problem among themselves or if the issue is a chronic problem, then the charge nurse or unit manager should intervene. Helping the new nurse to look at the chart should not be necessary at this point. Asking the patient does not address the problem of the missing documentation. **Focus:** Supervision
6. **Ans: 1, 2, 3** Helping with hygienic care and reinforcing instructions that have been explained by the RN are within the scope of practice of the nursing assistant. Mr. H should not need any specialized equipment, so the nursing assistant can prepare the bed and gather routine equipment, such as devices for measuring vital signs. Mr. O's skin care and assessment should be performed by the RN; the problem is extensive, and pain medication may need to be titrated. The assistant could get coffee, but Ms. J's family should be encouraged to take occasional breaks off the floor. Also, sending one of the family members to get things is a way for the family to have an active role. A nurse should assess Mr. A, because his oxygen saturation was decreasing during the night. **Focus:** Delegation
7. **Ans: 1, 3, 5** Because communication is limited in unresponsive patients, all staff members should be watchful for signs. The RN should instruct the nursing assistant on specific things. Reminding patients that staff are available to help relieve pain is appropriate. If the nursing assistant suspects pain, asking the patient a direct yes or no question is appropriate; then the nurse can be notified. Assessing pain and evaluating outcomes are the responsibilities of the RN. **Focus:** Delegation
8. **Ans: 2, 4, 1, 4, 2, 3** It is unlikely that Mr. O's pump will deliver excess medication; however, it is appropriate to quickly turn it off until its functioning can be completely checked. Delegate the nursing assistant to help Mr. A back into bed and put his oxygen cannula back on. Mr. L is probably having ongoing pain issues, but loud calls for assistance must be investigated. Mr. A must be assessed for mental status changes related to hypoxia or encephalopathy. Go back and troubleshoot the problem with Mr. O's PCA pump. The other nurse could ask someone else to witness if necessary. **Focus:** Prioritization
9. **Ans: 3** Mr. L is having an exacerbation of pain that is probably related to the movement of a kidney stone. This type of pain is severe, but usually transient. If the bolus dose is inadequate, the physician could be notified for a dosage increase. Deep breathing may help somewhat, but the patient will have trouble focusing. Reminding him to use the PCA pump is not necessary at this point. **Focus:** Prioritization
10. **Ans: 4** Use a matter-of-fact tone of voice to acknowledge his underlying problem (pain). Restarting the IV line addresses the immediate issue. Contacting the physician for oral medications might be considered if no one is able to restart the IV line. Calling the supervisor is a possibility if the patient continues to complain and wants to make a report. Defensive statements such as "It's not my fault" can make the situation worse. **Focus:** Prioritization
11. **Ans: 3** Scant output suggests that the stone is lodged and obstructing the outflow of urine. This can result in damage to the kidney. Hematuria with or without pain can occur because the stone has irritated the tissue. Dull pain that radiates into the genitalia and urgency are common with stones. **Focus:** Prioritization
12. **Ans: 3** Elevating the injured extremity will minimize the swelling. If the leg swells, there is additional pressure on nerves. Moving the toes helps, but Mr. O may be too sleepy to consistently comply because of the narcotics. Diversion therapy is less useful in the

acute phase of injury and treatment. Placing the patient in high Fowler position will necessitate raising the leg to a higher and more uncomfortable position. **Focus:** Prioritization

13. **Ans: 1** Pain on passive motion is a sign of possible compartment syndrome. A sudden increase in pain is more associated with arterial obstruction. Pain with dorsiflexion is more suggestive of deep vein thrombosis. Absence of pain without medication could be related to maintaining elevation, ice application, and rest. **Focus:** Prioritization
14. **Ans: 3** Measure vital signs first and then report your findings to the physician. Mr. O is at risk for occult abdominal trauma, and your findings represent a change of status and could be signs of internal bleeding. **Focus:** Prioritization
15. **Ans: 2** Mr. H is anticipating that the pain is going to be worsened by activity. Giving medication 45 minutes before the activity assures him that the pain will be minimized. The second-best option is to reassure him that medication is available if he needs it. Around-the-clock medication and notification of the physician are not necessary at this point. **Focus:** Prioritization, knowledge
16. **Ans: 3** Mr. H may be experiencing urinary retention because of bladder atony related to the surgical procedure. A distended bladder can mimic hernia pain and cause significant discomfort, and Mr. H may not have the urge to void. Calling the physician and allowing the patient nothing by mouth are premature at this point. Reassurance may be somewhat comforting, but does not address the immediate symptom. **Focus:** Prioritization
17. **Ans: 4** Mr. A has complex needs. Although the staff get tired of hearing continual complaints, everyone should work together to try and solve the problem. Reminding staff that patients have a right to care is rhetorical and not very useful. Offering to care for Mr. A every day does not help the team to overcome bias or improve patient care. When feedback is given, statements that begin with "You should" should be avoided. **Focus:** Supervision
18. **Ans: 1. Physical therapist, 2. RN, 3. RN, 4. RN, 5. RN, 6. Nursing assistant, 7. Nursing assistant** TENS requires specialized equipment and training and should be handled by a physical therapist. An RN should give medications, answer questions, and assess for aggravating factors. Personal comfort items are permissible, but the RN should remind the family that belongings can get misplaced. The nursing assistant is qualified to help with routine position changes and can reinforce instructions given by the RN. **Focus:** Assignment
19. **Ans: 2** First call the pharmacy and ask about compatibilities. If the solutions and medications are compatible, you can give them simultaneously. If there are incompatibilities, you may decide to call the physician for an order to stagger medications times or to establish a second IV site. **Focus:** Prioritization
20. **Ans: 4** Conduct additional pain assessment with vital sign measurement. This will determine what interventions are needed. **Focus:** Prioritization
21. **Ans: 2** If you decide to question the nurse or check on the patients, specific examples are more useful than vague generalizations. Specific examples will also help you determine whether there are extenuating circumstances that the nursing assistant may be misinterpreting. Comments about patient care issues should not be ignored; all team members should be encouraged to watch out for the health and safety of the patients. **Focus:** Supervision
22. **Ans: 1** A patient like Ms. J will have been taking opiates for a long time. Constipation is the only opioid side effect to which the patient does not develop tolerance. Respiratory depression, nausea, vomiting, and sedation may have occurred when Ms. J was first receiving opioids but are now less of a concern. **Focus:** Prioritization
23. **Ans: 3** Lorazepam is an anxiolytic. Naproxen is a nonsteroidal antiinflammatory drug. Doxepin is used for depression or neuropathic pain. Dicyclomine is given to reduce smooth muscle spasms. **Focus:** Prioritization, knowledge
24. **Ans: 4** Communication skills are important in dealing with the family and the physician. If you have exhausted this route, the next step is to move up the chain of command. Calling another physician is not appropriate. If the son calls the physician, it may make the situation worse. You must function under the current orders and use additional nonpharmaceutical measures until the issue is resolved. **Focus:** Prioritization
25. **Ans: 3** Help the nurse to prioritize what has to be done, and help her recognize what can and cannot be delegated. Offering help is appropriate if patient safety is compromised, and it does contribute to team building; however, it does not help her learn to organize her work. Letting her struggle is one method of learning, but new nurses deserve guidance and support. Help her to determine what tasks can be passed on to the next shift, and then she can discuss this during shift report. **Focus:** Supervision

Case Study 11: Multiple Clients with Cancer, pages 115-118

1. **Ans: 1, 2, 5, 6** When the client responds to a question, you gather information about ease of respirations and cerebral perfusion. Noting the presence of complex equipment will help in making assignments, particularly if the staff is inexperienced. Measuring vital signs, checking intake and output, and palpating for pain are not necessary during this brief assessment unless there is reason to suspect that the client is decompensating.

(Note: Some nurses will briefly palpate radial pulse to detect irregularities and assess peripheral perfusion.) **Focus:** Prioritization

2. **Ans: 3, 4** Mr. B and Ms. C are clients in relatively stable condition who would be capable of speaking with a nursing student for a prolonged time. Mr. N is also communicative and in stable condition, but limiting the number of people that enter the room is best practice for neutropenic clients. Mr. L has recently been transferred from the SICU. His tracheostomy tube with secretions and the nasogastric tube will make communication very tedious and overwhelming for him and the student. Mr. U needs frequent skilled assessment, and he is likely to be very uncomfortable, exhausted, and possibly dyspneic. Ms. G needs emotional support and preoperative teaching that are beyond the abilities of a first-semester student. **Focus:** Assignment, supervision
3. **Ans: 2** Staff and visitors with potentially communicable diseases should not enter Mr. N's protective environment. Pregnancy, inexperience, and fear do not automatically exclude staff members from this assignment. If the team leader has time and options for personnel, then opportunities for duty sharing for pregnant staff members and teaching for the inexperienced and fearful can be explored. **Focus:** Assignment, supervision
4. **Ans: 3** Acknowledge the student for taking responsibility for the error. Helping the student to feel comfortable in reporting errors rather than hiding mistakes is essential for client safety. Notifying the instructor is appropriate so that the student can be counseled and procedures reviewed. All involved parties may elect to write separate incident reports. **Focus:** Supervision
5. **Ans: 2** Catheterizing this client increases the risk for infection, and the clean-catch method is adequate for a urinalysis. The other orders would be appropriate for this client. **Focus:** Prioritization
6. **Ans: 4** Increased secretions, difficulty swallowing, and loss of the protective epiglottis put Mr. L at risk for aspiration. The other diagnoses also apply to this client, but are of lower priority. **Focus:** Prioritization
7. **Ans: 1** Pulsation suggests that the tube may be malpositioned and pushing against the innominate artery. This is a medical emergency. Presence of food particles and difficulty with cough or expectoration suggest that cuff pressures should be monitored more closely. Increased secretions are expected in the postoperative period. **Focus:** Prioritization
8. **Ans: 3** The bag valve mask (Ambu bag) will be the first thing that is needed if there is a problem with the tracheostomy equipment or with respiratory effort. With a tracheostomy, there should be no need for an endotracheal tube or a laryngeal scope. The insertion tray is also probably unnecessary, because the site should mature within 72 hours. **Focus:** Prioritization
9. **Ans: 2, 3, 5, 6, 7** Mouthwash should not include alcohol, because it has a drying action that leaves mucous membranes more vulnerable. Insertion of suppositories, probes, or tampons into the rectal or vaginal cavity is not recommended. All other options are appropriate. **Focus:** Prioritization, knowledge
10. **Ans: 2, 3, 1, 4, 6, 5** A Foley catheter with a drainage bag will be inserted. The BCG fluid is instilled through the catheter, and then the catheter is clamped for 2 hours. During those hours, Mr. B should be reminded to change position from side to side or prone to supine every 15 to 30 minutes. At the end of the 2 hours, the catheter is unclamped, and the fluid is drained. Two glasses of fluid are given to further flush the bladder. **Focus:** Prioritization
11. **Ans: 3** The toilet should be disinfected for 6 hours after discarding the fluid. The nursing assistant should receive these specific instructions to safely manage this biohazard. Wearing a lead apron or sterile gloves is not necessary. **Focus:** Delegation, supervision
12. **Ans: 3** The goal is resumption of normal voiding within 3 days. Immediately after catheter removal and for 1 to 2 days thereafter, Mr. B may experience dysuria, urgency, and frequency. **Focus:** Prioritization
13. **Ans: 4, 2, 3, 5, 1** Mr. L is at risk for aspiration and an immediate airway obstruction if his tracheostomy tube is not suctioned. If a chest drainage system tips over, it is unlikely that anything untoward will occur; however, if the chest tube has been displaced, Mr. U is at risk for an open pneumothorax. The physician must be notified about Mr. N's fever so that therapy can be changed and cultures ordered to determine the source of infection. Ms. C must be assessed for signs of deep vein thrombosis. Mr. B needs reassurance that the dysuria is transient and to be expected after intravesical therapy. **Focus:** Prioritization
14. **Ans: 1. Nursing assistant, 2. RN, 3. RN, 4. Enterostomal therapist, 5. Enterostomal therapist** The nursing assistant is able to assist Ms. C with hygienic care. The RN should explain the need for drains and give medications and assess outcomes. An enterostomal therapist will usually answer initial questions about ostomy care and prevention of complications for clients with new stomas. **Focus:** Assignment
15. **Ans: 4** Asking for extra help and delaying independent action is a type of regression that allows Ms. C to cope with the changes in self-image and bodily functions. The nurse should evaluate the situation daily to help Ms. C find alternative coping strategies. The other diagnoses may be relevant as her situation changes. **Focus:** Prioritization
16. **Ans: 4** Have her hold the clamp or do some other small task to engage her in participation. This creates the expectation that she can participate and will eventually handle the equipment. Verbally reexplaining the procedure and providing written material does

