1. Rice, regardless of the type, is not high in calcium. One cup of rice contains approximately 5 to 33 mg of calcium.
2. Celery is not high in calcium. One stalk of celery contains approximately 15 mg of calcium.
3. Sardines are an excellent source of dietary calcium. Three ounces of sardines contain approximately 371 mg of calcium.
4. Tomatoes are not high in calcium. One tomato (2½ inches in diameter) contains approximately 9 mg of calcium.

2.1. Hypoxia is insufficient oxygen anywhere in the body. To compensate for this lack of oxygen, the heart increases its rate to improve cardiac output, thereby increasing oxygen to all body cells.
2.2. Difficulty breathing (dyspnea) is a late, not early, sign of hypoxia.
2.3. An increase in respirations (tachypnea), not a decrease in respirations (bradypnea), occurs as the body attempts to deliver more oxygen to body cells.
2.4. Skin color changes are not early adaptations to hypoxia. Pallor is caused by peripheral vasoconstriction that shunts blood away from the skin to the vital organs and occurs with the stress response.

3.1. Persistent chronic pain becomes an unchanging part of life. As the duration of exposure increases, the individual may learn cognitive and behavioral strategies to cope with the pain.
3.2. Chronic pain can markedly impair activities of daily living.
3.3. Chronic pain may, or may not, have an identifiable cause.
3.4. Acute pain and chronic pain both decrease the efficiency of the immune system.

4.1. A slight elevation of body temperature is expected after surgery because of the body's response to the stress of surgery.
4.2. Dehiscence, separation of the wound margins, is more likely to occur between the fifth and eighth postoperative days, and it is not life threatening.
4.3. Dependent edema indicates problems, such as a fluid and electrolyte imbalance, impaired kidney function, or decreased cardiac output. All are serious, but generally manageable.

4. An acute onset of chest pain within 24 hours of surgery may indicate myocardial infarction in response to the stress of surgery. Also, it can be caused by a pulmonary embolus, although this is more likely to occur between the seventh and tenth postoperative days. Both of these complications are life threatening.

5. 1. Abdominal distention is a defining characteristic for the nursing diagnosis Constipation, not Perceived Constipation.
5.2. The passage of hard, dry stools is a defining characteristic for the nursing diagnosis Constipation, not Perceived Constipation.
5.3. The defining characteristics for the nursing diagnosis Perceived Constipation are the expectation of a daily bowel movement with the resulting overuse of laxatives, enemas, and/or suppositories and the expected passage of stool at the same time every day.
5.4. Straining at stool is a defining characteristic for the nursing diagnosis Constipation, not Perceived Constipation.

6. 1. Although this is done, it is not the priority.
6.2. The consent for surgery must be signed before preoperative medications are administered because they depress the central nervous system impairing problem solving and decision making.
6.3. This is unnecessary. This can be done at any time during the preoperative phase or at the beginning of the intraoperative phase of surgery.
6.4. Although this is done, it is not the priority.

7. Answer: 5 mL. Use ratio and proportion to first convert 500 milligrams to its equivalent in grams as well as to solve the problem.

\[
\begin{align*}
\text{Desire} & : 500 \text{ mg} = x \text{ gram} \\
\text{Have} & : 1000 \text{ mg} = 1 \text{ gram}
\end{align*}
\]

\[
1000x = 500 \\
x = \frac{500}{1000} \\
x = 0.5 \text{ grams (is equal to 500 mg)}
\]

\[
\begin{align*}
\text{Desire} & : 0.5 \text{ gram} = x \text{ mL} \\
\text{Have} & : 1 \text{ gram} = 10 \text{ mL}
\end{align*}
\]

\[
x = 0.5 \times 10 \\
x = 5 \text{ mL}
\]
8. 1. Primary nursing is not a cost containment strategy in managed care, but rather a nursing-care delivery system that ensures a comprehensive and consistent approach to identifying and meeting patients' needs. Primary nursing occurs when one nurse is assigned the 24-hour responsibility for the planning and delivery of nursing care to a specific patient for the duration of the patient's hospitalization.

