**Institution:** Great Bay Community College

**Course:** Nursing I, NURS 111

**Required Text:** *Fundamentals of Nursing*, 7th Edition; Potter and Perry

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Great Bay Community College

Department of Nursing

Course Information

Course Number:     NURS111
Course Title:      Nursing I
Theory Hours:     90
Learning Laboratory & Clinical Learning:  135
Course credit:      9
Prerequisites:      Admission to the Nursing Program
Faculty:      Nursing faculty
Placement in Curriculum:    First semester freshman year
Co-requisite or completion of:   Anatomy & Physiology I (BIOL110)
Introduction of Psychology (PSYC110)

I.  Course Description:

Students begin learning the roles of the Associate Degree Nurse as a provider and manager of care and member of the discipline of nursing. Students develop beginning intellectual, interpersonal and psychomotor competencies to assess well clients and clients with common actual or possible alterations in health. The roles of the nurse, communication theory, lifespan development, ethical-legal standards, and nursing process are basic concepts of the practice of nursing for the Associate Degree Nurse. Students are introduced to the concept that the person is a system in dynamic interaction with the internal and external environments. The eleven Functional Health Patterns organize the study of concepts common to a basic knowledge of the client’s state of wellness and possible or actual health problems. The Learning Laboratory provides opportunities to practice nursing skills in simulated activities. Clinical Learning provides experiences to practice nursing by caring for well clients or clients with common basic health problems in the nursing home and structured health settings.
II. Course Outcomes:

At the completion of the course the student will be able to:

1. Utilize beginning intellectual, interpersonal, and psychomotor skills when providing safe nursing care for adult clients in structured settings.
2. Utilize the eleven Functional Health Patterns as a method of gathering client data.
3. Utilize process recordings to identify verbal and nonverbal interpersonal communication in the nurse-client relationship.
4. Utilize nursing process to assess select clients.
5. Identify components of a teaching plan for adult clients.
7. Communicate with members of the health care team regarding client information.
8. Identify legal and ethical situations in caring for clients.
9. Identify, with faculty assistance, personal learning needs and needed remediation.

III. Learning Methods

Classroom discussion, case presentations, assessment tools, care plans, computer assisted instruction (CAI), audiovisuals, and simulated/clinical learning including modified functional health pattern care plans, process recordings, and teaching plans.

IV. Evaluation Methods

Written testing, final examination, observation and performance of procedures in learning and clinical laboratory are used to evaluate learning. Test material will be taken from all required readings, audiovisuals, CAIs, handouts and classroom content.

- Tests are worth 75% of the grade.
- Final exam is worth 25% of the grade.
- Clinical is a Pass/Fail grade.
- Skills laboratory is a Pass/Fail grade.

Theory and clinical components must be successfully completed concurrently. If the student receives a failing grade in the clinical portion, they will receive a failing grade in the nursing course. Students must demonstrate competency in math and laboratory learning skills in order to proceed to NURS112. Students that fail the course because of unsafe practice involving actions or non-actions are not eligible for re-admission to the nursing program.
V. Health Requirements/Technical Standards

All nursing students must have submitted copies of the following documentation one week prior to the first scheduled day of clinical. Other Health Requirements/Technical Standards may also be applicable as deemed necessary by individual clinical agency contracts.

A. Health Record Documentation

- Health and immunization forms completed and signed by MD/ARNP/PA within 1 year of beginning first nursing course including history, examination and immunization data, and titers, as necessary.

- Verification of 2-step Mantoux test for tuberculosis (TB) must remain current throughout the program.
  - If the student has tested within the past year for TB, then documentation verifying the previous year’s Mantoux test results should be provided.
  - If the student has not been tested within the past year, a 2-step Mantoux is required: Step I: A Mantoux test is given and read within 48-72 hours. Step II: 2-3 weeks later, the process is repeated.
  - If a student has tested positive for TB or has had the BCG vaccination, then documentation from the physician including a negative chest X-ray is required.

- Hepatitis B vaccine 3 dose and titer documentation: If a student does not wish to have the vaccine, a signed waiver is required. If a student has begun the Hepatitis B vaccine series, documentation of doses is required.

B. Insurance

- Personal Health and Accident Insurance: A copy of the card with number or copy of the check with information (if obtained through Commercial Travelers Mutual Insurance Company, after July 1) must be presented. The insurance must be kept current throughout the program.
- Liability Insurance Group Policy: A copy of the receipt obtained from the cashier at Great Bay Community College must be kept current throughout the program.

C. CPR

A copy of the front and back of the CPR Professional Rescuer, 1 and 2 person with adult, infant and child, and AED. This certification must be kept current throughout the program.
D. Criminal Background Check:

Students will be required to undergo background checks through Certified Background at least on an annual basis and more frequently if indicated. Certain clinical agencies may require an additional background check, and they may or may not bear the costs depending on the circumstances.

Results of the criminal background check that will result in exclusion of applicants from the program include, but are not limited to, felony parameters set by the New Hampshire Board of Nursing as bars to licensure as a Registered Nurse or Practical Nurse. These can be found at: http://www.nh.gov/nursing/board/permanent_bar.htm

If a background check reveals other significant criminal history, you will be notified in writing and will be requested to submit a written explanation. The results of acceptable criminal background checks will be maintained in a locked file in the Nursing Department Office and shredded when the student graduates. Background check reports that reveal a history of legal problems will be kept in a locked file for seven years, regardless of whether the student is allowed to matriculate or whether the nursing student completes the program.

