ANSWERS AND RATIONALES

The correct answer number and rationale for why it is the correct answer are given in **boldface type.** Rationales for why the other possible answer options are incorrect also are given, but they are not in boldface type.

1. 1. The new graduate must work under this charge nurse; confronting the nurse would not resolve the issue because the nurse can choose to ignore the new graduate. Someone in authority over the charge nurse must address this situation with the nurse.
2. The night supervisor or the unit manager has the authority to require the charge nurse to submit to drug screening. In this case, the supervisor on duty should handle the situation.
3. The new graduate is bound by the nursing practice acts to report potentially unsafe behavior regardless of the position the nurse holds.
4. The nurse educator would not be in a position of authority over the charge nurse.

Content – *Management of Care:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Implementation:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Application*

2. 1. The nurse should stop the behavior from occurring in a public place. The charge nurse can discuss the issue with the UAPs and determine whether the manager should be notified.
2. The first action is to stop the argument from occurring in a public place. The charge nurse should not discuss the UAPs' behavior in public.
3. The second action is to have the UAPs go to a private area before resuming the conversation.
4. The charge nurse may need to mediate the disagreement; this would be the third step.

Content – *Management of Care:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Implementation:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Application*

3. 1. The graduate nurse should handle the situation directly with the UAP first before notifying the charge nurse.
2. This may need to be completed, but not prior to directly discussing the behavior with the UAP.
3. The graduate nurse must address the insubordination with the UAP, not just complete the tasks that are the responsibility of the UAP.
4. The graduate nurse must discuss the insubordination directly with the UAP first. The nurse must give objective data as to when and where the UAP did not follow through with the completion of assigned tasks.

Content – *Management of Care:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Implementation:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Application*

4. 1. This should not be implemented until verification of the allegation is complete, and the shift manager has discussed the situation with the UAP.
2. The shift manager should have objective data prior to confronting the UAP about the allegation of falsifying vital signs; therefore, the shift manager should take the client's vital signs and compare them with the UAP's results before taking any other action.
3. The shift manager should not confront the UAP until objective data are obtained to support the allegation.
4. Written documentation should be the last action when resolving staff issues.

Content – *Management of Care:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Implementation:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Synthesis*

5. **1. The nurse should first assess the client prior to taking any other action to determine if the client is experiencing any untoward reaction.**
2. An incident report must be completed by the nurse but not prior to taking care of the client.
3. The nurse should administer the correct medication but not prior to assessing the client.
4. The client's HCP must be notified, but the nurse should be able to provide the HCP with pertinent client information, so this is not the first intervention.

Content – *Medical/Surgical:* ***Category of Health Alteration*** – *Medication Administration:* ***Integrated Processes*** – *Nursing Process: Implementation:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Application*

6. 1. The serum blood glucose level requires a venipuncture, which is not within the scope

of the UAP's expertise. The laboratory technician would be responsible for obtaining a venipuncture.
2. This is a sterile dressing change and requires assessing the insertion site for infection; therefore, this would not be the most appropriate task to assign to the LPN.
3. The nurse should ask the UAP to bathe the client and change bed linens because this is a task the UAP can perform. The LPN could be assigned higher-level tasks.
4. **The UAP can add up the urine output for the 12-hour shift; however, the nurse is responsible for evaluating whether the urine output is what is expected for the client.**

***Content** – Medical/Surgical: **Category of Health Alteration** – Management of Care: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

7. 1. The client on the ventilator is unstable; therefore, the nurse should not delegate any tasks to the UAP.
2. **The UAP can take specimens to the laboratory; these are not medications and they are not vital to the client.**
3. The client in an Addisonian crisis is unstable; therefore, the nurse should not delegate any tasks to the UAP.
4. The UAP cannot assist the HCP with an invasive procedure at the bedside.