2. Critical pathways are a case management system that identifies specific protocols and timetables for care and treatment by various disciplines designed to achieve expected patient outcomes within a specific time frame. The purpose is to discharge patients sooner, thereby reducing the cost of health care.

3. Functional method refers to a model of nursing-care delivery that assigns a specific task for a group of patients to one person. Although it is efficient, it is impersonal and contributes to fragmentation of care because it is task oriented rather than patient centered.

4. Quality management (also known as continuous quality improvement, total quality management, or persistent quality improvement), refers to a program designed to improve, not just ensure, the quality of care delivered to patients. Also, it includes an educational component to support growth and provide for corrective action.

9. 1. Patients with dementia do not have the cognitive ability to perform a procedure independently.

2. When progressing through each aspect of the bath, give simple, direct statements to limit the amount of incoming stimuli at one time. This will promote comprehension and self-care.

3. The patient has a problem with cognition, not vision.

4. This intervention may precipitate anxiety. The patient does not have the cognitive ability or attention span to understand a detailed explanation before a procedure.

10. 1. This describes narcolepsy, which is a sudden overwhelming sleepiness (hypersonnia) in the daytime.

2. This describes Restless Legs Syndrome, a feeling of creeping or itching sensation occurring in the lower extremities causing an irresistible urge to move and kick the legs.

3. This describes nightmares, which are vivid frightening dreams that occur during REM sleep and awaken the sleeper.

4. Episodes of sleep apnea begin with loud snoring followed by silence, during which the person struggles to breathe against a blocked airway. Decreasing oxygen levels cause the person to awaken abruptly with a loud snort.

11. 1. A clear liquid diet is contraindicated in the presence of abdominal distention because gas has accumulated in the intestines because of a lack of intestinal motility.

2. This is not the purpose of a clear liquid diet. A full-liquid diet or food will more likely stimulate gastric enzymes.

3. A clear liquid diet is administered after a postoperative ileus resolves, not to prevent its occurrence.

4. The molecules in clear liquids are less complex and easier to ingest, tolerate, and digest than those in a full-liquid diet or food.

12. 1. Diarrhea is related directly to a risk for damage to epidermal and dermal tissue. The gastric and intestinal enzymes present in feces are acids capable of eroding the skin.

2. Diarrhea is unrelated to the ability to provide self-care. The inability to care for self is the state in which the individual experiences an impaired motor or cognitive function, causing a decreased ability to perform self-care activities.

3. Diarrhea is not related directly to a sexual dysfunction, which is the state in which an individual experiences or is at risk of experiencing a change in sexual function that is viewed as unrewarding or inadequate.

4. Diarrhea is not related directly to a body image disturbance, which is the state in which an individual experiences, or is at risk of experiencing, a disruption in the way one perceives one's body image.

13. 1. This is not an example of battery. Battery is the purposeful, angry, or negligent touching of a patient without consent.

2. This is not an example of assault. Assault is an attempt, or threat, to touch another person unjustly.

3. This is not an example of negligence. Negligence occurs when the nurse's actions do not meet appropriate standards of care and result in injury to another.

4. Malpractice is misconduct, an act of commission or omission, performed in professional practice that results in harm to another.
14. Hyperglycemia event

**Laboratory Results:**
- BUN: 18 mg/dL
- Creatinine: 1.2 mg/dL
- Hemoglobin A1c: 8.0%
- Serum glucose: 350 mg/dL

**I&O Record (last 24 hr):**
- Intake: 2400 mL
- Output: 4200 mL

**Nursing Progress Note:**
- 10 AM—patient complains of being thirsty and "urinating a lot," and has lost 20 pounds over the last two months; has poor skin turgor and dry mucous membranes.

**ANSWER AND RATIONALES**

1. Generalized weakness and fatigue are not indicative of a brain attack because with a brain attack paresis or paralysis generally is unilateral and focal in nature.