Background checks are extremely rigorous and if at any time a student’s background check identifies any criminal record that would preclude participation in any clinical experience and/or that would prevent licensure, the student will be immediately suspended from the program for an indefinite period of time until the issue is resolved.

E. Drug Testing:

To ensure practice consistent with the Nurse Practice Act, all registered students are required to undergo drug testing each academic year. Students who do not complete required testing will not be allowed to attend clinical activities until the requirement is met. Days missed will count as clinical absences and must be made up. This testing is mandatory and there are no exceptions to this policy. You must complete urine testing screening that has been arranged at Seacoast RediCare, Occupational Health Services located in Somersworth, NH.

*Nursing students who have not completed Health Requirements/Technical Standards will not be permitted to begin their clinical rotation. Days missed due to incomplete documentation of Health Requirements/Technical Standards will count as clinical absences and will need to be made up following the Clinical Makeup Policy.

Revised 04/07; 02/08; 02/09; 5/10


Recommended Textbooks

Drug Reference Books

Lab & Diagnostic Tests

Medical Dictionary
1. A sixteen year old marathon runner is admitted to the emergency room on a hot, summer day with temperature of 39.5°C, flushed, dry skin, poor skin turgor, weakness and muscle cramps. The heart rate is 140 beats/minute and the blood pressure is 68/40. The nursing intervention with highest priority for this client is:

   a. Initiate intravenous infusion to restore fluid balance
   b. Initiate a cooling blanket to restore normothermia
   c. Administer an antipyretic to restore normothermia
   d. Provide frequent oral hygiene and change of damp linens for comfort

2. A newborn infant returns to the nursery after spending two hours with the mother. The nurse notes that the infant’s axillary temperature is 34°C. Potential contributing causes of the altered thermoregulation in this infant include:

   a. Excessive blankets tucked around the infant in a warm room
   b. Overdeveloped thermoregulatory mechanisms
   c. Lack of infant head covering while rooming with the mother
   d. Skin to skin contact between the infant and mother while nursing

3. The assessment finding most likely to represent a serious condition in a 2 year old is:

   a. A heart rhythm that increases with inspiration and slows down with expiration.
   b. A murmur.
   c. Pulse rate of 50 beats per minute.
   d. Respiratory rate of 20 breaths per minute.

4. Nurse explains the blood pressure to a client as:

   a. The pressure in the veins generated by the pumping of the heart
   b. The pressure in the arteries when the heart fills and contracts
   c. The pressure in the heart when it is at rest
   d. The pressure in the heart when it is pumping on the right side.
5. A client is receiving oxygen therapy at 5 liters nasal cannula as ordered by the physician. Nursing interventions to promote comfort and prevent complications of oxygen therapy include all of the following EXCEPT.

a. Provide frequent mouth care.
   b. Apply petroleum jelly to the lips.
   c. Pad the tubing on the nasal cannula to prevent pressure on the ears.
   d. Humidify the oxygen.

6. The best intervention to optimize gas exchange for a client who demonstrates wheezing on auscultation of the lungs is:

a. Encourage use of incentive spirometer.
   b. Encourage oral fluids.
   c. Encourage coughing and deep breathing.
   d. Administer bronchodilator therapy by nebulizer.

7. A nurse is manually removing fecal material from the rectum of a client (disimpacting). The client complains of dizziness during the procedure. The nurse should:

a. Discontinue the procedure and take vital signs
b. Explain that this is a normal response to disimpaction
c. Proceed to give an enema
d. Instruct the client to take slow, deep breaths

8. The correct way to administer an enema is:

a. Assist the client to lie on the right side during the procedure
b. Suspend the enema bag three feet above the abdomen
c. Insert the enema tubing 10 inches into the bowel
d. Warm the enema solution to room temperature

9. Signs of poor neurological functioning in an ADULT include all of the following except: (Choose all that apply)

a. Inability to follow commands
b. Negative Babinski reflex (downgoing toes)
c. Does not open eyes to voice
d. Positive sucking and rooting reflex
10. Signs of neurological problems in toddlers may include:
   a. Wide, staggering gait
   b. Poor school performance
   c. Delayed attainment of developmental milestones
   d. Limited frustration tolerance

11. Initial sensory assessment includes:
   a. Assessment of ability to identify pain by pricking the client with a safety pin
   b. Testing all dermatones for ability to identify pain, light touch and position sense
   c. Testing select dermatones to identify pain, light touch and position sense
   d. Testing young children in the same manner as an adult

12. A newly admitted client reports a penicillin allergy. The doctor has ordered a second-generation cephalosporin as part of the therapy. Which of the nursing actions below is appropriate?
   a. Call the doctor to clarify the order because of the client’s allergy.
   b. Give the medication and monitor of adverse effects.
   c. Ask the pharmacy to change the order to a first-generation cephalosporin.
   d. Administer the drug with an non-steroidal anti-inflammatory to reduce effects.

13. While assessing a woman who is receiving an antibiotic for community acquired pneumonia, the nurse notes that the client has a thick, white vaginal discharge. The client is also complaining about perineal itching. The nurse suspects that the client has
   a. Resistance to the antibiotic.
   b. An adverse effect of the antibiotic.
   c. A superinfection.
   d. An allergic reaction.