***Content** – Medical/Surgical: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

8. 1. **The client must have lost decision-making capacity because of a condition that is not reversible or must be in a condition that is specified under state law, such as a terminal, persistent vegetative state, irreversible coma, or as specified in the advance directive. A client who is exhibiting decerebrate posturing is unconscious and unable to make decisions.**
2. The client on a ventilator has not lost the ability to make healthcare decisions. The nurse can communicate by asking the client to blink his or her eyes to yes/no questions.
3. The client receiving dialysis is alert and does not lose the ability to make decisions; therefore, the advance directive should not be consulted to make decisions for the client.
4. Mental retardation does not mean the client cannot make decisions for him- or herself unless the client has a legal guardian who has a durable power of attorney for healthcare. If the client has a legal guardian, then the client cannot complete an advance directive.

***Content** – Medical/Surgical: **Integrated Processes** – Nursing Process: Assessment: **Client Needs** – Psychosocial Integrity: **Cognitive Level** – Analysis*

9. 1. The UAP can apply sequential compression devices to the client on strict bed rest.
2. The UAP can assist with a portable STAT chest x-ray, as long as it is not a female UAP who is pregnant.
3. **The client will need to be pre-medicated for a wound debridement; therefore, this task cannot be delegated to the UAP.**
4. The UAP can obtain intake and output for clients.

***Content** – Medical/Surgical: Integrated Process: Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

10. 1. **A quality improvement project looks at the way tasks are performed and attempts to see whether the system can be improved. A medication delivery system in which it takes a long time for the nurse to receive a STAT or "now" medication is an example of a system that needs improvement, and should be addressed by a quality improvement committee.**
2. Financial reimbursement of the staff is a management issue, not a quality improvement issue.
3. Collective bargaining is an administrative issue, not a quality improvement issue.
4. The number of medication errors committed by a nurse is a management-to-nurse issue and does not involve a systems issue, unless several nurses have committed the same error because the system is not functioning properly.

***Content** – Medical/Surgical: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Application*

11. 1. **A secondary nursing intervention includes screening for early detection. The bone density evaluation will determine the density of the bone and is diagnostic for osteoporosis.**
2. Spinal screening examinations are performed on adolescents to detect scoliosis. This is a secondary nursing intervention, but not to detect osteoporosis.
3. Teaching the client is a primary nursing intervention. This is an appropriate intervention to help prevent osteoporosis, but it is not a secondary intervention.

4. Discussing risk factors is an appropriate intervention, but it is not a secondary nursing intervention.

***Content** – Medical/Surgical: **Category of Health Alteration** – Musculoskeletal: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Physiological Integrity: Reduction of Risk Potential: **Cognitive Level** – Synthesis*

12. 1. Isometric exercises such as weight lifting increase muscle mass. The HH nurse should not instruct the HH aide to do this type of exercises.
2. The HH aide may go to the emergency department, but the HH nurse should address the aide's back pain. Many times, the person with back pain does not need to be seen in the emergency room.
3. An occurrence report explaining the situation is important documentation and should be completed. It provides the staff member with the required documentation to begin a workers' compensation case for payment of medical bills. However, the HH nurse on the phone should help decrease the HH aide's pain, not worry about paperwork.
4. **The HH aide is in pain, and applying ice to the back will help decrease pain and inflammation. The HH nurse should be concerned about a coworker's pain. Remember: Ice for acute pain and heat for chronic pain.**

***Content** – Medical/Surgical: **Category of Health Alteration** – Musculoskeletal: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Physiological Integrity: Reduction of Risk Potential: **Cognitive Level** – Application*

13. 1. Allowing the client to stay in bed is inappropriate because a client with osteoarthritis should be encouraged to move, which will decrease the pain.
2. A bath at the bedside does not require as much movement from the client as getting up and walking to the shower. This is not an appropriate action for a client with osteoarthritis.
3. **Movement and warm or hot water will help decrease the pain; the worst thing the client can do is not to move. The HH aide should encourage the client to get up and take a warm shower or bath.**
4. Osteoarthritis is a chronic condition, and the HCP could not do anything to keep the client from "hurting all over."