2. Kidney failure can be ruled out because the 4200 mL of urinary output indicates that the kidneys are functioning. Also, with kidney failure, generally there is a weight gain, not loss. The BUN and creatinine levels are within the normal range and indicate that the kidneys are not in failure.

3. There are no data to support the conclusion that this event is a hypertensive episode. With the degree of polyuria, poor skin turgor, and dry mucous membranes, hypotension due to dehydration, not hypertension, is expected.

4. The serum glucose of 350 mg/dL is excessive and indicates a hyperglycemic event; the acceptable range is 80 to 120 mg/dL. A Hemoglobin A1c greater than 6% to 7% indicates inadequate glucose control over the last 90 to 120 days.

15. 1. Directive is not one of the four classic leadership styles.
   2. The autocratic leadership style is probably the least effective style to use with a professionally mature and motivated staff. Autocratic leaders give orders and directions and make decisions for the group. There is little freedom and a large degree of control by the leader, which frustrates motivated and professionally mature staff members.

16. 1. Pressure on the popliteal areas can cause damage to nerves and interferes with circulation and must be avoided.
   2. Transfer belts should be removed once the patient is transferred.
   3. This moves the patient too close to the front of the seat and is unsafe.
   4. The patient's feet should be positioned flat on the footrests of the wheelchair, not the floor, to protect the feet if the wheelchair is moved.

17. 1. A patient's perceptions are only one part of the data that must be collected before the nurse can establish the priority of the patient's needs. Maslow's Hierarchy of Basic Human Needs helps the nurse to determine the patient's needs in order of priority based on the collected data.
   2. Health perception reflects a person's knowledge, behavior, and attitudes regarding illness, disease prevention, health promotion, and what constitutes a healthy lifestyle. An assessment of these factors captures the uniqueness of each individual and is essential data that must be considered before needs are identified and a plan formulated.
   3. A healthy lifestyle can promote health and prevent some illness or even minimize complications; however, understanding a person's perceptions of health may not prevent human responses to disease.
   4. Only a patient, not a nurse, can choose a patient's place along the health-illness continuum. How people perceive themselves is subjective and is influenced by their own attitudes, values, and beliefs.

18. 1. A serving of ½ grapefruit contains only 162 μgRE of vitamin A.
   2. One medium-sized tangerine contains only 108 μgRE of vitamin A.
   3. Apricots are an excellent source of vitamin A. Three medium-sized apricots...
contain 867 μgRE (Retinol Equivalents) of vitamin A.

4. One medium-sized banana contains only 69 μgRE of vitamin A.

19. 1. Nonverbal behavior is controlled more by the unconscious than by the conscious mind.

2. Nonverbal behavior carries more, not less, weight than verbal interactions because nonverbal behavior is influenced by the unconscious.

3. Transculturally, nonverbal communication varies widely. For example, gestures, facial expressions, eye contact, and touch may reflect opposite messages among cultures and among individuals within a culture.

4. The opposite is true. Nonverbal behaviors often directly reflect feelings.

20. 1. These anatomic landmarks help to identify the deltoid muscle.

2. These anatomic landmarks help to identify the dorsogluteal site. This site contains the well-developed gluteus muscles, particularly the gluteus maximus, in the buttocks.

3. This is the initial placement of the hand when identifying landmarks for the ventrogluteal site.

4. This is associated with the vastus lateralis site. It is between one handbreadth above the knee and one handbreadth below the greater trochanter on the anterior lateral aspect of the thigh.

21. 1. Taping a patient’s get-well cards to the wall where the patient can see them supports the patient’s need to feel loved and appreciated and meets love and belonging needs according to Maslow’s Hierarchy of Needs.

2. This does not support a patient’s safety and security needs. Safety and security needs are related to being and feeling protected in the physiologic and interpersonal realms.

3. This does not support a patient’s self-esteem needs. Self-esteem needs are met from within. They are how the patient feels about oneself.

4. This does not support a patient’s physiologic needs. Physiologic needs are related to having adequate air, food, water, rest, shelter, and the ability to eliminate and regulate body temperature.