14. The type of family unit that presents the highest risk for fatigue, role overload, poverty and depression is the:
   a. Blended family
   b. Gay or lesbian family
   c. Single-parent family
   d. Two-career family
15. After the death of her husband, a 72-year-old client goes to live with her daughter, son-in-law, and two grandchildren. With this addition the family has changed from a(n):

   a. Extended family to a cohabitating family  
   b. Blended family to an adoptive family  
   c. Nuclear family to an extended family  
   d. Cohabitating family to a nuclear family

16. Which of the following is characteristic of a healthy community?

   a. Allows groups in the community to solve disputes among themselves in their own way.  
   b. Has a smoothly functioning government that requires minimal citizen participation.  
   c. Socially controls subgroups so that they do not influence community decisions.  
   d. Makes system resources available to all members of the community.

17. The mother of a 2-year-old child is frustrated because the child does not want to go to bed at the scheduled bedtime. The nurse should suggest that the parent:

   a. Offer the child a bedtime snack  
   b. Eliminate one of the naps during the day  
   c. Allow the child to sleep longer in the mornings  
   d. Maintain consistency in the same bedtime ritual

18. The nurse recognizes that the sleep patterns of older adults differ and older adults generally:

   a. Are more difficult to arouse  
   b. Require more sleep than middle-age adults  
   c. Take less time to fall asleep  
   d. Have a decline in stage 4 sleep

19. Which of the following symptoms should the nurse assess with a client who is deprived of sleep?

   a. Elevated blood pressure and confusion  
   b. Confusion and irritability  
   c. Inappropriateness and rapid respirations  
   d. Decrease temperature and talkativeness
20. A client is scheduled for cardiac surgery. The nurse is conducting a sexual history and is told that he is nervous about resuming sexual activities. The nurse uses therapeutic communication with the client when responding:

a. “You can have sexual intercourse after your surgery, but there are serious risks.”
b. “Your partner will be nervous about resuming sexual activities, but that is only normal.”
c. “Don’t worry. In about 2 months you will be able to return to your normal sexual patterns.”
d. “You are expressing a very normal concern, perhaps we could discuss your feelings further.”

21. The drug of choice for a treating a pregnant woman with Chlamydia is:

a. Doxycycline (Vibramycin).
b. Amoxicillin (Amoxil).
c. Acyclovir (Zovirax).
d. Miconazole (Monistat).

22. Which sexually transmitted disease (STD) causes a painless ulcer on the vulva or vagina?

a. Trichomoniasis
b. HIV
c. Chlamydia
d. Syphilis

23. A client’s basal body temperature (BBT) graph shows a nearly straight line. Which of the following describes the etiology of what the graph means?

a. The client is not ovulating.
b. The client is not having intercourse.
c. The client is ovulating late in her menstrual cycle.
d. The client is not taking her temperature correctly.

24. A major factor contributing to the increased incidence of multiple pregnancies is:

a. Increased use of fertility drugs.
b. Women becoming pregnant at a younger age.
c. Previous pregnancy.
d. Underlying iron deficiency anemia.
25. A client with fallopian tube blockage would be a candidate for which of the following methods of achieving pregnancy?

   a. Natural family planning  
   b. In vitro fertilization  
   c. Tubal ligation  
   d. Sperm washing

26. Which client needs to be seen first in the infertility clinic?

   a. 27 year old woman being seen for an initial infertility exam  
   b. 34 year old man in for semen analysis results  
   c. 32 year old woman on Pergonal and HCG complaining of severe abdominal pain  
   d. 30 year old woman in for pregnancy test following implanatatin of in vitro fertilization

27. Which condition would be most likely to contribute to infertility?

   a. Pelvic Inflammatory Disease (PID)  
   b. Alkalinity of the vaginal pH  
   c. Thin cervical mucus  
   d. A regular menstrual cycle

28. Which is a common discomfort of the third trimester?

   a. Nasal stuffiness  
   b. Nausea and vomiting  
   c. Backache  
   d. Breast sensitivity

29. A client reports that the first day of her last normal menses was January 7th. The calculated estimated date of delivery (EDD) is:

   a. October 14.  
   b. April 14.  
   c. September 31.  
   d. April 7.
30. A woman delivers a baby girl at 38 5/7 weeks gestation. Her baby is considered to have been born

   a. preterm  
   b. term  
   c. postterm  
   d. premature

31. Normal fetal heart rate (FHR) is:

   a. 110-150 beats/minute.  
   b. **120-160 beats/minute.**  
   c. 130-170 beats/minute.  
   d. 140-180 beats/minute.

32. Which signs are considered presumptive signs of pregnancy?

   a. **Nausea and vomiting**  
   b. Visualization of embryo or fetus  
   c. Chadwick’s sign  
   d. Lightening

33. What variables are assessed in a biophysical profile?

   a. Non-stress test, fetal weight, fetal breathing, muscle tone, body movements, and amniotic fluid volume  
   b. **Non-stress test, fetal breathing, body movements, fetal tone and amniotic fluid volume**  
   c. Non-stress test, fetal weight, length, breathing, muscle tone, and body movement  
   d. Fetal length, fetal breathing, muscle tone, body movements, kick count and amniotic fluid volume

34. If a client has a wound with MRSA, precautions for the nurse taking care of the client would include which of the following?

   a. wearing a gown, mask and gloves for all contact  
   b. just gloves for exposure to body fluids  
   c. no precautions special for the client  
   d. **gloves and gown for providing personal care**
35. The best method of limiting spread of pathogens between clients and staff is:
   a. hand washing before & after contact with client, before & after toileting and eating
   b. wearing gloves for all client contact
   c. using sterile technique for all dressings & equipment
   d. wearing two pairs of gloves

36. All clients are on what type of precautions?
   a. Contact isolation
   b. Enteric precautions
   c. **Standard precautions**
   d. Strict isolation