***Content** – Medical/Surgical: **Category of Health Alteration** – Musculoskeletal: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Physiological Integrity: Basic Care and Comfort: **Cognitive Level** – Application*

14. 1. **The HH aide's responsibility is to care for the client's personal needs, which includes assisting with a.m. care.**
2. The HH aide is not responsible for cooking the client's meals.
3. The HH aide is not responsible for taking the client to appointments. This also presents an insurance problem, because the client would be riding in the HH aide's car.
4. Even in the home, the HH nurse should not delegate teaching.

***Content** – Medical/Surgical: **Category of Health Alteration** – Management of Care: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

15. 1. The UAP may be at risk of contacting the illness.
2. **The UAP should wear appropriate personal protective equipment when providing any type of care.**
3. The UAP should not be told to skip performing assigned tasks.
4. The fetus is not affected by anthrax.

***Content** – Medical/Surgical: **Category of Health Alteration** – Respiratory: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Safety and Infection Control: **Cognitive Level** – Synthesis*

16. 1. The mortuary service is considered part of the healthcare team in this case. The personnel in the funeral home should be made aware of the client's diagnosis.
2. **The mortuary service is considered part of the healthcare team. In this case, the personnel in the funeral home should be made aware of the client's diagnosis.**
3. The nurse does not need to ask the family for permission to protect the funeral home workers.
4. The nurse, not the HCP, releases the body to the funeral home.

***Content** – Medical/Surgical: **Category of Health Alteration** – Communicable Disease: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Safe and Effective Care Environment: Safety and Infection Control: **Cognitive Level** – Application*

17. 1. The clients would not understand the importance of the specific tasks. Clients will tell the nurse whether the UAP is pleasant when in the room but not whether the delegated tasks have been completed.
2. The nurse retains responsibility for the delegated tasks. The charge nurse may be able to tell the nurse that the UAP has been checked

off as being competent to perform the care but would not know whether the care was actually provided.

3. The nurse retains responsibility for the care. Making rounds to see that the care has been provided is the best method to evaluate the care.

4. The nurse would not have time to complete his or her own work if the nurse watched the UAP perform all of the UAP's work.

***Content** – Medical/Surgical: **Category of Health Alteration** – Management of Care: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Safe and Effective Care Environment: Safety and Infection Control: **Cognitive Level** – Application*

18. 1. A client in a crisis should be assigned to the registered nurse (RN).

2. Biliary atresia involves liver failure, involving multiple body systems. This client should be assigned to the RN.

3. Anaphylaxis is an emergency situation. The client should be assigned to the RN.

4. The LPN can administer routine medications and care for clients who have no life-threatening conditions.

***Content** – Medical/Surgical: **Category of Health Alteration** – Management of Care: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Safety and Infection Control: **Cognitive Level** – Synthesis*

19. 1. The nurse would expect the client with DIC to be oozing blood; therefore, the nurse should not need to assess this client first.

2. The nurse would expect the client with BPH to have urinary signs and symptoms such as terminal dribbling, so the nurse should not need to assess this client first.

3. The nurse would not expect the client with renal calculi to have blood in the urine (hematuria) and the pain should not be severe; therefore, this client should be assessed to determine if the client is having complications.

4. The nurse would expect the client with Addison's disease to have a bronze pigmentation and hypoglycemia; therefore, the nurse should not need to assess this client first.

***Content** – Medical/Surgical: **Category of Health Alteration** – Genitourinary: **Integrated Processes** – Nursing Process: Assessment: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Analysis*

20. 1. The most experienced nurse should be assigned to the client who requires teaching and evaluation of knowledge for home healthcare, because the client is in the surgery center for less than 1 day.

2. A routine preoperative client does not require the most experienced nurse.

3. Any nurse can administer and monitor blood transfusion to the client.

4. Although the creation of an arteriovenous fistula requires assessment and teaching on the part of the most experienced nurse, this client is not being discharged home at this time.

***Content** – Medical/Surgical: **Category of Health Alteration** – Management of Care: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

21. 1. The Glasgow Coma Scale ranges from 0 to 15, with 15 indicating the client's neurological status is intact. A Glasgow Coma Scale score of 13 indicates the client is stable and would be the most appropriate client to assign to the graduate nurse.