22. 1. This is unnecessary. When obtaining a specimen from a retention catheter, the aspiration port of the catheter (not the exit tube) is wiped with a disinfectant before inserting the syringe. Urine specimens from a retention catheter should come from the port, not the bag, because this urine is the most recently excreted.

2. This should not be done until a step mentioned in another option is performed first. The drainage tubing should be clamped approximately 1 to 2 inches below the aspiration port for 15 to 20 minutes to allow urine to accumulate.

3. This is unnecessary to obtain a urine specimen because only 10 to 30 mL are needed. This position is used to move urine toward the trigone (the triangular area at the base of the bladder where the ureters and urethra enter the bladder) where it is accessible to the catheter, which promotes the flow of urine through the urinary catheter to the drainage bag.

4. Wearing personal protective equipment, such as clean gloves, is a medical asepsis practice that protects the nurse from the patient’s body fluids.

23. 1. Clean gloves are adequate.

2. A skin barrier, such as zinc oxide, protects the skin from the digestive enzymes in feces.

3. Cranberry juice makes urine more alkaline; it does not influence bacteria and enzymes in stool.

4. Patients should attempt to have a bowel movement after a meal to take advantage of the gastrocolic reflex.

24. 1. The nurse does not need a practitioner’s order to provide nursing care that is within the realm of nursing practice.

2. Providing hygiene, an activity of daily living, is within the scope of nursing practice.

3. The nurse does not need to collaborate with other health-care professionals to provide nursing care.

4. The nurse does not need a practitioner’s order, with or without a restriction, to implement nursing care that is within the realm of nursing practice.

25. 1. Kool-Aid contains no sodium and is permitted on a 2-gram sodium diet.

2. Club soda contains no sodium and is permitted on a 2-gram sodium diet.

3. Twelve fluid ounces of lemonade contains approximately 12 mg of sodium and is permitted on a 2-gram sodium diet.

4. Twelve fluid ounces of diet root beer contains approximately 170 mg of sodium and should be avoided on a 2-gram sodium diet.
26. Although stomatitis—inflammation of the mouth—can occur from irritation caused by the tube used for delivering general anesthesia to a patient during surgery, it is uncommon and not life threatening.

2. Although atelectasis is serious, it is not as serious as an adaptation in another option. Anesthesia delivered by intubation can interfere with the action of surfactant, resulting in the collapse of alveoli (atelectasis).

3. Although the tube used for intubation commonly does irritate the posterior oropharynx, resulting in a sore throat, it is not as serious as an adaptation in another option. This is a potentially life-threatening complication because it prevents the exchange of gases between the lungs and atmospheric air. Laryngeal spasm can result from intubation caused by the presence of the intubation tube in the glottis (space between the vocal cords) during surgery.

27. The reference is too general to be related to the location of pain, which is the actual site the pain is felt.

2. Intensity refers to the strength or amount of pain experienced, which often is rated from mild to excruciating.

3. Quality refers to the description of the pain sensation.

4. The pattern of pain refers to time of onset, duration, recurrence, and remissions.

28. In the semi-Fowler’s position, the abdominal organs drop by gravity, which permits maximum thoracic excursion. In addition, slight flexion of the hips reduces abdominal muscle tension, which limits pressure on the suture line and facilitates diaphragmatic (abdominal) breathing.

2. Resting in bed in any position promotes flatus retention. Ambulation promotes intestinal motility, which promotes the passage of flatus.

3. Inactivity results in decreased detrusor muscle tone, incomplete bladder emptying, and urinary stasis. The high-Fowler’s position and ambulation use gravity to promote urinary elimination.

4. This position does not facilitate drainage via a portable wound drainage system. Negative pressure creates the vacuum that draws fluid into a portable wound drainage system.

29. Oil lubricates, not irritates, the intestinal mucosa.

2. Soap irritates the intestinal mucosa and thus stimulates the circular and longitudinal muscles of the intestinal wall, which respond with wave-like movements (peristalsis) that propel intestinal contents toward the anus.