37. If the nurse is caring for a client and family who speak another language and is unable to communicate their needs, the **best option** for the nurse would be:
   a. use paper and pen to help clarify what is needed
   b. ask another nurse to intervene
   c. talk to the supervisor about a translator who would be available
   d. use physical assessment skills to determine what the needs are

38. Which of the following is an example of subjective data?
   a. The client's face is red
   b. The abdomen is hard upon palpation.
   c. The nursing assistant tells you that the client was incontinent of urine
   d. **The client states he feels nauseated**

39. A client is alert and oriented. Three days after admission, you notice that he seems depressed. He tells you, “I’m tired of being sick. I wish I could end it all.” What is the most accurate and informative way to record this data in the nurses’ notes?
   a. Appears to be depressed, possibly suicidal
   b. Complains he is tired of being ill and wants to die
   c. Does not want to live any longer because he is tired of being ill
   d. **Client states, “I’m tired of being sick. I wish I could just end it all.”**
40. While taking an admission history from the mother of an 18-month-old being admitted for surgery, you note that the mother is twisting her rings, running her hands through her hair, and moving about restlessly. When you ask the mother about any problems or concerns, she replies, “Everything is just fine.” The mother’s response is an example of:

a. incongruent communication  
b. inappropriate communication  
c. inadequate language skills  
d. violation of personal space

41. Situation-Background-Assessment-Recommendation (SBAR) is a communication format that can be used for a variety of communication, oral or written. Which of the following statements would NOT be part of an SBAR communication for this particular scenario?

a. Hi Dr. Jones, I’m Jenn, Mr. Roger Smith’s nurse on 4North. He is vomiting mucus and phlegm with some blood tinged fluid.

b. His medical diagnosis is a small bowel obstruction. He hasn’t had results of x-rays yet. He has no bowel sounds in any quadrant and his abdomen is distended and tender to palpation.

c. Would you like us to take a set of vital signs?

d. His Hct & Hgb results are within normal limits, and his small stool was negative for blood via guiac test this morning. BP is 104/52, pulse is 98 and respirations are 28 and labored.

e. May we insert a nasogastric tube to low intermittent suction at this time?

42. You are preparing to give oral care to an unconscious client. How should you proceed?

a. Put the bed in high Fowler’s position before beginning  
b. Lower the head of the bed to almost flat and place the client in side-lying position  
c. Put the client in prone position, then turn her head to the side  
d. Place the client supine with her head lower than her body

43. You have a client who is complaining of abdominal pain. You look at his abdomen, listen for bowel sounds and then feel his abdomen. When you touch and feel his abdomen, this is an example of:

a. auscultation  
b. inspection  
c. palpation  
d. percussion
44. Which of the following menus is acceptable for a client on a clear liquid diet?

a. tea, cola, gélatine, popsicles, apple juice
b. cream of wheat, pudding, ice cream, milk
b. chicken noodle soup, cheese omelet, grapes

c. pancakes, sausage, coffee, orange juice

d. chicken noodle soup, cheese omelet, grapes

45. The label on a food item lists the following information per serving: Calcium 30%, Protein 12g, calories 180, total fat calories 2%, cholesterol 2 mg, and sodium 680 mg. Based on the “finger method” of determining a healthy food, is this a healthy food?

a. yes
b. not enough fat
c. too many carbohydrates
d. too much fat

46. The emaciated, cachectic client on bed rest is at especially high risk for developing which of the following skin problems?

a. blisters
b. pressure sores
c. pustules
d. stasis dermatitis

47. A 3-year-old child has diarrhea and the pediatrician has ordered a BRAT diet for the next 24 hours. The effectiveness of the diet is currently being challenged but still may be helpful in managing the child’s diet. BRAT stands for which foods?

a. Bran, rice crispies, apple juice, and tomatoes
b. Beans, red meat, apples, and tomatoes
c. Bananas, rice, applesauce, and toast/tea
d. Broccoli, red ice pops, apple butter, and tacos

48. Which one of the following foods contains all the complete essential amino acids?

a. eggs
b. whole-wheat cereal
c. potatoes
d. raisins
49. When assessing placement for a PEG tube, you could assess in all the following methods except:
   a. withdraw some gastric contents and test for acidic pH
   b. start the feeding, if it doesn’t run, the tube is plugged
   c. quickly inject small amount of air while listening over the abdomen with a stethoscope
   d. withdraw gastric contents and check for residual content in the stomach

50. A realistic, measurable client goal for someone who has a PEG tube to meet nutritional needs would be:
   a. the client will gain 3 pounds a week
   b. the client will lose only 1 pound a week
   c. the client will maintain current weight and his stage 3 decubiti will decrease in size 1 cm on each border in one week.
   d. none of the above.

51. A client who is receiving parenteral feedings via a PEG tube will be going home. You have just finished providing information to the client and his spouse about the care of the PEG tube. You know he understands how to care for his PEG tube insertion site when he says:
   a. “It’s important that I look at the device and the insertion site every day, take my temperature and call the MD office if I think there’s a problem.”
   b. “It’s important to be very still when the feeding bag is attached so the feeding will flow in properly.”
   c. “It’s important to wash my hands after I change the dressing and to make sure I don’t ever touch the site.”
   d. “It’s all right to keep the same dressings 2-3 days in a row as long as they are not too badly soiled.”