2. This client's K^+ level is low, and the client is at risk for developing cardiac dysrhythmias; therefore, the client should be assigned to a more experienced nurse.

3. This client has a low blood pressure and evidence of tachycardia and could possibly go into an Addisonian crisis, which is a potentially life-threatening condition. A more experienced nurse should be assigned to this client.

4. A positive Trousseau sign indicates the client is hypocalcemic and is experiencing a complication of the surgery; therefore, this client should be assigned to a more experienced nurse.

***Content** – Medical/Surgical: **Category of Health Alteration** – Neurological: **Integrated Processes** – Nursing Process: Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

22. 1. The therapeutic PTT level should be 1½ to 2 times the control. Most controls average 36 seconds, so the therapeutic levels of heparin would place the control between 54 and 72. With a PTT of 92, the client is at risk for bleeding, and the heparin drip should be held. The nurse should assess this client first.

2. A client diagnosed with pneumonia would be expected to have a fever. This client can be seen after the client diagnosed with a DVT.

3. Cystitis is inflammation of the urinary bladder, and burning on urination is an expected symptom.

4. Pancreatitis is a very painful condition. Pain is a priority but not over the potential for hemorrhage.

Content – *Medical/Surgical:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Planning:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Synthesis*

23. 3, 4, and 5 are correct.

1. Teaching is the responsibility of the nurse and cannot be delegated to a UAP.
2. The word "check" indicates a step in the assessment process, and the nurse cannot delegate assessing to a UAP.
3. **The client is 2 days postoperative and vital signs should be stable, so the UAP can take vital signs. The nurse must make sure the UAP knows when to immediately notify him/her of vital signs not within the guidelines the nurse provides to the UAP.**
4. **This action does not require judgment on the part of the UAP: it does not require assessing, teaching, or evaluating. This can be delegated to the UAP.**
5. **A client who is 2 days postoperative should be ambulating frequently. The UAP can perform this task.**

Content – *Medical/Surgical:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Planning:* ***Client Needs*** – *Safe and Effective Care Environment, Management of Care:* ***Cognitive Level*** – *Synthesis*

24.

1. Staff members will not stay if forced to always use their paid time off for the hospital's convenience.
2. **This nurse wants to take time off. Therefore, it is the best option to let the nurse desiring to be off from work to take time off if all other situations are equal.**
3. The nurse will not gain experience if always requested not to come to work, and presumably this nurse would not have benefit time to pay for the time out of work.
4. This nurse could be allowed to stay home only if the nurse is still ill.

Content – *Medical/Surgical:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Planning:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Synthesis*

25.

1. A nurse, not the UAP, should perform sterile dressing changes.
2. This client is unstable, and a nurse should perform this task.
3. **The UAP can check to see the amount of food the residents consumed and document the information.**
4. This is the job of the activity director and volunteers working with the activities department. Staffing is limited in any nursing area; the UAP should be assigned a nursing task.

Content – *Medical/Surgical:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Planning:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Synthesis*

26.

1. The charge nurse is not the nurse educator but is responsible for the UAPs working under him or her. This is adding additional duties to the charge nurse.
2. **The director of nurses should encourage responsible behavior on the part of all staff. The charge nurse is performing a part of the responsibility of the charge nurse and should be encouraged to work with the UAP.**
3. Because this is not a private conversation about a client, there is no reason for the charge nurse to be told to go to a private area. The charge nurse is not reprimanding the UAP.
4. The director of nurses should not interfere with a "better explanation." This could intimidate the charge nurse and make it difficult for the charge nurse to perform his or her duties.

Content – *Medical/Surgical:* ***Category of Health Alteration*** – *Management of Care:* ***Integrated Processes*** – *Nursing Process: Implementation:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Application*

27.

1. **Wound debriding formulations are medications, and a UAP cannot administer medications.**
2. The UAP can position the resident so that pressure is not placed on the resident's heels.
3. The UAP can turn the resident.
4. The UAP can give the resident a protein shake to drink.