3. Tap water is a hypotonic solution that exerts a lower osmotic pressure than the surrounding interstitial fluid, causing water to move from the colon into interstitial spaces. In addition, the volume of the fluid distends the lumen of the intestine. These processes stimulate peristalsis and defecation.

4. Normal saline, a solution having the same osmotic pressure of surrounding interstitial fluid (isotonic), works by drawing fluid from interstitial spaces into the colon. This fluid, in addition to the original volume of saline instilled, exerts pressure against the intestinal mucosa, which stimulates peristalsis and defecation.

30. 1. Water will not increase the absorption of medications administered orally. Water will facilitate the swallowing of and the movement of the medication down the esophagus to the stomach.

2. The time of day does not influence the rate of absorption of medications administered orally.

3. Food can delay the dissolution and absorption of many drugs; therefore, most oral medications should be administered on an empty stomach. Oral medications should be administered with food only when indicated by the manufacturer’s directions.

4. Physical rest does not influence the rate of absorption of medications administered orally.

31. 1. Infants react to pain in an intense way including physical resistance and lack of cooperation. Separation of an infant from the usual comforting contact with parents contributes to separation anxiety, which in turn lowers pain tolerance, which intensifies the pain experience. Infants express pain by irritability, rolling of the head, flexing the extremities, overacting to common stimuli, an inability to be comforted by holding and rocking, and physical responses indicating stimulation of the sympathetic nervous system.

2. Adolescents are less sensitive to pain than an age group in another option. Adolescents generally want to behave in an adult manner and, therefore, demonstrate a controlled behavioral response to pain.

3. Older adults have a decreased capacity to sense pain and pressure. Older adults often fail to notice situations that will cause acute pain in younger people.
4. Pregnant women generally are not more sensitive to pain than when not pregnant.

32. 1. Leavened bread and cake, not coffee and tea, are forbidden during Passover.
2. There are no restrictions on dairy products and eggs after sundown on Fridays.
3. Dairy products and meat/poultry are never served at the same meal or on the same set of dishes. Dairy products are not permitted within 1 to 6 hours after eating meat/poultry. Meat/poultry cannot be eaten for 30 minutes after consuming dairy products. Historically, this was practiced so that one food did not contaminate the other.
4. All crustaceans, shellfish, and fish-like mammals, such as crab, shrimp, and lobster, scallops, oysters, and clams are forbidden.

33. 1. Relaxation techniques are effective ways to reduce the autonomic nervous system response to a threat. However, they do not reduce the stressor contributing to this response.
2. Validating a patient’s feelings will help the patient feel accepted, understood, and credible. However, it is not as helpful as another option.
3. Minimizing environmental stimuli may support rest and sleep, which is an essential aspect of stress management in any setting. However, it is not as helpful as another option.
4. Anxiety is a response to an unknown threat to the self or self-esteem. Therefore, explaining what, how, why, when, and where of every procedure to the patient will reduce anxiety by minimizing the unknown.

34. 1. Perineal care, not a vaginal irrigation, should be performed before inserting a vaginal suppository.
2. The patient should be placed in the supine position with the knees flexed (dorsal recumbent) to facilitate insertion of a vaginal suppository. The left-lateral position is used for an enema.
3. This facilitates the placement of the vaginal suppository just outside the cervical os so that when it melts it will eventually disperse through the entire vaginal canal.
4. Medical, not surgical, asepsis is required for the insertion of a vaginal suppository.

35. 1. Although the leadership role is an important role and can be demonstrated on many different levels in the nursing profession, a word in another option has a stronger relationship with the role of the nurse when helping a patient negotiate the health-care system.
2. The health-care delivery system in the United States is complex and can be confusing at a time when patients have the least energy to explore and negotiate intervention options. When functioning as a resource person, the nurse identifies resources, provides information, and makes referrals.
3. The surrogate role is not a professional role of the nurse. A surrogate role is assigned to a nurse when a patient believes that the nurse reminds them of another person and projects that role and the feelings he/she has for the other person onto the nurse.
4. The role of counselor is only one area of nursing practice and a word in another option has a stronger relationship with the role of the nurse when helping a patient negotiate the health-care system. Counseling is related only to helping a patient recognize and cope with emotional stressors, improve relationships, and promote personal growth.