52. Eschar is black, hardened tissue present in a wound bed. What stage would a decubitus ulcer be if eschar is present?
   a. Stage 2
   b. Stage 3
   c. Stage 4
   d. When eschar is present, the wound is unable to be staged until the eschar is removed.
53. Which of the following client situations would help prevent skin breakdown?
   a. friction and shear
   b. turning every 2 hours
   c. incontinence
   d. inability to move independently

54. Which one of the following individuals most likely exhibits dysfunctional grieving?
   a. Someone who visits her mother’s grave frequently in the first 6 months following the death.
   b. Someone who separates from interactions with others for prolonged periods.
   c. Someone who cries for several hours at his partner’s funeral.
   d. Someone who cannot acknowledge the loss of a loved one to others.

55. A 62-year-old client just been diagnosed with terminal cancer and is being transferred to home hospice care. The client’s daughter tells the nurse, “I don’t know what to say to my mother, if she asks me if she is going to die?” Which of the following responses by the nurse would be appropriated?
   a. “Don’t worry; your mother still has some time left.”
   b. “You don’t have to answer her if she asks you about dying...just change the subject.”
   c. “You sound like you have some questions about your mother dying. Let’s talk about that.”
   d. “Don’t worry; hospice will take care of your mother’s needs.”

56. A newly graduated nurse is best prepared for the assignment of his/her first dying client if he/she:
   a. Completed a course dealing with death and dying
   b. Is able to control his/her own personal emotions about death
   c. Has previously experienced the death of a loved one
   d. Has developed a personal understanding of his/her own feelings about death and the dying process

57. A client presents to the ER with tachycardia, sweating, hyperventilation, and “feeling like I’m going to die.” An EKG is obtained and is negative. All medical tests are negative. The nurse plans to teach the client about:
   a. Relaxation techniques.
   b. Using nitroglycerin for chest pain.
   c. Avoiding all stressful situations.
   d. Checking his heart rate twice a day.
58. A student develops a sinus infection toward the end of every semester. When this occurs, which stage of stress is the student most likely experiencing?
   a. Alarm reaction stage
   b. Stage of resistance
   c. Stage of exhaustion
   d. Fight-or-flight stage

59. A client tells the nurse, “I’m told that I should reduce the stress in my life, but I have no idea where to start.” Which would be the best initial nursing response?
   a. “Why not start by learning to meditate? That technique will cover everything.”
   b. “In cases like yours, physical exercise works to elevate mood and reduce anxiety.”
   c. “Reading about stress and how to manage it might be a good place to start.”
   d. “Let’s talk about what is going on in your life and then look at possible options.”

60. A client has just found out that social services has taken custody of her two children due to her neglect. She is very angry, and when a milieu therapist asks her to go to group, she starts yelling and swearing at him. The defense mechanism that the client is using is:
   a. Displacement.
   b. Projection.
   c. Substitution.
   d. Regression.

61. A new nurse on a unit makes a charting error. Although the nurse rectifies the error appropriately, the nurse thinks, “I should have never become a nurse. I’m just no good at this.” What type of thinking does this reflect?
   a. Overgeneralization
   b. Catastrophic thinking
   c. Selective abstraction
   d. Minimization
62. A common mistake nurses make when beginning to develop therapeutic communication techniques is:

a. Using too many different techniques during an interaction
b. Allowing the client to become too anxious before changing the subject
c. Giving advice rather than encouraging the client to problem solve
d. Focusing on what the client is saying rather than on communication techniques

63. This is the first time that a newly admitted client has been in an inpatient psychiatric unit. The client states, “I'm not going to these groups. I'm here to get some rest.” Which nursing response reflects knowledge of milieu therapy?

a. “Group therapy gives you a chance to learn new coping skills and to practice them before you go home.”
b. “Group therapy is mandatory. All clients must attend.”
c. “Group therapy is optional. You can go if you think it will help you or if you find the topic interesting.”
d. “Group therapy is an economical way of providing therapy.”

64. As Client A is being given a tour of the unit, Client B starts to yell and punch the wall. Keeping in mind the principles of the therapeutic milieu, you:

a. Encourage Client B to express himself freely as long as he is not harming anyone else on the unit.
b. Ask Client A to leave the area, and then call staff to help intervene and set limits on Client B.
c. Ask Client A to leave the area, then stand next to Client B and discuss his inappropriate behavior.
d. Continue the tour, ignoring Client B, so Client A will know that such behavior is not rewarded with attention.

65. On the multiaxial DSM-IV-TR assessment, Axis II includes:

a. Mood disorders.
b. Personality disorders.
c. Psychotic disorders.
d. Medical disorders.
66. Symptoms of Major Depressive Disorder include:
   a. Suicidality, hallucinations, delusions.
   b. Elevated mood, pressured speech, guilty feelings.
   c. Sleep disturbance, recklessness, poor appetite.
   d. Low energy, poor concentration, anhedonia.

67. A client with depression refuses to get out of bed for group sessions. Which nursing statement appropriately educates the client about the benefits of physical activity?
   a. “Physical activity is good for everyone especially clients with psychiatric illnesses.”
   b. “Low-intensity exercise is more beneficial than high-impact exercise.”
   c. “People with depression lack certain chemicals in their brains that are improved through physical activity.”
   d. “When you are active physically, it helps you mentally.”