reinforce the initial teaching, but being told will not help her master the psychomotor aspects. Having a family member or a staff member take over the procedure does not support the goal of eventual independence. **Focus:** Prioritization

17. **Ans: 3** Use 10 minutes to determine if Ms. C has an urgent need, but set some boundaries so that she will know what to expect. Making reference to other clients' needs is not appropriate. Telling her that she is okay minimizes her concerns. Calling a volunteer might be useful after you determine that social needs could be met by a volunteer. **Focus:** Prioritization
18. **Ans: 1** Ms. G is demonstrating fear and anxiety related to uncertainty of the future. The other diagnoses are pertinent, but bringing the anxiety under control should precede giving her information, facilitating decision making, and dealing with body image. **Focus:** Prioritization
19. **Ans: 4** First acknowledge Ms. G's feelings and do additional assessment about "things" that you could help her with. It is natural for her to be anxious about the surgery, but there may be other issues (i.e., problems with family, money, work, etc.). The other options might be appropriate after the situation is assessed. **Focus:** Prioritization
20. **Ans: 2** Obtain and administer the medication in the dosage and form in which it has been ordered. You can call the physician if you are unable to read the order, or if you are seeking to have the order changed (i.e., the pharmacy does not have the medication). Asking preference for immediate versus controlled-release action is an inappropriate way to phrase the question to the client. **Focus:** Prioritization
21. **Ans: 1** All of the conditions warrant calling the physician. However, tracheal deviation is a symptom of tension pneumothorax, and the nurse may have to intervene before the physician can arrive or phone in orders. Dysrhythmias are one sign of tumor lysis syndrome secondary to hyperkalemia. Decreased urinary output for Mr. B is probably related to an obstruction, but other causes should be investigated. Ms. C is at risk for hemorrhage or peritonitis. **Focus:** Prioritization
22. **Ans:** Tracheal deviation, severe dyspnea, extreme agitation, increased respiratory rate, increased pulse, progressive cyanosis, distended jugular veins, and lateral or medial shift in the point of maximum impulse. **Focus:** Prioritization
23. **Ans: 1** For Mr. U, the tension pneumothorax has most likely been induced iatrogenically by the covering of the chest wound. (For clients without open chest wounds, the priority action is performing a needle thoracotomy.) Initiating CPR is inappropriate at this point. Having the crash cart and intubation equipment nearby is a precaution, but should not delay other interventions. **Focus:** Prioritization
24. **Ans: 2, 1, 4, 3** Using the SBAR format, the nurse first identifies himself or herself, gives the client's name, and describes the current situation. Next, relevant background information, such as the client's diagnosis, medications, and laboratory data, is stated. The assessment includes both client assessment data that are of concern and the nurse's analysis of the situation. Finally, the nurse makes a recommendation indicating what action he or she thinks is needed. **Focus:** Prioritization

Case Study 12: Gastrointestinal Bleeding, pages 119-120

1. **Ans: 3** Vomiting of bright red blood is a sign of active bleeding. The patient's physical assessment findings and vital sign values are indicative of physiologic compensation for blood loss. Risk for aspiration is not an immediate concern because Mr. S is currently alert and there is no reason to suspect that his gag reflex is not intact. Anxiety and noncompliance can be addressed later. **Focus:** Prioritization
2. **Ans: 2, 3, 4, 5** Mr. S is at risk for hypovolemic shock. Decreases in urine output or hemoglobin level and hematocrit should be monitored. Occult blood (Hemoccult) testing of emesis and stool should be performed to confirm upper and lower gastrointestinal bleeding. Semi- or high Fowler position is used to decrease risk for aspiration during vomiting and/or NG tube insertion. A 22-gauge catheter is not the best choice for this patient. He may require a blood transfusion and/or large fluid volumes; 16- to 18-gauge catheters are better choices. Preparing the patient for surgery at this point is premature, because bleeding resolves spontaneously in most hospitalized patients. **Focus:** Prioritization
3. **Ans: 1** Repeating vital sign measurements falls within the scope of the nursing assistant's abilities. There is no indication that blood glucose level should be checked every 2 hours. Gathering certain types of equipment can be delegated. However, NG lavage is not a typical task for a nursing assistant; if you delegate the gathering of equipment for this procedure, you will have to provide an itemized list. The nursing assistant should not be responsible for notification of the family, even with the patient's permission. **Focus:** Delegation
4. **Ans: 1. Nursing assistant, 2. Paramedic or RN, 3. RN, 4. LPN/LVN, 5. RN, 6. Clergy, 7. RN** In an emergency situation, many team members will perform tasks simultaneously. There will be variation and overlap in the roles and duties of personnel according to the facility's policies. The nursing assistant is capable of measuring vital signs. Either an RN or a paramedic can insert peripheral IV lines. NG tube insertion and lavage should be done by the RN,

because the initial gastric return and response to lavage should be continuously assessed. Foley insertion can be done by the LPN (also by the RN). (Note: Some institutions will allow nursing assistants with additional training to insert Foley catheters.) Clergy (if available) can assist by comforting and supporting family members. If clergy is unavailable, the RN must assume this responsibility. Assessment should be performed by the RN. **Focus:** Assignment, delegation

5. **Ans: 3** A tense, rigid abdomen could signal perforation, peritonitis, and/or a worsening hemorrhage. The other findings are relevant but are less immediately urgent. **Focus:** Prioritization
6. **Ans: 2, 1, 6, 7, 4, 3, 5** Place the patient in high Fowler position to prevent aspiration. The length is measured for tip placement into the stomach. Check for the most patent nostril by inspecting or by occluding each nostril and checking for air flow. (Note: Checking for nostril patency could precede measuring the length of the tube.) Gently insert the tube into the most patent nostril. When the tube is just above the oropharynx, have the patient tip the chin down, then gently advance the tube. When the tip reaches the posterior pharynx, have the patient sip water. Swallowing closes the epiglottis and helps to prevent tracheal intubation. Checking placement is essential before instilling saline. **Focus:** Prioritization
7. **Ans: 4** Page the physician and document your actions. The physician may opt to order restraints if the patient cannot make safe decisions. The physician may try to convince the patient to agree to the therapy or have the patient sign an AMA form if he continues to refuse treatment. The nursing supervisor and the patient advocate can be notified if the situation escalates. **Focus:** Prioritization
8. **Ans: 2** To expedite the stat order, draw the specimen yourself. (Note: In addition, you may delegate to the unit clerk the task of calling the laboratory and alerting them to the error in labeling.) The other options will only delay the stat order. After Mr. S's condition is stabilized, tracking down the cause of the error will help prevent recurrences. **Focus:** Prioritization, supervision
9. **Ans: 1** In a medical emergency, the patient can receive O-negative blood. An antibody reaction could result if type A or B blood is administered without typing and cross matching. **Focus:** Prioritization, knowledge
10. **Ans: 4, 5, 6, 1, 2, 3, 7, 8** Inspect the bag. If the product appears unusable or if the bag is damaged, contact the blood bank for another unit. Checking labels and identification is essential. At the bedside, two licensed professionals should compare bag and identification band. (Note: Priming of the tubing and filter could be done anytime before starting the transfusion. Many nurses will perform this step while they are measuring the vital signs using an automated blood pressure cuff. In an emergency situation, equipment preparation can be done while waiting for the unit to come from the blood bank.) Measuring vital signs immediately before starting the transfusion provides a baseline in case of transfusion reaction. A reaction is most likely to result with transfusion of the initial milliliters of blood (or within 15 minutes) if it is going to occur. Frequent measurement of vital signs (according to hospital policy) and complete documentation are standard requirements. **Focus:** Prioritization
11. **Ans: 2** Denial is the most common defense mechanism seen among substance abusers. Option 1 represents rationalization, or giving reasons for behavior. Option 3 represents projection, which is a transfer of unacceptable behavior onto others. Option 4 represents suppression, which is a conscious awareness and avoidance of dealing with the problem. **Focus:** Prioritization, knowledge
12. **Ans: 3** Assess Mr. S for his ability to make a clear and logical plan. He does have a right to leave and may have an acceptable alternative (i.e., he wants to go to another hospital or to call his family physician); however, if he is not able to make safe decisions for himself (or others) then you are obligated to act to ensure his safety. The use of "Why?" should be avoided, because it creates a defensive response. After assessing, you may decide that calling the wife and the physician are appropriate actions. **Focus:** Prioritization
13. **Ans: 1** Watch for signs of neurologic irritability (physical and psychologic). Delusions and seizure are later signs. Slurred speech is more frequently associated with alcohol intoxication. **Focus:** Prioritization
14. **Ans: 1, 2, 3, 5, 6** Death can occur from myocardial infarction, fat embolism, peripheral vascular disease, aspiration pneumonia, electrolyte imbalance, sepsis, or suicide. Anaphylaxis would not ordinarily occur unless the patient were allergic to one of the treatments (i.e., drug allergy). **Focus:** Prioritization
15. **Ans: 2** First assess the patient and try to determine exactly what occurred. You may decide to use the other options based on your assessment findings. **Focus:** Prioritization