36. 1. Bathing daily, even using a moisturizing soap, is drying to the skin. Two to three times a week is adequate for an older adult who is continent.
2. Woolen fabrics are coarse and irritate the skin, and therefore should be avoided.
3. The percentage of body water dramatically decreases with age, and older adults have altered thirst mechanisms that place them at risk for inadequate fluid intake and dehydration. In addition, the skin of older adults is drier because of a decreased ability to sweat and a decreased production of sebum.
4. Lotion is preferable to baby powder because lotion lubricates the skin. Also, baby powder should be avoided because when aerosolized, it is a respiratory irritant.

37. 1. Treatment refers to actions designed to help the patient achieve homeostasis, not adaptive capacity.
2. A major component of adaptive capacity is the ability to be flexible in all realms of human dimension, as a person seeks to regain homeostasis or balance. Adaptive capacity refers to the quality and quantity of resources one can draw on to regain balance after one is threatened.
3. The threat that a person perceives is the stressor, not the adaptation.
4. Illness refers to a maladaptive response to a stressor, not to adaptive capacity.

38. 1. Cold lowers the temperature of skin and underlying tissue, which causes vasoconstriction, reducing blood flow to the area. This controls bleeding and slows the passage of fluid from the intravascular to the interstitial compartment, which limits edema.
2. Direct pressure may limit bleeding but will not affect edema or pain. Acupressure closes the gate mechanism to pain or stimulates areas near pain fibers leading to the brain, thereby blocking the perception of pain.
3. Effleurage—long, smooth strokes sliding over the skin—reduces pain by using the Gate Control Theory of Pain. Peripheral stimuli transmitted via large-diameter nerves close the gate to painful stimuli that use small-diameter nerves, thereby blocking the perception of pain.
4. Massage is cutaneous stimulation that uses the Gate Control Theory of Pain, not vasoconstriction, to limit pain.

39. 1. Although the physical trauma of surgery causes pain and it must be relieved, it is not the priority.
2. Although anesthesia can cause nausea, it is not the priority problem in the Post-Anesthesia Care Unit.
3. With an altered level of consciousness, the pharyngeal, laryngeal, and gag reflexes may be impaired. The inability to cough or swallow can result in aspiration of oral secretions.
4. Excessive fluid loss precipitates a deficient fluid volume, but the nurse generally has time to safely meet this need.

40. 1. The only way to reestablish patency of the air vent lumen of a double-lumen nasogastric tube is to instill air into the lumen. The injected air will push the secretions blocking the lumen back into the stomach where the fluid can be removed by the drainage lumen. Keeping the end of the air vent lumen higher than the stomach prevents reflux of gastric contents into the air vent lumen.
2. This will not reestablish patency of the air vent lumen. The patient is placed in this position as the tube is being inserted to facilitate its passage into the stomach.
3. This will draw more fluid from the stomach into the air vent lumen by the principle of gravity.

4. This will not reestablish patency of the air vent lumen. This is done to ensure that the catheter is in the correct anatomic location.

41. 1. This action does not require an incident report. The nurse manager should discuss this behavior with the nurse and may document it in the nurse’s personnel file.
2. Not receiving an ordered medication may have the potential to cause harm. Therefore, an incident or adverse occurrence report should be completed to document the incident to add to the data so that similar situations can be prevented in the future.
3. An incident report does not have to be completed in this instance. The incident should be documented in the patient’s medical record.
4. An incident report is unnecessary in this situation. Patients have the right to refuse care; however, the patient’s refusal of care and the reasons for the refusal should be documented in the patient’s medical record.

42. 1. Intermittent episodes of pain that occur despite continued use of an analgesic (breakthrough pain) can be managed by administering an immediate-release analgesic to reduce pain (rescue dosing). This reduces pain during an unanticipated pain episode without unnecessarily raising the dosage of the long-acting analgesic.
2. This will not promote absorption via the transdermal patch; it could result in the destructive effects of immobility and may interfere with the quality of life.
3. This is ineffective in this situation. The patient has intractable (malignant) pain that requires an opiate at this time.
4. This is not the priority. Although this may eventually be necessary, the patient’s pain must be relieved immediately.