68. A client experiencing hallucinations, delusions of persecution, and poor self care will probably be prescribed a medication in which of the following classifications?
   a. benzodiazepines
   b. mood stabilizers
   c. neuroleptics
   d. antidepressants

69. A client has been diagnosed with Bipolar Disorder. Which of the following symptoms would meet the criteria for this disorder?
   a. Impulsivity, elevated mood, hypervocal speech pattern, alternating with periods of sadness and anhedonia
   b. Difficulty concentrating, delusions of paranoia, poverty of speech alternating with periods of hypomania
   c. Sadness, insomnia, poor appetite, anxiety, anhedonia, alternating with periods of euthymia
   d. Angry outbursts, self-mutilation, unstable personal relationships, black-and-white thinking patterns
70. A 23-year-old client with schizophrenia and auditory hallucinations is refusing her antipsychotic medication. The nurse knows that:

a. if a client is experiencing psychotic symptoms, antipsychotic medications must be given.
b. because the client’s judgment is severely impaired, medication may be disguised in soda or juice.
c. the client will not be allowed in the milieu until compliant with antipsychotic medications.
d. the client can refuse all medication and treatment unless found incompetent by a court of law.

71. The home health nurse is making the initial visit to a 42-year-old male client with terminal cancer. The client is first-generation American-Vietnamese and lives with his parents, wife, and three children. Which behavior would best promote a therapeutic nurse-client relationship?

a. Use questions that require “yes” and “no” answers when possible.
b. Touch the client’s head to assess warmth in case of fever.
c. Assume the client’s smile means the client understands the teaching.
d. Initially address conversation to the eldest family member.

72. After evaluating the meal tray of a Jewish client, the nurse notices that the client ate none of the meal. Which intervention should the nurse implement first?

a. Request the client’s family bring meals the client can eat.
b. Contact the dietary department and request a kosher meal.
c. Notify the local rabbi to request meals be provided for the client.
d. Determine why the client is not eating any of the meal.

73. The client with an Advance Directive (AD) tells the nurse, “I have changed my mind about my AD. I really want everything possible done if I am near death since I have a grandchild.” Which action should the nurse implement?

a. Notify the hospital chaplain to come and talk to the client.
b. Remove the AD from the client’s chart and shred the document.
c. Inform the client that he has the right to revoke his AD at any time.
d. Explain that this document cannot be changed once it is signed.
74. What type of authority regulates the practice of nursing?

a. International standards and codes
b. Federal guidelines and regulations
c. **State nurse practice acts**
d. Institutional policies

75. Nurse advocates often are conflicted about respecting a client’s right to be self-determining, while at the same time wanting to do everything in their power to promote the client’s best interests. Which is the best general guideline for situations like these?

a. Client rules! “It’s my life.”
b. Nurse rules! “It is your life, but in this instance you don’t have enough information to make the right choice.”
c. **When in conflict, weigh the benefits and risks of following each option and choose wisely.**
d. None of the above.

76. The client is to undergo an invasive procedure. While presenting information about the procedure, the nurse provides legal protection of a client’s right to autonomy by advocating for which of the following?

a. Informed consent
b. Beneficence
c. Good Samaritan law
d. Advance directives

77. Which of the following is a true statement regarding the half-life of a medication?

a. **The greater the half-life, the longer it takes for the drug to be excreted.**
b. The longer the half life of a drug, the shorter the effect the drug will have on the body.
c. Half-life and therapeutic range are terms that may be used interchangeably.
d. When you know the loading dose, you know the half-life of the drug.
78. Which of the following routes of medication delivery do not avoid the first-pass effect?
   a. Rectal
   b. Musculoskeletal
   c. Oral
   d. Parenteral

79. A nurse discovers that she has made a medication error. Which of the following should be her first response?
   a. Record the error on the medication sheet
   b. Notify the physician regarding course of action.
   c. Check the client’s condition to note any possible effect of the error.
   d. Complete an incident report, explaining how the mistake was made.

80. When asked why ibuprofen (Motrin et al.), an NSAID, can be more effective than acetaminophen (Tylenol et al.) in the treatment of osteoarthritis, what would be the provider’s correct response?
   a. acetaminophen (Tylenol) has less analgesic activity.
   b. acetaminophen (Tylenol) has no antipyretic activity.
   c. acetaminophen (Tylenol) has no anti-inflammatory activity.
   d. “There really are no differences; it is a matter of personal preference.”

81. A nurse receives an order for aspirin 82 mg po once daily. The nurse knows this medication is given at this dose level for what reason?
   a. To prolong clotting time
   b. To fight infection
   c. To relieve pain
   d. To decrease inflammation

82. A client presents to the Emergency Department with a known overdose of morphine sulfate. What high priority nursing assessment would the nurse be likely to make in this situation?
   a. Dilated pupils
   b. Depressed respirations
   c. Hypertension
   d. Diarrhea
83. Which of the following is a cardioselective beta-blocking agent?

   a. propranolol (Inderal)
   b. doxazosin (Cardura)
   c. ipratropium (Atrovent)
   d. atenolol (Tenormin)

84. The primary action of digoxin (Lanoxin) that makes it very effective at treating heart failure is its ability to do which of the following?

   a. Dilate the coronary arteries
   b. Increase impulse conduction across the myocardium
   c. Decrease blood pressure
   d. Increase cardiac contractility/output

85. A medication order reads: potassium chloride (K-Dur), 20 mEq PO bid. When does the nurse correctly give this drug?

   a. Daily before bedtime
   b. By mouth every other day
   c. Twice a day by the oral route
   d. Once a week after recording an apical rate

86. You are to administer a medication using a nasogastric tube. Before giving the medication, what should you do?

   a. Crush the enteric-coated pill for mixing in a liquid.
   b. Flush the tube with 60 mL of very warm water.
   c. Check for proper placement of the nasogastric tube.
   d. Take the client’s vital signs.