Content – *Medical/Surgical:* ***Category of Health Alteration*** – *Drug Administration:* ***Integrated Processes*** – *Nursing Process: Planning:* ***Client Needs*** – *Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** – *Synthesis*

28.

1. The nurse should implement the least restrictive measures to ensure client safety. Restraining a client is one of the last measures implemented.
2. **Moving the client near the nursing station where the staff can closely observe the client is one of the first measures in most fall prevention policies.**
3. This is considered medical restraints and is one of the last measures taken to prevent falls.
4. Four side rails are considered a restraint. Research has shown that having four side rails up does not prevent falls and only gives the client farther to fall when the client climbs over the rails before falling to the floor.

***Content** – Medical/Surgical: **Category of Health Alteration** – Safety: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Safe and Effective Care Environment: Safety and Infection Control: **Cognitive Level** – Application*

29. **1. The first intervention is for the nurse to ensure the client is safe in the home. Assessing for grab bars in the bathroom is addressing the safety of the client.**
2. Taking a shower in a stall shower may be safer than getting in and out of a bathtub, but the nurse should first determine whether the client has grab bars and safety equipment even when taking a shower.
3. According to the NCLEX-RN® test blueprint for management of care, the nurse must be knowledgeable of referrals. The physical therapist is able to help the client with transferring, ambulation, and other lower extremity difficulties and is an appropriate intervention, but it is not the nurse's first intervention. Safety is priority.
4. NSAIDs are used to decrease the pain of osteoarthritis, but this intervention will not address safety issues for the client getting into and out of the bathtub.

***Content** – Medical/Surgical: **Category of Health Alteration** – Safety: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Safe and Effective Care Environment: Safety and Infection Control: **Cognitive Level** – Synthesis*

30. 1. The employee health nurse should keep the clients at the clinic or send them to the emergency department. The clients should be kept together until the cause of their illnesses is determined. If it is determined that the clients are stable and not contagious, they should be driven home.
2. The employee health nurse should be aware that six clients with the same signs/symptoms indicate a potential deliberate or accidental dispersal of toxic or infectious agents. The nurse must notify the public health department so that an investigation of the cause can be instituted and appropriate action to contain the cause can be taken.
3. As long as the clients are stable, the nurse should keep the clients in the employee health clinic. These clients should not be exposed to other clients and emergency department staff. If the clients must be transferred, decontamination procedures may need to be instituted.
4. The client may need to provide stool specimens, but this would be done at the emergency department. Employee health clinics do not have laboratory facilities to perform tests on stools.

***Content** – Medical/Surgical: **Category of Health Alteration** – Infection Control: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Safe Effective Care Environment: Safety and Infection Control: **Cognitive Level** – Application*

31. 1. This child needs an x-ray to rule out a fractured left leg, but this is not life threatening.
2. Drooling and not wanting to swallow are the cardinal signs of epiglottitis, which is potentially life threatening. This child should be assessed first. The nurse should not attempt to visualize the throat area and should allow the HCP to do this in case an emergency tracheostomy is required.
3. A child usually does not complain of a headache and this child should be assessed, but it is not life threatening.
4. This client may have type 1 diabetes mellitus and should be assessed, but this is not life threatening at this time.

***Content** – Medical/Surgical: **Category of Health Alteration** – Pediatrics: **Integrated Processes** – Nursing Process: Assessment: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Analysis*

32. 1. This is an example of community-based nursing where nurses care for a client living in the community.
2. Community-oriented, population-focused nursing practice involves the engagement of nursing in promoting and protecting the health of populations, not individuals in the community. Therefore, this is an example of community-oriented, population-focused nursing.
3. This is an example of community-based nursing where nurses care for a client living in the community.
4. This is an example of community-based nursing where nurses care for a client living in the community.