Case Study 13: Head and Leg Trauma and Shock, pages 121-124

1. **Ans: 4** Ms. A's slow and irregular respiratory rate is a risk factor for hypoxemia, which would decrease oxygen delivery to the brain as well as other vital organs and tissues. The other assessment information should also be obtained quickly, because Ms. A is at risk for hypothermia, blood loss associated with a possible left leg fracture, and aspiration. **Focus:** Prioritization

2. **Ans: 3** The Glasgow Coma Scale (GCS) offers a standardized and objective way to assess and document LOC. Although the other responses also accurately describe the client's LOC, they do not provide objective data that can be readily used to determine changes in the client's neurologic status. **Focus:** Prioritization
3. **Ans: Decerebrate** Stiff extension of the arms and legs is seen in decerebrate posturing, which indicates damage to the midbrain and brainstem. **Focus:** Prioritization
4. **Ans: 2, 3** Ms. A's bradycardia and hypotension suggest that she is experiencing neurogenic shock in response to her head injury. It is also important to remember that with any traumatic injury, hypovolemic shock caused by hemorrhage should be considered. In this case, Ms. A should be assessed for blood loss associated with her leg injury and for internal bleeding caused by blunt trauma to her chest and abdomen. **Focus:** Prioritization
5. **Ans: 4** Lumbar puncture is contraindicated in a client who may have increased intracranial pressure (ICP), because it increases the risk for herniation of the brainstem through the tentorial notch. Checking for a positive Babinski sign and obtaining an electrocardiogram are not priorities for this client, but would not place the client at any increased risk. Increasing the IV rate is appropriate based on the client's blood pressure. **Focus:** Prioritization
6. **Ans: 3** The initial care of clients with traumatic injuries in the ED requires the expertise of an RN with extensive ED experience. Neither the agency RN nor the ICU RN will be familiar with the location of equipment and with the organization of care in your ED. Although the LPN has experience in the ED, the LPN/LVN scope of practice does not include the complex assessments and interventions that will be needed in caring for this client. (The LPN could be assigned to assist the RN caring for Ms. A.) **Focus:** Assignment
7. **Ans: 1** The most important goal for an unconscious client who is vomiting is to prevent aspiration. Turning Ms. A to her side is the best method to ensure that she does not aspirate. Suctioning would also be utilized, but does not clear the airway as well as having the client positioned on her side. Hyperoxygenation may also be required for this client, but will not protect the airway while she is vomiting. A nasogastric tube is usually not inserted in clients with possible facial fractures. Insertion of an orogastric tube may be ordered, but would not protect from aspiration at the present time. **Focus:** Prioritization
8. **Ans: 4** Ms. A's arterial blood gas results indicate uncompensated respiratory acidosis and hypoxemia. Because her respiratory drive is suppressed, she will need rapid intubation and ventilation using a mechanical positive pressure ventilator. She may need surgery, in which case it would be appropriate to have blood available in the blood bank. Although ongoing monitoring of the magnesium level is indicated, the magnesium level is in the low-normal range, so administration of magnesium is not a priority at this time. Insulin would not typically be administered for a small glucose elevation like this in a nonfasting client. **Focus:** Prioritization
9. **Ans: 2** The CT scan is necessary to determine the collaborative interventions needed for this client, who may have chest and abdominal trauma that will require surgery, in addition to her head injury. The other orders are also appropriate for the client, but do not need implementation as rapidly. **Focus:** Prioritization
10. **Ans: 1** The client's fixed and dilated pupils, widened pulse pressure, and bradycardia are caused by increasing pressure on the brainstem and indicate that she is at risk of herniation of the brainstem through the tentorial notch, which would result in brain death. Immediate surgical intervention is needed to prevent this complication. She is at risk for the other complications, but they are not as life threatening. **Focus:** Prioritization
11. **Ans: 4** Normal ICP is 0 to 10 mm Hg and CPP should be maintained at 70 mm Hg or higher. CPP is calculated using the formula MAP − ICP = CPP. Ms. A's CPP is 63 mm Hg (80 − 17 = 63), so interventions should be implemented immediately to decrease her ICP. Interventions to increase Ms. A's MAP may also be used to improve her CPP. The other data indicate a need for ongoing monitoring but do not require immediate intervention. **Focus:** Prioritization
12. **Ans: 1, 2, 7, 8** The therapeutic effect of dexamethasone and mannitol for clients with increased ICP is to decrease cerebral edema. Positioning the head of the bed at 30 degrees also reduces cerebral edema by promoting venous drainage from the cerebral circulation. Administration of vasopressors such as norepinephrine will improve MAP and CPP. Although neurologic assessments such as checking the GCS score and observing pupil reaction to light are necessary, the stimulation caused by these interventions can increase ICP. Suctioning and repositioning also cause transient increases in ICP. It is important to monitor ICP, MAP, and CPP during these procedures and modify care to avoid unnecessary increases in ICP or decreases in CPP. **Focus:** Prioritization
13. **Ans: 1, 6, 7, 8** Client data collection, collection of urine specimens, and administration of medications through an OG or NG tube are included in LPN/LVN education and scope of practice. An experienced LPN/LVN would be expected to report any changes in client status to the supervising RN. Usually repositioning a client would also be included in the LPN/LVN role;

however, this client is at risk for increased ICP during positioning and should be monitored by the RN during and after repositioning. Assessments of breath sounds, neurologic status, and the endotracheal tube cuff in critically ill clients should be accomplished by an experienced RN. **Focus:** Delegation

14. **Ans: 1** Lower-than-normal $Paco_2$ levels cause cerebral vasoconstriction and result in further cerebral hypoxia. The RN should notify the physician and obtain an order to decrease the ventilator rate. The oxygen percentage being delivered by the ventilator should be evaluated, because a lower fraction of inspired oxygen (Fio_2) may be adequate, and prolonged use of high Fio_2 levels can lead to alveolar damage and acute respiratory distress syndrome. The decrease in HCO_3^- reflects a compensatory mechanism for the client's respiratory alkalosis and will resolve spontaneously when the $Paco_2$ level rises. **Focus:** Prioritization
15. **Ans: 3** Ms. A's high urine output suggests that she has developed diabetes insipidus (DI), a common complication of intracranial surgery. Because DI can rapidly lead to dehydration in a client who is unable to take in oral fluids, the priority action here is to obtain an order to increase the IV rate. Continuing to monitor the output and checking the specific gravity would also be needed but would not correct the risk for dehydration. Because Ms. A's neurologic status is so poor, it is unlikely that changes in her neurologic status would be helpful in determining the effects of DI. **Focus:** Prioritization
16. **Ans: 4** All of the orders contain abbreviations that, according to the Institute for Safe Medication Practices, may increase the chance for medication errors. However, the Joint Commission has mandated that the abbreviation "U" (for units) should be included on hospital "Do Not Use" lists. **Focus:** Prioritization
17. **Ans: 2** Gastric stress ulcers are a common complication of head injury unless histamine 2 (H_2) blockers (such as famotidine) or proton pump inhibitors (such as pantoprazole [Protonix]) are administered prophylactically. Administration of famotidine may decrease the risk of pneumonitis if aspiration occurs, minimize the effects of gastroesophageal reflux, and decrease stomach irritation, but none of the other responses addresses the use of H_2 blockade in head injury. **Focus:** Prioritization
18. **Ans: 2** Because the client has just been repositioned, it is likely that the elevated ICP is caused by poor client positioning. The head and neck should be maintained in good alignment, because neck flexion can cause venous obstruction and an increase in ICP. Administration of mannitol and further elevation of the head of the bed may be used to lower ICP if repositioning Ms. A's head and neck is ineffective. However, these measures should be used only if her MAP is high enough to maintain a CPP of 70 mm Hg. Checking Ms. A's pupils would not offer any additional information, and the stimulation may increase her ICP. **Focus:** Prioritization
19. **Ans: 1** The assessment data suggest the development of compartment syndrome, an emergency that can lead to permanent neuromuscular damage within 4 to 6 hours without rapid treatment. Elevation of the leg will further reduce blood flow to the leg. Continuing to monitor the leg without correcting the compartment syndrome will allow the ischemia to persist. Although restlessness may indicate pain in clients with intact neurologic function, Ms. A's neurologic status is severely compromised, and monitoring for restlessness will not be helpful in assessing for ischemic leg pain. **Focus:** Prioritization
20. **Ans: 2** When a family member is available, the surgeon should obtain written permission from the family member after discussing the benefits and risks of the surgery. Emergency procedures can take place without written consent for an unconscious or incompetent client when no family or legal representative is available to give permission. The nursing supervisor does not have the authority to consent to surgery for an unconscious client. **Focus:** Prioritization

Case Study 14: Septic Shock, pages 125-128

1. **Ans: 2** The oxygen saturation indicates that the patient is severely hypoxic (despite an increased respiratory rate). Because this hypoxia will affect all other body systems, it should be treated immediately. The other orders also should be rapidly implemented, but they do not require action as urgently as the low oxygen saturation. **Focus:** Prioritization
2. **Ans: 2** A nonrebreather mask can provide a fraction of inspired oxygen (Fio_2) of close to 100%, which will be needed for this severely hypoxemic patient. Nasal cannulas deliver a maximum Fio_2 of 44%, simple face masks deliver up to an Fio_2 of 60%, and Venturi masks provide a maximum Fio_2 of 55%. **Focus:** Prioritization
3. **Ans: 1, 2, 6** Checking vital signs and urine output is included in nursing assistant education. An experienced nursing assistant would be able to do this and would know which patient information to report immediately to the supervising RN. A nursing assistant working in the ED setting would also have been trained and know how to establish cardiac monitoring, although dysrhythmia analysis and treatment would be the responsibility of the RN. Obtaining and documenting assessments and starting an IV line should be done by the RN. **Focus:** Delegation
4. **Ans: 1** Although atrial fibrillation at rapid rates can cause a significant drop in cardiac output and blood pressure, the rate of 90 to 114 is not a likely cause of the patient's hypotension, and cardioversion is not

indicated. Ongoing cardiac rhythm monitoring is necessary. Lidocaine would be used if the patient had ventricular dysrhythmias such as premature ventricular contractions or ventricular tachycardia. Adenosine is used to treat paroxysmal supraventricular tachycardia and is not effective for atrial fibrillation. **Focus:** Prioritization