87. The nurse is to administer 25 mg of promethazine (Phenergan) intramuscularly (IM) to a 150-pound client. The nurse knows that this medication should be given deep into a large muscle mass. Which site should the nurse select to inject the medication?

   a. Deltoid
   b. Dorsogluteal
   c. Vastus lateralis
   d. Ventrogluteal
88. The nurse must monitor for the most serious adverse effect of anticoagulant therapy. Which of the following is the most serious?

   a. Hemorrhage
   b. Severe headaches
   c. Electrolyte depletion
   d. Cardiac arrhythmias

89. The nurse is preparing an intramuscular (IM) injection of hydroxyzine (Vistaril) which is especially irritating to subcutaneous tissue. To prevent “tracking” of the medication and irritation to the tissues, it would be best for the nurse to take which action?

   a. Use a small-gauge needle.
   b. Administer at a 45-degree angle.
   c. Apply ice to the injection site.
   d. Use the Z-track technique.

90. A client complains of pain in a site that is different from where it originates. The nurse documents this as what type of pain?

   a. Transient pain
   b. Superficial pain
   c. Phantom pain
   d. Referred pain

91. To relieve her pain, Ann concentrates on a favorite vacation setting. The nurse interprets this technique as which of the following?

   a. Distraction
   b. Imagery
   c. Relaxation
   d. Recall

92. Mrs. Young is receiving a long acting opioid for treatment of terminal cancer. She has recently reported several episodes of breakthrough pain. What treatment is most effective to manage these sudden flare-ups of pain?

   a. Increasing the dose of her long acting medication
   b. Restricting her physical activity
   c. Doing nothing more because her cancer is terminal
   d. Supplementing with doses of a short acting opioid
93. Ten year old Brianna is having a well child check up prior to attending summer camp. When auscultating heart sounds, the nurse identifies a third heart sound. What is her appropriate course of action?

a. She calls it to the attention of Brianna’s pediatrician immediately.
b. She documents the finding and recognizes it as a normal occurrence in children.
c. She advises that Brianna may attend camp, but that she should not engage in strenuous activities like mountain climbing.
d. She suggests that Brianna’s mom start including more leafy green vegetables in the child’s diet.

94. Monica, a pediatric nurse practitioner, will perform a head to toe assessment for 6 year old Jeremy who is scheduled for repair of a right inguinal hernia next week. In preparation for this examination, which one of the following actions will Monica correctly plan to implement?

a. Adhere strictly to the standardized head to toe assessment pattern because this has proven to give the best results.
b. Firmly, but kindly, tell Jeremy’s mom that she must leave during the assessment.
c. Adapt the pattern of assessment to Jeremy’s particular developmental needs.
d. Document the assessment according to the exam sequence used.

95. When auscultating lung sounds for a client with advanced emphysema, what deformity is the nurse likely to observe?

a. kyphosis.
b. barrel chest.
c. scoliosis.
d. funnel chest.

96. Which action would the nurse take to use a wide base of support when assisting a client to get up from a chair?

a. Bend at the waist and place arms under the client’s arms and lift.
b. Face the client, bend knees, and place hands on client’s forearms and lift.
c. Spread feet apart before touching the patient.
d. Tighten the pelvic muscles before assisting the client.
97. Using the principles of standard precautions, the nurse decides to apply gloves when performing which of the following nursing interventions?

a. Providing a back massage
b. Feeding a client
c. Providing hair care
d. Providing oral hygiene

98. Which of the following care approaches would be the most appropriate for the nurse to use when caring for an unresponsive comatose client?

a. Keep radio or TV on at a moderate volume at all times.
b. Avoid verbal communication while client appears unresponsive; focus instead on gentle touch and physical care.
c. Speak normally and as if client can hear and understand what is being said.
d. Direct verbal communication to family members at that bedside, providing them realistic updates on client’s condition.

99. The hospital sets up a booth at the elementary school open house to distribute written information regarding use of helmets for school age children when riding bikes or roller skating. This type of outreach is an example of:

a. Primary Prevention
b. Recreational Advice
c. Tertiary Prevention
d. Ambulatory Care

100. Which of the following health care plans is a federally funded and administered program for US residents over the age of 65?

a. Preferred provider organization (PPO)
b. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
c. Long term care insurance
d. Medicare
101. Factors affecting health care today include:

1. Economics
2. Younger population
3. Less technology due to lawsuits
4. Advances in pharmaceuticals

   a. 2 and 3
   b. 1 and 4
   c. 1, 2 and 4
   d. 1, 2 and 3

102. You have a client who is complaining of abdominal pain. You look at his abdomen, listen for bowel sounds and then feel his abdomen. When you touch and feel his abdomen, this is an example of:

   a. auscultation
   b. inspection
   c. palpation
   d. percussion

103. Which of the following is an example of subjective data?

   a. The client’s face is red.
   b. The abdomen is hard upon palpation.
   c. The nursing assistant tells you that the client was incontinent of urine.
   d. The client states he feels nauseated.