***Content** – Medical/Surgical: **Category of Health Alteration** – Community Health: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Comprehension*

33. 1. Dyspnea and confusion are not expected in a client diagnosed with AIDS; therefore, this client would warrant a more experienced nurse to assess the reason for the complications.
2. The client with financial problems should be assigned to a social worker, not to a nurse.
3. A full-thickness (third-degree) burn is the most serious burn and requires excellent

assessment skills to determine whether complications are occurring. This client should be assigned to a more experienced nurse.

4. The client diagnosed with diabetic neuropathy would be expected to have pain; therefore, this client could be assigned to a nurse new to home health nursing. The client is not exhibiting a complication or an unexpected sign/symptom.

Content *– Medical/Surgical:* ***Category of Health Alteration*** *– Endocrine:* ***Integrated Processes*** *– Nursing Process: Planning:* ***Client Needs*** *– Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** *– Synthesis*

34. 1. The nurse cannot delegate assessment to the HH aide.
2. The HH aide cannot assess the incisional wound, and the wound should be assessed. The nurse cannot delegate assessment.
3. The HH aide can place the right leg on two pillows. This task does not require assessment, teaching, or evaluating, and the client is stable.
4. Mopping the floor is not part of the HH aide's responsibility. This is not an appropriate task to delegate.

Content *– Medical/Surgical:* ***Category of Health Alteration*** *– Musculoskeletal:* ***Integrated Processes*** *– Nursing Process: Planning:* ***Client Needs*** *– Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** *– Synthesis*

35. 1. The nurse would expect the client diagnosed with a myocardial infarction to have an elevated troponin level; thus, the nurse would not assess this client first.
2. Because the client's PTT of 68 seconds is 1.5 to 2 times the normal range, it is considered therapeutic and would not warrant the nurse's assessing this client first.
3. The nurse would expect a client with end-stage liver failure to have an elevated ammonia level.
4. The therapeutic range for Dilantin is 10 to 20 mg/dL. This client's higher level warrants intervention because the serum level is above the therapeutic range.

Content *– Medical/Surgical:* ***Category of Health Alteration*** *– Laboratory Values:* ***Integrated Processes*** *– Nursing Process: Assessment:* ***Client Needs*** *– Physiological Integrity: Reduction of Risk Potential:* ***Cognitive Level*** *– Analysis*

36. 1. This client would not benefit from acupuncture.
2. Mental health issues are not treated with acupuncture. They may be treated with herbal supplements.
3. The client with asthma must be treated with a medical regime.
4. Acupuncture, the most common complementary therapy recommended by healthcare providers, would benefit a client with osteoarthritis.

Content *– Medical/Surgical:* ***Category of Health Alteration*** *– Complementary Alternative Medicine:* ***Integrated Processes*** *– Diagnosis:* ***Client Needs*** *– Physiological Integrity: Pharmacological and Parenteral Therapies:* ***Cognitive Level*** *– Analysis*

37. 1. The nurse should not make the client dependent on family members to prepare meals. If the family were willing to do this, they would probably already be doing it.
2. The occupational therapist would teach the client how to cook, but this client is 88 years old and needs meals provided. Therefore, providing meals through Meals on Wheels is the most appropriate intervention.
3. The HH aide's duties do not include cooking all three meals for the client.
4. Meals on Wheels delivers a hot, nutritionally balanced meal once a day on weekdays, usually at noon for older people who do not have assistance in the home for food preparation. This intervention would be most helpful to the client.

Content *– Medical/Surgical:* ***Integrated Processes*** *– Nursing Process: Implementation:* ***Client Needs*** *– Psychosocial Integrity:* ***Cognitive Level*** *– Application*

38. 1. HH care agency employees are responsible for knowing and adhering to the professional boundary-crossing standards. The nurse should not discuss this with the client.
2. Home healthcare agencies are required by law to address the concepts in the National Association for Home Care (NAHC) Bill of Rights with all home health clients on the initial visit. The agencies may also make additions to the NAHC's original Bill of Rights.
3. The nurse should discuss this with the client, but it is not a legal intervention.
4. This is a true statement, but it is not a legal intervention. If the client is not homebound, he or she is not eligible for home healthcare.