5. **Ans: 2** The ABG values indicate that the patient is hypoxemic (low Pao_2 and oxygen saturation) and has a severe uncompensated respiratory acidosis (low pH and elevated $Paco_2$). Because she is unable to maintain adequate oxygenation and ventilation independently, intubation and mechanical ventilation are indicated. Sodium bicarbonate is administered only if there is a metabolic acidosis. Although the patient will need ongoing respiratory monitoring and may also benefit from albuterol therapy, these therapies are not adequate in a patient with these severe ABG abnormalities. **Focus:** Prioritization
6. **Ans: 5, 4, 3, 9, 6, 1, 7, 2, 8** The need for intubation should be explained to the patient and family. The patient should be placed supine with the head and neck in the "sniffing" position just before intubation, because lying flat usually increases dyspnea. The patient should be preoxygenated for 3 to 5 minutes before the intubation attempt. Inflation of the endotracheal tube cuff is needed for effective ventilation. Checking end-tidal carbon dioxide level is the most accurate way to assess endotracheal placement; the presence of bilateral breath sounds also is used to check placement. After initial assessment of endotracheal placement is completed, the tube should be secured before obtaining a chest radiograph to confirm optimal placement. **Focus:** Prioritization
7. **Ans: 4** The low blood pressure indicates that systemic tissue perfusion will not be adequate, so measures to improve the blood pressure need to be implemented rapidly. The second priority is to treat the infection that is a likely cause of the temperature elevation and hypotension. The crackles heard in the patient's left lung do not need immediate intervention, because her oxygen saturation is 93%. The nonpalpable pedal pulses are associated with the hypotension and will improve if blood pressure is increased. **Focus:** Prioritization
8. **Ans: 1, 3, 4, 5, 6, 7** The decreased blood pressure and increased heart rate are indicators of shock. The elevation in temperature suggests that sepsis (and massive vasodilation) may be the cause of the shock. The blood-streaked and cloudy urine, and back and abdominal pain point to a urinary tract infection (UTI) and/or pyelonephritis as the cause of the sepsis. Diabetic patients are at increased risk for UTI and sepsis. Atrial fibrillation is not an indicator of sepsis and is unlikely to be the cause of Ms. D's hypotension. **Focus:** Prioritization
9. **Ans: 3, 4, 1, 5, 2** The first action should be fluid infusion, because Ms. D's minimal urine volume and history of not taking in fluids indicate that she is hypovolemic. In addition, sepsis is associated with massive vasodilation, which leads to hypotension and decreased tissue perfusion, so increasing the circulating volume is essential for this patient. The dopamine infusion should be started next to counteract the circulatory vasodilation. The blood for culture (and specimens for any other ordered cultures) should be obtained before the antibiotics are started. All of these orders should be implemented rapidly, because septic shock quickly leads to multiple organ dysfunction syndrome, which is usually fatal. Acetaminophen can be given to decrease the patient's temperature, but the other actions have a higher priority. **Focus:** Prioritization
10. **Ans: 3** The most common complication of too-rapid intravenous infusion of fluids is volume overload leading to heart failure. Although peripheral edema, decreased urine output, and jugular venous distention may be indicators that heart failure is developing, they do not occur as rapidly as the backup of fluids into the pulmonary capillaries and then into the alveoli. **Focus:** Prioritization
11. **Ans: 1** The first action should be to evaluate the patient for symptoms of toxic effects of dopamine, because interventions may be needed to correct these. Dopamine is a high-alert medication, and dosage calculations should be double-checked by at least two licensed personnel; however, initial actions after a medication error should focus on evaluation of the patient. Notification of the physician and appropriate documentation of the medication error are also needed, but should be done after evaluating the patient. **Focus:** Prioritization
12. **Ans: 4** High doses of dopamine are sympathomimetic and increase cardiac conduction and automaticity. The elevated heart rate for this patient will increase her cardiac workload and may cause cardiac ischemia. The blood pressure increase is a therapeutic effect of dopamine. The changes in respiratory rate and oxygen saturation require intervention, but would not be caused by dopamine infusion. **Focus:** Prioritization
13. **Ans: 1, 4** LPNs/LVNs are educated and licensed to perform tasks such as monitoring and documentation of intake and output, bedside blood glucose monitoring, and administration of insulin under the supervision of an RN. Although LPNs/LVNs can collect data about patients, the other assessments and patient care activities listed would require more education and are RN-level skills. **Focus:** Delegation
14. **Ans: 3** The decrease in PA wedge pressure indicates that the patient is still hypovolemic and will need an

increase in IV fluids. The arterial blood pressure is improved, and you already have an order to increase the dopamine if needed. The atrial fibrillation rate is not dangerously elevated. Although the patient's temperature still is elevated, it has decreased from the previous reading. **Focus:** Prioritization

15. **Ans: 2** The elevated glucose level will require that you administer the ordered insulin lispro using the hospital standard sliding-scale insulin orders. The other abnormalities indicate the need for continued monitoring, but will not require any immediate action at this time. **Focus:** Prioritization
16. **Ans: 1** The traveler RN has the required ICU experience to provide care in this complex case and has been working at the hospital long enough to be familiar with how to obtain supplies, communicate with other departments, and so on. The other nurses either lack experience in caring for critically ill patients (the new graduate and the PACU nurse) or will not be able to offer the continuity of care that is desirable for the patient. **Focus:** Assignment

Case Study 15: Heart Failure, pages 129-132

1. **Ans: 3** The Joint Commission mandates that "MS" as an abbreviation for morphine sulfate should be on all hospital "Do Not Use" lists, because this abbreviation can be interpreted as magnesium sulfate. Orders 1 and 4 also use abbreviations that the Institute for Safe Medication Practices suggests may lead to confusion, although these are still acceptable to the Joint Commission. The parameters for oxygen delivery could be stated in the order; however, the CCU policy will clarify this. **Focus:** Prioritization
2. **Ans: 3** The client's symptoms indicate acute hypoxemia, so improving oxygen delivery is the priority action. The other actions are also appropriate, but not as the initial action. **Focus:** Prioritization
3. **Ans: 1** The client's symptoms of hypoxemia and pink frothy sputum and her history of increasing shortness of breath and mitral valve regurgitation suggest pulmonary edema (severe left ventricular failure) as a probable diagnosis. (She also has symptoms of right ventricular failure, but these are not as great a concern.) The client's history does not indicate that she has pulmonary hypertension, so cor pulmonale is not a likely concern. Myocardial infarction may be a precipitating cause for pulmonary edema, but the acute dyspnea is the first concern for treatment. Although hypoxemia occurs with a pulmonary embolus, crackles and frothy sputum are not consistent with this complication. **Focus:** Prioritization
4. **Ans: 2** The client is hypoxemic, so giving oxygen at the highest level possible is the priority. Activation of the rapid response team and administration of morphine are also appropriate actions. Coughing and deep breathing are not likely to be helpful, because they will not clear fluid from the alveoli. **Focus:** Prioritization
5. **Ans: 4** The best clinical indicators of sudden changes in cardiac output are vital signs such as blood pressure, pulse rate, and respiratory rate. The other data may also be useful in determining the adequacy of perfusion, but they are not as important as the blood pressure and pulse rate. **Focus:** Prioritization
6. **Ans: 3** Although the assessment indicates that a loop diuretic is indicated, before administering furosemide, it is essential to know the client's potassium level. Her PVCs indicate ventricular irritability, which can be caused by hypokalemia. Angiotensin-converting enzyme (ACE) inhibitors can increase potassium levels, so it is also essential to know the potassium level before giving the enalapril. The retention catheter is also appropriate for this client, but the priority is to ensure that her potassium level is within normal limits and then administer the diuretic to decrease her volume overload. **Focus:** Prioritization
7. **Ans: 4** LPN/LVN education and scope of practice include insertion of catheters. Administration of medications to clients in unstable condition is best accomplished by RNs who have experience in caring for critically ill clients. Drawing blood for laboratory tests is usually done by laboratory staff. **Focus:** Delegation
8. **Ans: 4** Morphine is used in pulmonary edema for its effect as a venodilator, which decreases venous return to the heart and reduces ventricular preload. Although morphine is used to treat angina, this client has not complained of chest pain. Morphine may decrease Ms. C's respiratory rate, but this is not a desired effect. Morphine may decrease the client's anxiety, but this is not the primary reason for administration to clients with pulmonary edema. **Focus:** Prioritization
9. **Ans: 2** Administration of KCl at a rate no faster than 20 mEq/hr is recommended. Although it is important to increase the client's potassium level quickly, administration of KCl over 1 minute or 10 minutes could lead to cardiac arrest. Administration of the KCl over 8 hours would delay the administration of the furosemide and also leave the client vulnerable to continued dysrhythmias. **Focus:** Prioritization
10. **Ans: 4** Because Ms. C's major problem is pulmonary edema, the most useful information will be changes in her lung sounds. The other information is also helpful in assessing for volume overload, but not as pertinent to the diagnosis of pulmonary edema. **Focus:** Prioritization
11. **Ans: 2** Because nesiritide causes vasodilation and diuresis, hypotension is the most common adverse effect. Systolic blood pressure of less than 90 mm Hg is a contraindication for nesiritide infusion. The other

data will also be useful in determining whether the client's condition is improving or in assessing for adverse effects but are not as important as frequent blood pressure measurement. **Focus:** Prioritization

12. **Ans: 1** An RN with experience on a coronary step-down unit would be familiar with the care of clients with left ventricular failure. You have not had an opportunity to evaluate the knowledge level of the agency RN; in addition, this RN will not be familiar with hospital or CCU policies, location of supplies, and so on. The experienced CCU nurse is caring for a client whose condition is potentially very unstable, which leaves little time to assess and intervene for Ms. C. The new graduate is not experienced enough to care for a client like Ms. C, whose condition still may deteriorate. The new graduate could be teamed with a more experienced nurse to learn more about the care of clients with severe left ventricular failure. **Focus:** Assignment
13. **Ans: 2** Dysrhythmias and visual disturbances are symptoms of digoxin toxicity, a common problem in clients taking digoxin. Digoxin toxicity can lead to fatal dysrhythmias such as ventricular tachycardia and ventricular fibrillation, so measurement of digoxin level should be ordered. The other findings would not be unusual in a client with chronic heart failure and mitral valve disease, although ongoing assessments are indicated. **Focus:** Prioritization
14. **Ans: 1, 5** Because you are concerned that the client may have digoxin toxicity, you should hold the digoxin. Hypokalemia can contribute to the risk for digoxin toxicity, and Ms. C is not acutely short of breath, so the furosemide (which causes potassium loss) should also be held until you consult with Ms. C's physician. There are no indications that the other medications are causing any adverse effects, so they should all be administered. **Focus:** Prioritization
15. **3, 4, 1, 2** Using the SBAR format, the nurse first identifies himself or herself, gives the client's name, and describes the current situation. Next, relevant background information, such as the client's diagnosis, medications, and laboratory data, are stated. The assessment includes both client assessment data that are of concern and the nurse's analysis of the situation. Finally, the nurse makes a recommendation indicating what action he or she thinks is needed. **Focus:** Prioritization
16. **Ans: 1, 3, 7** Daily weights are an excellent means of monitoring volume status. Clients should be taught to call the physician (or other provider) when symptoms first begin to worsen, rather than waiting until they need to be admitted to the hospital. ACE inhibitors such as captopril can cause orthostatic hypotension, so changing positions slowly is important to avoid dizziness and falls. A weight gain of 2 or 3 lb in a day is an indication of volume overload. Ms. C should be taught to notify the physician if her pulse is lower than 60 beats/min rather than not taking the digoxin, because she still may need the inotropic effect of the medication. Furosemide should not be taken in the evening, because it will affect sleep quality. High fluid intake can cause volume overload in clients with heart failure. **Focus:** Prioritization
17. **Ans: 1** It is important that clients with heart failure be taught that when therapy with beta-blockers is started, symptoms such as weight gain and fatigue may get worse. As the client takes the medication for a longer period, these symptoms should resolve. The client's bradycardia is also an expected effect of carvedilol. If clients are not told to expect these symptoms, they may discontinue the beta-blocking medications. The other actions are not indicated, based on Ms. C's assessment. **Focus:** Prioritization