104. A client is alert and oriented. Three days after admission, you notice that he seems depressed. He tells you, “I’m tired of being sick. I wish I could end it all.” What is the most accurate and informative way to record this data in the nurses’ notes?

   a. Appears to be depressed, possibly suicidal
   b. Complains he is tired of being ill and wants to die
   c. Does not want to live any longer because he is tired of being ill
   d. Client states, “I’m tired of being sick. I wish I could just end it all.”
105. What is the problem with the following outcome goal? “Client will ambulate 50 yards with walker and one assist”?

a. None, the goal is written correctly  
b. It is not measurable  
c. No time frame is given  
d. Client behavior is missing

106. The nursing process components may overlap in practice. In which of the following are the components listed in the order in which they generally occur?

a. assessing, planning, diagnosing, evaluating, implementing  
b. assessing, diagnosing, planning, implementing, evaluating  
c. planning, assessing, diagnosing, implementing, evaluating  
d. diagnosing, implementing, evaluating, assessing, planning

107. An example of objective data is:

a. report of nausea  
b. measurement of blood pressure  
c. complaint of joint pain  
d. report of headache

108. Which of the following activities are performed during the planning step of the nursing process?

a. Collect, validate and organize data  
b. Establish priorities, determine client goals, and outcome behaviors  
c. Perform nursing interventions and record actions  
d. Evaluate outcome behaviors and appropriateness of interventions

109. If the nurse is caring for a client and family who speak another language and is unable to communicate their needs, the best option for the nurse would be:

a. use paper and pen to help clarify what is needed  
b. ask another nurse to intervene  
c. talk to the supervisor about a medical translator who would be available  
d. use physical assessment skills to determine what the needs are
110. According to Erikson’s theory of psychosocial development, the central task in infancy is the establishment of?

   a. Autonomy  
   b. Trust  
   c. Independence  
   d. Cognitive awareness

111. The most important cancer screening test for middle age or older adult males is a(n):

   a. monthly testicular self-examination  
   b. monthly blood pressure check  
   c. annual prostate examination and annual PSA (prostate-specific antigen)  
   d. annual MRI scan

112. Using Erikson as a framework, which activity would best support the developmental crisis of a sixteen-year-old boy hospitalized with asthma?

   a. Allow him to choose his own foods from a menu to encourage autonomy.  
   b. Allow him to use Legos since he should have mastered that skill and this would improve his feelings of inferiority.  
   c. Encourage him to learn to manage his asthma with inhalers to be able to effectively participate on his high school soccer team since identity is a task of the adolescent.  
   d. Encourage him to create a list of how he contributes to society to avoid role confusion.

113. An elderly, terminally ill client is being cared for by her only daughter. The daughter expresses a fear of not knowing how to care for her mother appropriately. Which nursing diagnosis is most appropriate?

   a. Social isolation  
   b. Powerlessness  
   c. Situational low self-esteem  
   d. Ineffective role performance
114. The nurse is interviewing an adolescent client. The nurse can best facilitate communication with the adolescent client by making which statement?

a. “If you read the pamphlet you’ll know all you need to know.”
b. “Tell me about the last time you had sexual intercourse.”
c. “We can talk about this with your mother.”
d. “Other teenage girls also feel depressed.”

115. A client has been in the intensive care unit for 4 days and has started to show signs of restlessness and anxiety, and the nurse believes the client is experiencing sensory overload. Which of the following interventions will be most therapeutic in assisting the client?

a. Limiting interaction with the client to the safe minimum
b. Moving the client to a space furthest from the nursing station
c. Keeping the client’s lights dimmed and curtains partially drawn
d. Asking the client’s health care provider to consider early discharge from the unit

116. At the end of a teaching session, the nurse suggests that the client practice drawing up and injecting medication several times before their next teaching session. This suggestion is based on the principle that:

a. Readiness is essential for learning.
b. Meaningful feedback enhances learning.
c. Repetition facilitates retention of newly learned material.
d. Learning is facilitated by organizing material so that it proceeds from simple to complex.

117. The nursing diagnosis of deficient knowledge can be related to:

a. Cognitive limitation
b. Lack of exposure to the subject
c. Lack of recall
d. All of the above
118. Shelley is having a problem with urination. When she voids, the urine is warm and burning, she feels she has to void frequently and yet has hesitation when she does go to the bathroom. The physician has ordered sulfamethorazide with trimethoprin (Bactrim DS) for 5 days. As the nurse, what recommendations would you give to Shelley as you are discussing the proposed sulfonamide treatment?

1. drink plenty of fluids, 1500 - 2000 mls daily  
2. take exactly as prescribed and for as long as prescribed  
3. divide dosage over a 24 hour period  
4. avoid acidic foods  
   f. 2 and 3  
   g. 3 and 4  
   h. 1 and 2  
   i. 1,2 and 4

119. The wife of an elderly client asks why her husband is wearing a condom catheter instead of having a “tube” inside of him. The best response by the nurse would be:

a. “He will have less chance of infection with a condom catheter.”  
b. “I could not get the tube inside of him.”  
c. “I did not want to hurt him.”  
d. “I did not want him to pull it out.”

120. Adult urine output of less than _______ indicates possible renal alterations.

a. 30 mL/hr  
b. 10 mL/hr  
c. 100 mL/hr  
d. 200 mL/hr

121. The nurse is caring for a male client who has recently had his left leg amputated. To assess body image, the nurse should gather subjective data such as the:

a. **Client’s feelings regarding surgery.**  
b. Strength of femoral pulses bilaterally.  
c. Client’s description of his personality.  
d. Status of wound healing.
122. An elderly client expresses difficulty sleeping because her spirit is disturbed due to sin in her life. The nurse should select which of the following as the priority intervention?

   a. Call the chaplain and schedule a visit.
   b. **Ascertain what religious practice is appropriate to the client.**
   c. Pray immediately with the client.
   d. Administer sleep medications as ordered.

123. What would be an effective intervention for a client with a medical illness diagnosis who is struggling with loss of independence?

   a. Assist the client with all activities.
   b. Help the family assist with all activities.
   c. Tell the client he needs to be independent in his care.
   d. **Allow the client to do what he is able to do.**