FUNDAMENTALS OF NURSING

1. Answer **B**. Sensory deficits could cause a geriatric patient to have difficulty retaining knowledge about prescribed medications. Decreased plasma drug levels do not alter the patient's knowledge about the drug. A lack of family support may affect compliance, not knowledge retention. Toilette syndrome is unrelated to knowledge retention.

2. Answer **C**. The nurse should systematically assess all areas of the abdomen, if time and the patient's condition permit, concluding with the symptomatic area. Otherwise, the nurse may elicit pain in the symptomatic area, causing the muscles in other areas to tighten. This would interfere with further assessment.

3. Answer **C**. Subjective data come directly from the patient and usually are recorded as direct quotations that reflect the patient's opinions or feelings about a situation. Vital signs, laboratory test result, and ECG waveforms are examples of objective data.

4. Answer **C**. A safety device on the wrist may impair circulation and restrict blood supply to body tissues. Therefore, the nurse should assess the patient for signs of impaired circulation, such as cool, pale fingers. A palpable radial or lunar pulse and pink nail beds are normal findings.

5. Answer **A**. Frontal or coronal plane runs longitudinally at a right angle to a sagittal plane dividing the body in anterior and posterior regions. A sagittal plane runs longitudinally dividing the body into right and left regions; if exactly midline, it is called a midsagittal plane. A transverse plane runs horizontally at a right angle to the vertical axis, dividing the structure into superior and inferior regions.

6. Answer **A.** Shock and dismay are early signs of denial-the first stage of grief. The other options are associated with depression—a later stage of grief.

7. Answer **B**. After placing the patient in high Fowler's position and moving the patient to the side of the bed, the nurse helps the patient sit on the edge of the bed and dangle the legs; the nurse then faces the patient and places the chair next to and facing the head of the bed.

8. Answer **D**. Demonstrating by the nurse with a return demonstration by the patient ensures that the patient can perform wound care correctly. Patients may claim to understand discharge instruction when they do not. An interpreter of family member may communicate verbal or written instructions inaccurately.

9. Answer **A**. As a safety precaution, the nurse should discard an unlabeled syringe that contains medication. The other options are considered unsafe because they promote error.

10. Answer **B**. Aging-related physiological changes account for the increased frequency of adverse drug reactions in geriatric patients. Renal and hepatic changes cause drugs to clear more slowly in these patients. With increasing age, neurons are lost and blood flow to the GI tract decreases.

11. Answer **B**. When teaching a patient about medications before discharge, the nurse is acting as an educator. The nurse acts as a manager when performing such activities as scheduling and making patient care assignments. The nurse performs the care giving role when providing direct care, including bathing patients and administering medications and prescribed treatments. The nurse acts as a patient advocate when making the patient's wishes known to the doctor.

12. Answer **D**. Anxiety may result from feeling of helplessness, isolation, or insecurity. This response helps reduce anxiety by encouraging the patient to express feelings. The nurse should be supportive and develop goals together with the patient to give the patient some control over an anxiety-inducing situation. Because the other options ignore the patient's feeling and block communication, they would not reduce anxiety.

13. Answer **C**. The scrub nurse assist the surgeon by providing appropriate surgical instruments and supplies, maintaining strict surgical asepsis and, with the circulating nurse, accounting for all gauze, sponges, needles, and instruments. The circulating nurse assists the surgeon and scrub nurse, positions the patient, applies appropriate equipment and surgical drapes, assists with gowning and gloving, and provides the surgeon and scrub nurse with supplies.

14. Answer **C**. The nurse should return shortly to the patient's room and remain there until the patient takes the medication to verify that it was taken as directed. The nurse should never leave medication at the patient's bedside unless specifically requested to do so.

15. Answer **C**. The nurse solves the problem as follows:

    10,000 units/7,500 units = 1 ml/X

    10,000 X = 7,500

    X= 7,500/10,000 or ¾ ml

16. Answer **C**. To convert Fahrenheit degrees to centigrade, use this formula:

    C degrees = (F degrees – 32) x 5/9

    C degrees = (102 – 32) 5/9

    + 70 x 5/9

    38.9 degrees C

17. Answer **D**. All of these test help evaluate a patient with respiratory problems. However, ABG analysis is the only test evaluates gas exchange in the lungs, providing information about patient's oxygenation status.