Case Study 16: Multiple Patients with Peripheral Vascular Disease, pages 133-134

1. **Ans: 5, 4, 2, 6, 1, 3** The worsening back pain of Mr. S may signal an AAA that is enlarging, and he is at risk for rupture, which is urgent and immediately life threatening. Ms. Q's hypertension should be assessed next, because she is at risk for complications such as stroke. Next, the patient with the severe pain should be assessed and given pain medication. The patient scheduled for Doppler studies may have questions and need teaching before the procedure. The patient with Raynaud disease should be assessed, although the symptoms of which she is complaining are typical of this problem. Finally, you should see Mr. Z to discuss arranging for someone to talk with him about smoking cessation. **Focus:** Prioritization
2. **Ans: 2** Palpation of the abdomen must be avoided, because the mass may be tender and there is risk of causing a rupture. Auscultating for a bruit and observing for pulsation are appropriate assessment techniques. Pain assessment is appropriate, because such patients typically experience steady, gnawing abdominal, flank, or back pain that is unaffected by movement and may last for hours or days. **Focus:** Supervision, prioritization
3. **Ans: 3** The patient's symptoms and your assessment findings indicate an AAA that may be expanding, and this places the patient at risk for rupture. This is an urgent situation, and the physician should be notified immediately. You should not place the patient in high sitting position, because this may place added pressure on the patient's AAA. **Focus:** Prioritization
4. **Ans: 1** LPN/LVN educational preparation includes insertion of Foley catheters. In some states LPNs/LVNs can insert IV catheters and administer IV drugs, but this is not true of all states and facilities. To perform these actions, the LPN/LVN would need additional

education and training. Check local, state, and facility policies. The nursing assistant could be delegated to measure the patient's vital signs, with instructions from the nurse about what findings to report. **Focus:** Delegation, supervision

5. **Ans: 1, 2, 3** The nursing student should be able to provide teaching about simple concepts such as coughing and taking deep breaths, perform simple assessments such as measuring peripheral pulses, and administer oral medications. The nurse remains responsible for these actions. The nurse or someone with special training in performing venipuncture should draw blood for the laboratory tests. The patient may have questions about the surgery, so the discussion about the reasons for surgery should be carried out by an experienced nurse. The nurse could mentor the student by allowing the student to be present during the discussion. **Focus:** Delegation, supervision
6. **Ans: 4** Postoperatively after AAA repair, bowel sounds are usually absent for 2 or 3 days, and patients have a nasogastric tube in place on low suction until bowel sounds return. The nurse should document the finding only and teach the student that this is to be expected and why. **Focus:** Delegation, supervision, prioritization
7. **Ans: 1** Administering the patient's blood pressure medications is aimed at correcting the problem. Getting the patient back into bed and reassessing the patient's blood pressure are appropriate actions but do not focus on the problem of lowering the patient's blood pressure. **Focus:** Supervision, delegation, prioritization
8. **Ans: 4** The nurse should intervene when the patient asks to have the docusate held, because narcotic analgesics often cause side effects like constipation. The patient needs to be taught about the importance of this medication in preventing unwanted side effects. If the patient has a good reason for refusing the docusate (e.g., he has been having episodes of diarrhea), then the nurse may hold the drug. The other actions are appropriate. Giving the pain medication before the dressing change will make the procedure less painful. **Focus:** Delegation, supervision
9. **Ans: 2, 3** Mr. Z is in stable condition, and the PACU nurse could begin educating him about smoking cessation. The PACU nurse is skilled at blood pressure monitoring and would have no difficulty meeting Ms. Q's needs for care. Ms. A and Ms. C need the care of a nurse who is experienced in caring for and educating patients with peripheral vascular disease to teach and answer questions. **Focus:** Assignment
10. **Ans: 1, 2, 3, 5** The underlying pathophysiology of Raynaud disease is vasospasm of the arterioles and arteries of the upper and lower extremities, usually unilaterally. All of the other teaching points are appropriate to share with a patient with Raynaud disease. **Focus:** Prioritization
11. **Ans: 3, 4** The nursing assistant can remind about and reinforce nursing care measures that have already been taught by the RN. Assessing and inspecting the patient require additional education and skills appropriate to the RN's scope of practice. **Focus:** Delegation, supervision
12. **Ans: 2** Heparin at low doses interacts with antithrombin III to produce inhibition of clotting factors, which results in inhibition of fibrin formation. The drug does not "thin" a patient's blood or dissolve an existing clot. **Focus:** Prioritization
13. **Ans: 1** The nursing assistant's scope of practice and education includes actions related to assisting patients with activities of daily living such as ambulation. Monitoring, assessing, and providing instructions for the patient require additional education and skills, and are part of the RN's scope of practice. **Focus:** Delegation, supervision
14. **Ans: 1, 2, 4, 5** Placing the patient in a supine position and then elevating his foot places the extremity above heart level, which slows arterial blood flow to the foot and may lead to increased pain. All of the other actions are appropriate for a patient with Buerger disease. **Focus:** Prioritization
15. **Ans: 4** Although all of these lipid profile findings are abnormal, the HDL cholesterol ("good cholesterol") level is much too low. A desirable HDL cholesterol level is 40 mg/dL in men and 50 mg/dL in women. The other results are of concern and must be attended to, but they are not as excessively abnormal as is the HDL level. **Focus:** Prioritization

Case Study 17: Respiratory Difficulty After Surgery, pages 135-138

1. **Ans: 3** The marked decrease in oxygen saturation over the last few hours indicates that Mr. E is developing respiratory complications that will require immediate nursing action. The other information also calls for assessment and possible intervention, but not as urgently as the change in his respiratory status. **Focus:** Prioritization
2. **Ans: 2** Samples for measurement of antibiotic trough levels are drawn just before the next scheduled dose. Drawing the blood at 9:00 AM will give a slightly inaccurate trough level. Obtaining blood at 11:30 AM would be appropriate for assessment of peak gentamicin level. **Focus:** Prioritization
3. **Ans: 2** Oxygen saturations of less than 90% indicate hypoxemia, so the most important action is to improve oxygenation. Sitting in a chair usually improves gas exchange because the lungs can expand more easily. Mr. E's anxiety is due to hypoxemia, so

morphine is not an appropriate intervention to decrease anxiety. The assessment should be completed after interventions to improve oxygenation have been implemented. **Focus:** Prioritization

4. **Ans: 1** The ABG results indicate that Mr. E is hypoxemic and has a metabolic acidosis because of a cellular shift to the anaerobic metabolic pathway. These abnormalities should be corrected by increasing the Pao_2 level. The nonrebreather mask is capable of delivering FIO_2 levels of close to 100%. He is hyperventilating in response to hypoxemia, so administration of morphine is not indicated. Although you will continue to monitor this client's respiratory status, monitoring alone is not enough at this time. **Focus:** Prioritization
5. **Ans: 3** The increase in white blood cell (WBC) count is an indicator of infection, a major concern in a client who has had a ruptured appendix. The WBC count may indicate that a change in antibiotic therapy is needed. The abnormalities in the other parameters indicate that ongoing CBC monitoring is necessary, but do not require any acute interventions. **Focus:** Prioritization
6. **Ans: 1** An RN with experience in caring for pediatric clients would be familiar with the care of clients with infection and hyperglycemia, including blood glucose monitoring and administration of insulin. The new graduate does not have enough experience to care independently for a client who is still in somewhat unstable condition. Ms. O will require assessment and interventions before the on-call RN will be able to arrive. The agency RN will not be familiar with the location of supplies or with hospital policies, such as the standard sliding-scale insulin protocol. **Focus:** Assignment
7. **Ans: 4** The client's symptom of worsening hypoxemia even with increases in supplemental oxygen occurring a few days after the initial injury (i.e., a ruptured appendix) are most consistent with ARDS. The other complications are possible diagnoses for this client, but are not as likely as ARDS. **Focus:** Prioritization
8. **Ans: 2, 4, 1, 3** Using the SBAR format, the nurse first introduces himself or herself, then indicates the current client situation that requires intervention. The nurse then gives pertinent background information about the client. Next, the assessment and analysis of the client's problem are communicated. Finally, the nurse makes a recommendation for the needed action. **Focus:** Prioritization
9. **Ans: 1** Improving Mr. E's oxygenation is the priority goal. BiPAP provides noninvasive positive pressure ventilation, which can decrease the work of breathing and rapidly improve gas exchange. Intubation and mechanical ventilation may be needed for this client but will take longer to accomplish. Administering a bronchodilator and obtaining specimens for culture are also indicated but should be done after starting BiPAP ventilation. **Focus:** Prioritization
10. **Ans: 1** A chest radiograph will confirm that the ET tube is correctly placed 3 to 5 cm above the carina and is the best method for checking correct placement of the ET tube. The initial assessments performed after intubation are listening for bilateral breath sounds, checking for exhaled carbon dioxide, and observing for symmetrical chest wall movement with ventilation. Monitoring of oxygen saturation is useful in assessing response to treatment, but it is not the best indicator of correct ET tube placement, especially in severely hypoxemic clients. **Focus:** Prioritization
11. **Ans: 2** The pH and $Paco_2$ indicate that Mr. E is retaining carbon dioxide, and increasing the respiratory rate will improve the rate at which the lungs can blow off carbon dioxide. The therapeutic goal for clients in respiratory failure is to achieve a Pao_2 of 60 mm Hg or more. Increasing the FIO_2 to a higher level may temporarily improve oxygenation, but it is avoided because exposure to high oxygen levels causes alveolar damage. Raising V_T will increase the chance for complications such as pneumothorax. The CMV mode is generally used for clients who are unconscious or paralyzed, because it allows the client no control of respirations and is very uncomfortable. **Focus:** Prioritization
12. **Ans: 1, 6, 7** The PAWP and urine output suggest that Mr. E is hypovolemic, so increasing his IV fluid intake is essential. Nutritional interventions are important in critically ill clients. Enteral feeding is the preferred method for administration of nutrition, because nutrient metabolism is better and fewer complications occur than with total parenteral nutrition. Because Mr. E's temperature and WBC count are elevated despite receiving gentamicin and ceftriaxone, obtaining specimens for culture is appropriate. Furosemide administration would lead to further dehydration. The client's hypotension and tachycardia are most likely due to dehydration, so norepinephrine and diltiazem would not be ordered. Total parenteral nutrition is used when the enteral route is not possible. **Focus:** Prioritization
13. **Ans: 3** Having a family member at the bedside will decrease the sense of isolation and anxiety that occurs in the ICU environment, especially in clients who cannot easily communicate because of intubation. The other methods listed may also be used. Restraints are sometimes needed in agitated or confused clients, although the need for restraints must be reevaluated frequently. Many clients do benefit from the use of antianxiety medications, although use of neuromuscular blockade or paralysis is avoided unless absolutely necessary to improve ABG values. Reminding the client frequently not to pull at the ET tube may also be helpful. **Focus:** Prioritization