Content *– Legal:* ***Integrated Processes*** *– Nursing Process: Implementation:* ***Client Needs*** *– Safe and Effective Care Environment: Management of Care:* ***Cognitive Level*** *– Application*

39. 1. Taping petroleum gauze over the chest tube insertion site will prevent air from entering the pleural space. This is the first intervention.

2. The nurse should make sure the UAP knows the correct method to assist a client with a chest tube, but the safety of the client is the first priority.
3. This is the second intervention the nurse should implement. Remember, if the client is in distress and the nurse can do something to relieve that distress, then the nurse should not assess first. The nurse should take action to take care of the client.
4. The nurse should obtain the necessary equipment for the HCP to reinsert the chest tube, but the priority intervention is to prevent air from entering the pleural space.

***Content** – Medical/Surgical: **Category of Health Alteration** – Respiratory: **Integrated Processes** – Nursing Process: Implementation: **Client Needs** – Physiological Integrity: Reduction of Risk Potential: **Cognitive Level** – Analysis*

40. **1. The LPN can administer routine medications.**
2. The UAP, not the LPN, should be assigned to take the routine vital signs.
3. The unit secretary, not an LPN, should be assigned to transcribe the HCP orders.
4. The RN, not the LPN, should assess the urinary output of the client. The RN should not delegate assessment.

***Content** – Management of Care: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

41. 1. The clinical manager may need to discuss the MAR with some nurses individually, but it is not the clinical manager's first intervention.
2. The first intervention should be to arrange meetings to explain the new MAR and allow nurses to ask questions to clarify the new policy.
3. The clinical manager can provide a written handout explaining the new MAR, but the first intervention should be small discussion groups.
4. A video is an excellent tool for explaining new procedures, but the first intervention should be small discussion groups so that all questions can be answered.

***Content** – Medical/Surgical: **Category of Health Alteration** – Drug Administration: **Integrated Processes** – Nursing Process: Planning: **Client Needs** – Safe and Effective Care Environment: Management of Care: **Cognitive Level** – Synthesis*

42. 1. The nurse would expect the client with an abdominal aortic aneurysm to have an audible bruit; therefore, this client does not warrant immediate intervention.
2. The nurse would expect the client with ARDS to have respiratory signs/symptoms; therefore, this client does not warrant immediate intervention.
3. One of the signs/symptoms of bacterial meningitis is nucal rigidity; therefore, this client does not warrant immediate intervention.
4. The client with Crohn's disease should be asymptomatic, so pain and diarrhea warrant intervention by the nurse. Pain could indicate a complication.

***Content** – Medical/Surgical: **Category of Health Alteration** – Gastrointestinal: **Integrated Processes** – Nursing Process: Assessment: **Client Needs** – Physiological Integrity: Reduction of Risk Potential: **Cognitive Level** – Analysis*

43. 1. The client with chronic kidney disease (CKD) would have an elevated creatinine level. The normal creatinine level is 0.7 to 1.8 mg/dL. The data would not warrant immediate intervention.
2. Peritonitis, inflammation of the peritoneum, is a serious complication that would result in a hard, rigid abdomen; therefore, a soft abdomen would not warrant immediate intervention.
3. The dialysate return should be colorless or straw colored but should never be cloudy, which indicates an infection; therefore, the data warrant immediate intervention.
4. Because the client has ESRD, fluid must be removed from the body, so the output should be more than the amount instilled; therefore, this indicates the peritoneal dialysis is effective and does not warrant intervention.

***Content** – Medical/Surgical: **Category of Health Alteration** – Genitourinary: **Integrated Processes** – Nursing Process: Assessment: **Client Needs** – Physiological Integrity: Reduction of Risk Potential: **Cognitive Level** – Analysis*

44. 1. The nurse could ask this question, but the client has already told the nurse that 3 years have passed, so the client has tried approximately 36 times.
2. This is the best question to assess the client. The nurse would not want to suggest an intervention that has been futile.
3. Infertility treatments are very expensive, but the nurse should assess the client's attempts.
4. This question is not helpful for assessing the client or addressing the client's statement.