18. Answer **B**. The diaphragm of a stethoscope detects high-pitched sound best; the bell detects low pitched sounds best. Palpation detects thrills best.

19. Answer **C**. In most cases, an outpatient must fill a prescription for a controlled substance within 6 months of the date on which the prescription was written.

20. Answer **D**. The nurse must consider the patient's cognitive abilities to understand drug instructions. If not, the nurse must find a family member or significant other to take on the responsibility of administering medications in the home setting. The patient's ability to recover, occupational hazards, and socioeconomic status do not affect drug administration.

21. Answer **A**. Primary prevention precedes disease and applies to health patients. Secondary prevention focuses on patients who have health problems and are at risk for developing complications. Tertiary prevention enables patients to gain health from others' activities without doing anything themselves.

22. Answer **A**. When making a surgical bed, the nurse leaves the bed in the high position when finished. After placing the top linens on the bed without pouching them, the nurse fanfolds these linens to the side opposite from where the patient will enter and places the pillow on the bedside chair. All these actions promote transfer of the postoperative patient from the stretcher to the bed. When making an occupied bed or unoccupied bed, the nurse places the pillow at the head of the bed and tucks the top sheet and blanket under the bottom of the bed. When making an occupied bed, the nurse rolls the patient to the far side of the bed.

23. Answer **C**. The nurse should give ½ ml of the drug. The dosage is calculated as follows:

$$250\ mg/X=500\ mg/1\ ml$$

$$500x=250$$

X=1/2 ml

24. Answer **C**. Patients can become dependent on barbiturates, especially with prolonged use. Because of the rapid distribution of some barbiturates, no correlation exists between duration of action and half-life. Barbiturates are absorbed well and do not cause hepatotoxicity, although existing hepatic damage does require cautions use of the drug because barbiturates are metabolized in the liver.

25. Answer **A**. Elevating the head of the bed during enteral feeding minimizes the risk of aspiration and allows the formula to flow in the patient's intestines. When such elevation is contraindicated, the patient should be positioned on the right side. The nurse should give enteral feeding at room temperature to minimize GI distress. To limit microbial growth, the nurse should hang only the amount of formula that can be infused in 3 hours.

26. Answer **C**. The nurse should instruct the patient to touch the tip of the tongue to the roof of the mouth and then place the sublingual tablet on the floor of the mouth. Sublingual medications are absorbed directly into the bloodstream form the oral mucosa, bypassing the GI and hepatic systems. No drug is administered on top of the tongue or on the roof of the mouth. With the buccal route, the tablet is placed between the gum and the cheek.

27. Answer **A**. The nurse always should clean around a wound drain, moving from center outward in ever-larger circles, because the skin near the drain site is more contaminated than the site itself. The nurse should never remove the drain before cleaning the skin. Alcohol should never be used to clean around a drain; it may irritate the skin and has no lasting effect on bacteria because it evaporates. The nurse should wear sterile gloves to prevent contamination, but a mask is not necessary.

28. Answer **C**. Giving 1,000 ml over 8 hours is the same as giving 125 ml over 1 hour (60 minutes) to find the number of milliliters per minute:

125/60 min = X/1 minute

60X = 125X = 2.1 ml/minute

To find the number of drops/minute:

2.1 ml/X gtts = 1 ml/15 gtts

X = 32 gtts/minute, or 32 drops/minute

29. Answer **A**. Early in shock, hyperactivity of the sympathetic nervous system causes increased epinephrine secretion, which typically makes the patient restless, anxious, nervous, and irritable. It also decreases tissue perfusion to the skin, causing pale, cool clammy skin. An above-normal heart rate is a late sign of shock. A urine output of 30 ml/hour is within normal limits.

30. Answer **D**. During a rapid assessment, the nurse's priority is to check the patient's vital functions by assessing his airway, breathing, and circulation. To check a patient's circulation, the nurse must assess his heart and vascular network function. This is done by checking his skin color, temperature, mental status and, most importantly, his pulse. The nurse should use the carotid artery to check a patient's circulation. In a patient with a circulatory problem or a history of compromised circulation, the radial pulse may not be palpable. The brachial pulse is palpated during rapid assessment of an infant.