14. **Ans: 4** Application of suction causes hypoxemia and trauma to the tracheal mucosa. Suction should only be applied to the catheter while it is being withdrawn to minimize these problems. Hyperoxygenation is necessary before performing suction for a client who is at risk for hypoxemia, although 5 minutes of hyperoxygenation is usually not necessary. Use of a closed-suction technique helps decrease the cost of suction catheters and is preferred for clients receiving positive end-expiratory pressure (PEEP) ventilation, but an open-suction technique may also be used. Some clients may require sedatives or analgesics before suctioning, although these are not routinely given. **Focus:** Prioritization
15. **Ans: 3** The current guidelines of the Centers for Disease Control and Prevention (CDC) indicate that keeping the head of the bed elevated will decrease gastric reflux and the risk for VAP. Current research does not support the need for changing ventilator tubing every 24 hours, and the CDC does not recommend this. Research has not established which method of giving enteral feedings (continuous or intermittent) is best for clients receiving mechanical ventilation. Continuous pulse oximetry may be used for this client, but will not decrease the risk for VAP. **Focus:** Prioritization
16. **Ans: 1, 3, 5** LPN/LVN education covers skills such as providing oral care, monitoring NG tube feedings, and taking rectal temperatures. An experienced LPN/LVN would know which client data need to be reported to the supervising RN immediately. Positioning a client is also included in LPN/LVN education; however, placing a client with an ET tube and multiple hemodynamic monitoring lines in a prone position requires multiple staff members and should be supervised by the RN caring for the client. ET tube suctioning may be delegated to an experienced LPN/LVN in some settings, but in a client in unstable condition, suctioning should be done by the RN. Education and hemodynamic monitoring are RN-level responsibilities. **Focus:** Delegation
17. **Ans: 1** When an alarm sounds, the initial action should be to assess the client. In this situation, assessment of the breath sounds, chest movement, and respiratory effort should indicate which respiratory complication the client may be experiencing. Depending on the assessment findings, the other actions may also be necessary. **Focus:** Prioritization
18. **Ans: 2** The absence of breath sounds on the right and the high pressures needed to ventilate the client suggest a pneumothorax caused by barotrauma associated with positive pressure ventilation and the use of PEEP. Displacement of the ET tube into one side or extubation also may lead to decreased breath sounds, but the ET tube position would change with these. Aspiration pneumonia is a common complication but does not present with a sudden onset and absent breath sounds. **Focus:** Prioritization
19. **Ans: 3** With a pneumothorax, there are usually only a few milliliters of blood in the collection chamber, because there is no blood or fluid trapped in the pleural space. The presence of 100 mL of blood indicates that there may have been trauma to the lung during the chest tube insertion. The other data are expected with chest tube insertion and pneumothorax. The air leak should be monitored, and analgesics should be used to control the pain Mr. E is experiencing. **Focus:** Prioritization
20. **Ans: 4** Mr. E has multiple risk factors for acute renal failure, including his dehydration and use of the potentially nephrotoxic antibiotic gentamicin. Renal failure is one of the common complications of ARDS. The other laboratory values are also abnormal but do not indicate a need for a change in therapy at present. **Focus:** Prioritization

Case Study 18: Long-Term Care, pages 139-142

1. **Ans: 1, 4, 6** Although aspects of care for all six patients could be assigned to the nursing assistants, Mr. B, Ms. L, and Ms. Q all need assistance with ADLs, which fall within the scope of practice of the CNAs. Ms. R's change in level of consciousness needs to be assessed, because this is a change from her baseline. Many aspects of Mr. K's care can be assigned to a CNA, but his tube feeding and care need the attention of a nurse. Mr. W's difficulty with breathing also requires assessment, because this is a change from his baseline. **Focus:** Assignment
2. **Ans: 3** Mr. W is having difficulty breathing, which could be life threatening. Ms. R needs to be assessed second to determine the reason for her confusion. None of the other patients' conditions are life threatening or unstable. **Focus:** Prioritization
3. **Ans: 2** This is an oral feeding that is within the scope of practice of an LPN/LVN. A CNA's scope of practice includes assisting a patient to ambulate and reminding a patient to use the bathroom. Assessing Mr. W's oxygenation status is more appropriately done by an RN. **Focus:** Delegation
4. **Ans: 1** Checking oxygen saturation via pulse oximetry will give you important information about Mr. W's oxygenation status and a possible reason for why he is experiencing difficulty breathing. Although checking blood pressure and heart rate are important, they do not take first priority at this time. **Focus:** Prioritization
5. **Ans: 4** The priority concern for Mr. W at this time is difficulty breathing. He may be at risk for fluid excess because of his kidney failure, and this would be his second priority. He does not complain about chest pain. Decreased peripheral perfusion is not a priority at this time. **Focus:** Prioritization

6. **Ans: 4** Mr. W has crackles, a productive cough, and decreased gas exchange. The physician needs to be notified, because these signs and symptoms may indicate a respiratory infection that needs to be treated. Patients with COPD should receive low-flow oxygen (3 L/min or less), because their stimulus to breath is a low oxygen level. The patient is already having shortness of breath, which may be worsened with attempts to suction or to lay the patient flat in bed. **Focus:** Prioritization
7. **Ans: 2** All of the nursing responsibilities associated with the physician's orders are within the scope of practice of an LPN/LVN, but some, such as giving medications, are not within the scope of a CNA. You can direct the LPN to keep you updated regarding Mr. W's condition. As the nursing supervisor, you are responsible for assuring that all of the patient care is provided during your shift. **Focus:** Delegation, assignment
8. **Ans: 4** The changes in Ms. R's urine, presence of an indwelling catheter, and fecal incontinence point to a urinary tract infection. In older adults, sudden confusion is a sign of urinary tract infection. Although the other three nursing diagnoses are applicable to this patient, the priority is recognizing and treating the infection. The confusion and communication issues should resolve when the infection is treated. Keeping Ms. R clean and dry to prevent skin breakdown is your second priority. **Focus:** Prioritization
9. **Ans: 1, 4, 5, 6, 7** All of these orders are within the scope of practice of a CNA except giving medications. **Focus:** Assignment
10. **Ans: 2, 3** Although all of these physician and nursing orders fall within the scope of practice of an LPN/LVN, all but giving medications can be assigned to a CNA. However, administering medications is usually not within the scope of practice of a CNA. In some states, long-term care facilities employ medication nursing assistants. However, these assistants must complete a special state-approved program and must demonstrate competency to take the pulse and measure blood pressure. **Focus:** Assignment, delegation
11. **Ans: 3** The patient is much improved. A pulse oximetry reading of 90% is acceptable for a patient with COPD, and the oxygen flow does not need to be changed. Waking the patient every hour for incentive spirometry is counterproductive, because the patient will not get the rest he needs. **Focus:** Prioritization
12. **Ans: 4** Your priority at this time is to assess the patient, because you need to know why Mr. B does not want to get up and walk before you take action. Pain may be the reason, but you do not know that until you assess the patient. Patients do have the right to refuse treatment, but the purpose of Mr. B's admission is rehabilitation so that he can go home, and early ambulation is important in the prevention of respiratory complications. First priority is assessment to gather more information. **Focus:** Prioritization
13. **Ans: 1, 3, 5, 6** Mr. B does need to get up and walk. Administering his prn pain medication may facilitate this. It is important to be attentive to the underlying problem and to strategize how to ensure that he receives appropriate rest, which will aid his recovery. If he is unaware of the respiratory risks associated with failing to ambulate, it is an opportunity to teach him about this. It is not appropriate to belittle Mr. B's concerns by reminding him of the other patients' needs. Although you may want to talk with the CNA about getting more information and allowing patients to rest, there may be times when it is important to awaken patients from naps. **Focus:** Prioritization
14. **Ans: 2** A fairly common side effect of calcium therapy is gastrointestinal upset with nausea and vomiting, and giving this drug with food can minimize or eliminate this side effect. Although Ms. Q is at risk for fractures, this answer does not focus on the problem. Giving the drug on an empty stomach will most likely make the nausea and vomiting worse. Holding the dose does not focus on the problem. **Focus:** Prioritization
15. **Ans: 3** Ms. L is pleasantly confused and should respond better to a gentle reorientation than to a loud, stern reprimand. The priority is assuring that Mr. K's tube feeding is restarted; then the LPN could escort Ms. L back to her room or assign this to the CNA. When Ms. L is being reoriented, the LPN should remind her that she is a patient. The fourth response could sound disrespectful toward Ms. L. **Focus:** Prioritization, assignment
16. **Ans: 4** Mr. K's living will is a legal document and must be respected. You should assess his status and check his advance directive document to make sure it is current, then respect his wishes. You would call the physician with notification of the patient's death. You should take his mother into a quiet room, calmly remind her of his wishes, have someone stay with her, and ask if there is someone you can call for her (e.g., a spiritual advisor or another family member). **Focus:** Prioritization

Case Study 19: Multiple Pediatric Clients in a Clinic Setting, pages 143-146

1. **Ans: 1. APN student, 2. RN and GN, 3. LPN, 4. Nursing assistant, 5. Social worker, 6. Nursing assistant, 7. RN and pediatrician, 8. Pediatrician** The APN student should perform the well-baby physical examinations under the supervision of a pediatrician (who could also perform this task). The RN should perform triage and mentor the GN in this task. The LPN would be best used in giving routine immunizations; the RN or GN could also perform this duty. Obtaining height and weight should be delegated to the nursing assistant. The social worker would be the best person to ensure that

ANSWER KEY

the play area is stocked and organized. Play therapy equipment is specialized, and even simple elements such as the organization of the furniture can affect the therapeutic aspects of play. Stocking of the treatment rooms should be delegated to the nursing assistant. The RN and pediatrician each perform physical assessments of all walk-in clients. The RN should also mentor the GN in this task. The APN student could also do this under the supervision of the pediatrician. The pediatrician must perform clinical supervision of the APN student. **Focus:** Assignment, delegation, supervision

2. **Ans: 2** First the nurse should assess the mother's decision and her level of knowledge. She may not understand the pharmacology of immunization or the child may have had a problem with previous immunizations. She has agreed to immunizations in the past, but now something has changed her mind. Other options may be appropriate depending on the assessment findings. **Focus:** Prioritization
3. **Ans: 2** Assess the child to gain additional information about illness. Acute febrile illness is generally considered a contraindication for administration of immunizing agents because side effects are additive to existing illness and the symptoms of the two will be confused. Notifying the pediatrician, advising the mother, rescheduling the appointment, administering an antipyretic, and giving fluid may be appropriate, but these actions should follow evaluation of the febrile condition. **Focus:** Prioritization
4. **Ans: 3** Inconsolable crying for 2 hours is excessive, prolonged, and abnormal. Instruct the parent to call 911. The swelling can be treated with ice packs. Vomiting can be a sign of increased intracranial pressure, but fewer than three episodes is associated with minor injuries. A laceration on the forehead needs suturing, which should be done within several hours to prevent infection and reduce scarring, but the more pressing issue is to reaffirm with the caller that the bleeding is controlled. **Focus:** Prioritization
5. **Ans: 4** Additional psychosocial and physical assessment is needed to intervene properly. The other three options may be appropriate after initial assessment is completed. **Focus:** Prioritization
6. **Ans: 2** The priority is oxygenation. The other diagnoses are appropriate, but less urgent. **Focus:** Prioritization
7. **Ans: 3** Agitation and sweating are signs of severe respiratory distress. In addition, the child is attempting to maximize the thoracic cavity and to oxygenate more effectively by sitting upright and hunching forward. **Focus:** Prioritization
8. **Ans: 1** Increased respiratory rate and decreased breath sounds are ominous signs suggesting that the airways are obstructed. Respiratory arrest is imminent. A productive cough warrants close observation, because the client is at risk for mucous plugs and bronchial spasm, which could cause an obstruction. Other symptoms such as itching, restlessness, and wheezing accompany exacerbation of asthma and require attention, but are less urgent. **Focus:** Prioritization
9. **Ans: 6, 3, 1, 5, 2, 4, 7** Administer humidified oxygen while you are preparing the albuterol treatment. (If the albuterol is immediately available, you should give the treatment first and then administer the oxygen after the treatment is completed.) In acute exacerbations of asthma, short-acting beta$_2$ agonists are given, followed by corticosteroid therapy. A chest radiograph and CBC are appropriate to demonstrate underlying pathology such as infection that may contribute to the episode. Arrangements should be made to transfer the client to the hospital after the client's condition has been stabilized. Measuring peak flow rates to determine personal best is part of long-term management and client education. Radioallergosorbent testing can be scheduled on an outpatient basis. **Focus:** Prioritization
10. **Ans: 1. Pediatrician, 2. RN, 3. RN, 4. Nursing assistant, 5. Pediatrician, 6. RN and pediatrician, 7. RN or LPN, 8. Nursing assistant** The pediatrician must give the physician-to-physician report. The RN must give the nursing report. The RN can delegate tasks such as photocopying but is responsible for ensuring that records are correct and complete. The nursing assistant can help collect personal items, but the RN should delegate and give instructions. The pediatrician must determine the stability of the client's condition. The RN and pediatrician must do independent summaries of the client's condition. The pediatrician may rely on the RN's report of ongoing response to treatments. The RN can check the patency of the IV line, or the LPN can be assigned this task. (Note: There is variation in the scope of practice of LPNs/LVNs according to states' nurse practice acts. Policies can also vary among facilities within the same state.) The nursing assistant can help the client transfer, but the RN must know that the assistant has had proper training in transfer techniques to prevent injury to self or client. **Focus:** Supervision, assignment, delegation
11. **Ans: 4, 1, 2, 3** James's condition is the most critical. He has airway compromise that could suddenly turn into a complete airway obstruction. Daisy is the next in priority. Although she is conscious, she cannot be allowed to continue unattended for a long period. At a minimum, delegate performing a blood glucose check to the LPN (or a nursing assistant if appropriate training has been given) with instructions that the results be reported to you immediately. Sarah, Sam, and Ms. A have complex social circumstances that will be very time consuming to address; however, this family is a flight risk. Quickly check on the A family

and alert all staff members about the need to support this family. Terry has a treatable ear infection; treatment and education are relatively straightforward. Go back and do an in-depth assessment of the A family. **Focus:** Prioritization

12. **Ans: 2** James has symptoms of epiglottitis and is at high risk for an airway obstruction. The other diagnoses are relevant, but have lower priority. **Focus:** Prioritization
13. **Ans: 2** The child has immediate need for oxygen. An upright position facilitates breathing, and parental comfort minimizes agitation and crying, which would increase oxygen consumption. Inspecting the throat is contraindicated because the procedure could exacerbate airway obstruction. Intubation equipment should always be available, but is not needed yet. (Note: If the clinic were attached to a hospital, you could alert the operating room about the need for a potential emergency intubation and/or tracheostomy.) Reassuring the parents that the condition will resolve spontaneously is inappropriate. **Focus:** Prioritization
14. **Ans: 3** In addition to the APN and the pediatrician, the best combination would be the experienced RN and GN. The child is acutely ill and may require immediate intervention for airway management. This is an opportunity for the experienced RN to closely supervise and mentor the GN. In the initial care of this child there are few tasks that can be delegated to the nursing assistant, and the expertise of the LPN is best utilized to monitor and assess other clients in more stable condition. **Focus:** Supervision, assignment
15. **Ans: 3** In a clinic setting, calling 911 is the best and safest option. Directing the parent to drive would be considered dangerous malpractice. There is a wide variation in skill set among ambulance drivers, whereas advanced paramedics that respond to 911 calls are routinely trained to intubate. Although the pediatrician is qualified to intubate, this is not a typical task in a clinic setting, and prophylactically intubating the child at this point would be inappropriate. **Focus:** Prioritization
16. **Ans: 4** Based on the available information, you would suspect and confirm hypoglycemia and then give food or fluids to prevent complications. According to the American Diabetic Association, milk is better than juice because blood glucose level is stabilized by the lactose, fat, and protein. The mother should be notified and advised to come to the clinic; however, emergency treatments would not be delayed if she cannot be located. Asking the child to describe how she feels is appropriate, but taking time to elicit details of history from a 4-year-old with hypoglycemia is not a good use of time in the immediate situation. The physician should be alerted about the child's condition; however, oxygen is not needed, and it is unlikely that IV access is required at this time. **Focus:** Prioritization
17. **Ans: 4** The mother is very emotional, and she must be allowed to express her feelings first. In addition, accusing others of "not taking care of her" suggests that the mother may be using the defense mechanism of projection (transferring feelings and inadequacies of self onto others). Her anger and fear may be related to guilt for not appropriately informing the neighbor about the child's health condition. You could consider using the other three options after you have allowed the mother to express herself and have further assessed the situation. **Focus:** Prioritization
18. **Ans: 1** Acute otitis media is painful. Symptoms are relieved with acetaminophen (Tylenol) and application of a warm, moist towel to the outer ear. Other diagnoses are pertinent, but less urgent. **Focus:** Prioritization
19. **Ans: 3** The LPN should perform an irrigation of the ear canal. Teaching of the parents should be done by the RN. "Watchful waiting" is not an appropriate medical approach for a child under 2 years of age because of the immaturity of the immune system. An order for an antihistamine, a decongestant, and a steroid should be questioned by the RN, because these are not recommended for the treatment of acute otitis media. **Focus:** Assignment
20. **Ans: 4** In pediatrics, RNs will frequently calculate the dosage independently of the physician as a safety measure. Having another RN double-check the order and the math is not mandatory, but it is a common practice and adds an additional safety check. Once the error is validated, bring it to the attention of the pediatrician. Options 1 and 2 are incorrect because the dosage is too high. Option 3 is a possibility, but in this case the pharmacist is unlikely to have additional information that will clarify this order. **Focus:** Prioritization
21. **Ans: 3** Remind the GN that the infant is refusing to suck and that therefore administering oral medication may be challenging. Mixing medication with applesauce is appropriate in some circumstances, but for this client the volume of 3 oz is excessive. In addition, applesauce may or may not have been introduced into the diet, and it is inappropriate to introduce new foods during an illness. **Focus:** Supervision
22. **Ans: 3** The priority for this family is safety and avoidance of injury. Both children have physical needs that are not being met. The infant may already have an arm injury. Ms. A's comment suggests that she does not have an understanding of appropriate developmental behavior for children, and there is concern about her ability to make safe judgments for herself and the children. The other diagnoses are also relevant for this family. **Focus:** Prioritization
23. **Ans: 1. RN, 2. RN and social worker, 3. All team members, 4. Social worker, 5. Nursing assistant,**

6. Nursing assistant, 7. LPN or RN, 8. Nursing assistant The RN must perform the initial physical assessment; it cannot be delegated. The RN and social worker both need to obtain an initial history. There is some overlap in history taking; however, in addition to the psychosocial circumstances, the RN needs to evaluate mechanism of injury to anticipate extent and type of injuries and potential for complications. All professional caregivers should observe for signs of abuse. The nursing assistant will have less formal training in this area, but his or her input is still valuable. Any caregiver can contact Child Protective Services; however, in this case, the social worker is present and is the most appropriate person. If a social worker were not available, then the RN should assume this responsibility. Holding one child can be delegated to the nursing assistant. Accompanying the infant can be delegated to the nursing assistant. The LPN can be assigned to give medication; the RN could also administer it. The nursing assistant can assist the toddler to eat. **Focus:** Delegation, assignment

24. **Ans: 4** Try to use therapeutic communication first. An AMA form is not appropriate in this situation, because the mother's ability to make good judgments and to care for her children is a concern. The pediatrician should be notified, because the mother may respond to the physician's advice if she will not listen to anyone else. Threatening to call the police is likely to increase the mother's agitation and fears. **Focus:** Prioritization

Case Study 20: Multiple Patients with Psychiatric Disorders, pages 147-152

1. **Ans: Mr. D and Ms. G** Mr. D has major depression, and Ms. G has dementia and depression. These two patients will require physical care and verbal coaching. The medical-surgical nurse would be most familiar with the care and conditions of these two patients. **Focus:** Assignment
2. **Ans: Ms. B, Ms. M, and Mr. S** Ms. B, with a borderline personality disorder, and Ms. M, with manic behavior, need continuous and firm limit setting from an experienced and preferably a female nurse. They may be excessively argumentative or manipulative. Mr. S shows bizarre behavior, but he has a chronic condition. **Focus:** Assignment
3. **Ans: Mr. P and Mr. V** Mr. P, who has paranoid schizophrenia, and Mr. V, who is actively suicidal, have the most acute conditions and therefore should be assigned to an experienced RN. **Focus:** Assignment
4. **Ans: Mr. D** Mr. D needs assistance and encouragement to meet hygienic needs, and he can understand and follow instructions. Ms. B and Ms. M can accomplish their own hygienic care, but specific boundaries may need to be set about dressing appropriately. Mr. P could be easily provoked because of his paranoia. Mr. S has severe communication barriers that a new nursing assistant may not understand. Mr. V is on suicide precautions. Ms. G could also be assigned to the assistant; however, patients with dementia do better if they have the same caregiver every day. **Focus:** Assignment
5. **Ans: Ms. M and Mr. V** Students generally prefer to complete this type of assignment with patients who are willing and able to carry on a reasonably coherent conversation. Ms. M (manic behavior) is probably the best choice, because she is likely to seek out the student (or any other person who enters the unit) and initiate a conversation. Mr. V (suicidal thoughts) would benefit from the attention that a student could give him, but the assigned nursing assistant and the student must be aware that the patient is on continuous one-to-one observation and that the presence of the student does not replace the observations made by the staff. Mr. D (depression) could answer questions appropriately, but his energy will not sustain a prolonged interview. Ms. B (borderline personality disorder) is likely to seek out the student; however, special attention from a young male is not likely to be part of her treatment plan. Mr. P (paranoid schizophrenia) is likely to refuse an interview or will have a low tolerance for interaction. Mr. S (disorganized schizophrenia) provides an interesting opportunity for observing symptoms, but he is not a good historian, and chart data may be limited. Ms. G (dementia) would be an interesting choice for a mental status examination; however, she is not a good historian, and prolonged questioning is likely to increase her restlessness and agitation. **Focus:** Supervision
6. **Ans: 2** Your first action would be to assess the patient for current mental status and for safety and comfort related to use of restraints. Additional information is necessary to validate the need for medications and restraints, and to determine if other interventions were tried before resorting to chemical and/or physical restraints. Based on your assessment of the patient and situation, you may decide to use the other three options. **Focus:** Prioritization, supervision
7. **Ans: 2** Although minimizing clutter is important, rearranging furniture and belongings can increase confusion. Options 1, 2, and 4 are appropriate interventions to use with a patient who has dementia. **Focus:** Supervision
8. **Ans: 4** AMA policies may vary, and transfer to specialty facilities can be complex and time consuming. Explain to the patient and/or family that leaving against advice may actually delay geropsychiatric placement, because the patient's place on waiting lists

may be lost or a relationship may have to be established with another referring provider. The health care provider writes the order for transfer but is usually not involved in making the administrative arrangements. False reassurance to placate the daughter is not the best approach. Once the AMA policy is verified, the daughter can be assisted in filling out the appropriate AMA forms if she still wants to take her mother home. **Focus:** Prioritization

9. **Ans: 4** Support the therapeutic milieu by demonstrating to all the patients that the psychiatric unit has social norms. Instructing Ms. M to stop interrupting is a concrete direction that delineates expected group behavior. Escorting her out may be the easiest solution, but parameters for behavior (i.e., raise your hand if you want to speak) and consequences (i.e., if you interrupt one more time you will have to leave) should be clarified first. The scenario suggests that the social worker is not able to control Ms. M. Frequently, the co-leader assists with individual behavioral management while the leader keeps the group on task. Ideally, these roles are discussed beforehand. Encouragement of confrontation could be used in a small group therapy session to teach patients to directly express and respond to one another; however, in this meeting having Ms. B defend herself is likely to lead to a loud and unproductive public screaming match. **Focus:** Prioritization
10. **Ans: 1** Have the student contact the instructor. An incident report should be filed so that a detailed record is available for review. The instructor can debrief the student, who is likely to be upset, and there may be unintentional elements of his behavior that triggered Ms. B's response. Ms. B should have an opportunity to talk about the incident also, but do not create a situation in which you find yourself having to defend one against the other. You should write an incident report that is separate and independent from the student's account. The incident is unlikely to be reported directly to the board of nursing, but it could go to peer review if the student's behavior appears to be questionable. **Focus:** Supervision
11. **Ans: 3** Acknowledging feelings is therapeutic; at the same time, you are not necessarily confirming or denying the veracity of Ms. B's statements. Explain that any verbalizations of potential harm must be shared with the physician and psychiatric team. Rather than spend additional time with Ms. B, gently inform her that you will contact the appropriate team members for follow-up. (The problem may be real, but Ms. B also has a long history of manipulating for attention.) Physical assessment will not provide any evidence of rape, but a rape crisis counselor could be contacted for long-term follow-up. **Focus:** Prioritization
12. **Ans: 1. Psychiatrist, 2. RN, 3. RN, 4. Nursing assistant, 5. RN, 6. Nurse anesthetist, 7. Nursing assistant, 8. RN, 9. Nursing assistant** The psychiatrist is responsible for obtaining informed consent. The RN is responsible for patient education and ensuring that all preprocedural and postprocedural orders are completed. Under appropriate supervision, a nursing assistant can assist patients to prepare for the procedure by removing and storing personal items. Also, assistants can take vital signs and assist with meals. The nurse anesthetist should administer anesthesia. **Focus:** Delegation, assignment
13. **Ans: 4** The patient is expressing a delusion of grandeur and religiosity with clang associations. Acknowledge the underlying "healthy" intent and express appreciation for the gesture. Addressing the patient as Jesus supports the delusion, while contradicting the delusion is thought to have a reinforcing affect. Redirecting to concrete, here-and-now topics is appropriate after you have acknowledged the underlying feelings. Redirection is also appropriate when the patient is repetitive with delusional content. **Focus:** Prioritization
14. **Ans: 2** With any patient, establishing trust, rapport, and mutual respect is the first step. With thought disorder patients, use short, simple questions that are easy to understand and respond to. If this particular patient can state his name in response to the question, it would be a therapeutic accomplishment because of his severe thought disorder. The other options show interest in the patient, but it is unlikely that this patient could sustain the concentration required to play cards, to sit for 15 minutes, or to recall the events preceding hospitalization. **Focus:** Prioritization
15. **Ans: 1. Nursing assistant, 2. LPN and RN, 3. RN, 4. All team members, 5. RN, 6. Nursing assistant, 7. RN, 8. RN** The nursing assistant can assist with hygiene. The RN can delegate one-to-one observation to the nursing assistant but must supervise and give specific instructions. An LPN or RN can give medication. The RN is responsible for teaching, ensuring safety, and documentation. All team members should use good communication techniques. Note: The nursing student could be involved in any of these actions with proper supervision. **Focus:** Delegation, assignment
16. **Ans: 2** Although Mr. P is paranoid, even psychiatric patients may be able to recognize their own medications. As with any patient, you should double-check the physician's order first to see if there has been an error. You could compare the order with the medication reconciliation list (if it is available) to see if the current order matches what the patient has taken in the past. The other options could be used after the medication order is clarified. **Focus:** Prioritization
17. **Ans: 1. RN, 2. Nursing assistant, 3. LPN, 4. LPN, 5. RN, 6. Nursing assistant** The nursing assistant can assist Mr. D with hygienic care and redirect Ms. G

away from the door. Remember to tell the nursing assistant that Ms. G is at risk for falls. The LPN can intervene with Ms. M, set boundaries, and direct her to dress appropriately. Administering oral medications is within the scope of practice of the LPN. Psychiatric patients are routinely observed for "pouching" of pills in the buccal area. The RN should assess Ms. B for suicide risk. Suicide precautions with one-to-one observation must be initiated. The psychiatrist must be notified, and the incident must be carefully documented. The RN should assess Mr. V for suicidal thoughts. Writing letters could be a positive and therapeutic action; however, letters may also contain evidence of final goodbyes. **Focus:** Delegation, assignment

18. **Ans: 7, 5, 2, 1, 4, 6, 3** Using the SBAR format, the nurse first identifies himself or herself, gives the client's name, and describes the current situation. Next, relevant background information, such as the client's diagnosis, medications, and laboratory data, is stated. The assessment includes both client assessment data that are of concern and the nurse's analysis of the situation. Finally, the nurse makes a recommendation indicating what action he or she thinks is needed. **Focus:** Prioritization
19. **Ans: 1** Assess the content of command hallucinations, because the patient may be getting a command to harm self or others. Ideas of reference occur when an ordinary thing or event (e.g., a song on the radio) has personal significance (e.g., belief that the lyrics were written for him or her). Clang association is a meaningless rhyming of words, and neologisms are new words created by patients. These communication patterns create frustration for staff and patients, but there is no need for immediate intervention. **Focus:** Prioritization
20. **Ans: 1** Assess the patient for behaviors that would warrant seclusion (i.e., represent a danger to self or to others), then discuss your concerns with the provider. If seclusion is punitive, there is a potential for violation of rights, regardless of whether the order is verbal or written. Although patients do need limit setting and clear boundaries, you must intervene in the "least restrictive" manner. After additional assessment, you may decide that documentation, seclusion, and continued care are options. However, you may also decide that you need to go up the chain of command to prevent future similar incidents. **Focus:** Prioritization
21. **Ans: 2** When the sodium level is low the body retains lithium, so there is an increased risk for lithium toxicity. The chloride and potassium levels are within normal limits. The glucose level would be considered elevated if the patient has not eaten within the past several hours. **Focus:** Prioritization
22. **Ans: 3, 4, 1, 6, 5, 2** The least restrictive method is verbal intervention. The patient should be allowed to stay in public areas if possible, and then moved to isolated spaces. Finally, if nothing else works, the patient can be physically restrained for safety purposes. **Focus:** Prioritization
23. **Ans: 4** The patient is in the preassaultive stage. Use a calm tone of voice and explain what you expect him to do. This will help him to gain control and convey that you respect his ability to participate in his own behavior control. Options 2 and 3 may be necessary after the verbal intervention. If at all possible, avoid sudden or quick actions, which could be interpreted as physical aggression. **Focus:** Prioritization
24. **Ans: 2, 4, 3, 6, 1, 5** The first step is to maintain an awareness of the ways that medication errors can occur. Check the original order for legibility and clarification. Consult a drug reference to determine if the patient's condition warrants the type of medication ordered and to see if *Klonopin* and *clonidine* are different names for the same drug. (Note: Medications become familiar. Experienced nurses will recognize that Klonopin [clonazepam] and clonidine are not the same drug and therefore may not consult a reference; however, all nurses should continue to look up new or unfamiliar drugs.) Call the physician if the order is not clear or if the medication does not seem appropriate for the patient's condition (physicians can get drug names confused, too). Advise the pharmacy about any errors or changes, so that the correct medication is delivered. Consider writing an incident report even though you did not make a medication error, so that system errors can be evaluated and prevented in the future. **Focus:** Prioritization
25. **Ans: 3** The patient is experiencing medication side effects. This condition is frightening and uncomfortable for the patient, but it is not usually harmful. The condition responds rapidly to intramuscular or intravenous administration of diphenhydramine. **Focus:** Prioritization
26. **Ans: 1, 4, 3, 2** The highest priority is patient 1, who has symptoms of neuroleptic malignant syndrome, which is rare but potentially fatal. This patient should be transferred to a medical unit. Patient 4 may have agranulocytosis. The mortality rate is high, and intervention includes discontinuing medication, aggressively treating infection, and providing protective isolation. Patient 3 has symptoms of tardive dyskinesia, which should be reported so that the medication can be discontinued. There is no known treatment, and discontinuation does not always relieve the problem. Patient 2 is showing anticholinergic effects, which can be treated symptomatically (i.e., provide sips of water or hard candy; encourage use of artificial tears; place a warm towel on the abdomen; give stool softeners; and encourage the use of sunglasses). **Focus:** Prioritization