43. 1. This should not be the first thing to do when unsure of the steps in a nursing procedure.
2. Fundamental nursing textbooks are not the best source for a step-by-step review of a nursing skill. Generally, fundamental nursing textbooks do not address every nursing skill in a step-by-step approach, nor do they include intermediate or advanced skills.
3. This is the first resource the nurse should use when unsure of the steps in a nursing procedure. A review of the procedure in the Procedure Manual may refresh the memory or support the confidence of the nurse so that it is safe to proceed.
4. This is premature. Another action should be implemented first.

44. 1. A pressure ulcer is not a microbiologic stressor. If an ulcer becomes infected, the organism causing the infection is a microbiologic stressor.
2. A pressure ulcer is not a developmental stressor. Developmental stressors are physiologic changes or transitional life events that occur during the expected stages of growth and development.
3. Pressure is a physical stressor that stimulates adaptations that cause an ulcer. Once an ulcer is present, the ulcer becomes a secondary stressor and is considered physiologic in nature.
4. A pressure ulcer is not a physical stressor. The pressure that caused the ulcer is a physical stressor.

45. 1. This is associated with cardiovascular problems.
2. This is associated with bowel and/or urinary incontinence.
3. This is associated with the older adult and people with peripheral neuropathy or neurologic diseases.
4. Cachexia involves weight loss, muscle atrophy, and decreased subcutaneous tissue, which results in a reduction in the padding between skin and bones, thus increasing the risk of pressure ulcer development.

46. 1. This is an inference based on inadequate data.
2. This is an example of paraphrasing, which restates the content of the patient’s message in similar words.
3. This is an example of reflective technique, which focuses on feelings.
4. This is an example of an open-ended statement, which invites the patient to elaborate on the stated concern.

47. 1. Using the same site consistently causes, not limits, skin irritation and excoriation. The sites for a transdermal patch should be rotated.
2. Both irritation of the skin and vasodilation can result from rubbing the skin, which can alter absorption of the medication.
3. A hairless site will ensure that there is effective contact with the skin.
4. The old patch should be removed at the same time that the new patch is applied.

48. 1. A task of this complexity requires the knowledge and judgment of a registered nurse. If the caregiver is unable to assess the patient’s condition adequately, this task has great potential for harm. In addition, it requires problem solving that may call for innovation in the form of an individually designed plan of care to address the presence of a dysrhythmia.

2. Patient teaching is a complex task. It requires knowledge of principles, such as identifying readiness to learn, progressing from simple to complex information, using motivational theory, and evaluating outcomes. Also, it requires knowledge of principles related to colostomy care such as: the bag opening must be at least 1/4-inch larger than the stoma, a pale stoma may indicate ischemia, and what to include in an assessment of the characteristics of intestinal output.

3. Applying a condom catheter is not a complex task. It requires simple problem-solving skills, involves a predictable outcome, and employs a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented, it is within the scope of practice of an unlicensed nursing assistant. It does not require the more advanced competencies of a registered nurse.

4. Making an occupied bed is not a complex task. It requires simple problem-solving skills, involves a predictable outcome, and employs a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented, it is within the scope of practice of an unlicensed nursing assistant. It does not require the more advanced competencies of a registered nurse.

5. Transferring a patient is not a complex task. It requires simple problem-solving skills, involves a predictable outcome, and employs a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented, it is within the scope of practice of an unlicensed nursing assistant. It does not require the more advanced competencies of a registered nurse.

49. 1. Digoxin (Lanoxin) can cause sensory changes, such as diplopia (double vision), halos, colored vision, blind spots, and flashing lights. If any of these signs of toxicity occur, the medication should be held and a serum digoxin level assessed to determine if the drug is exceeding its therapeutic range of 0.5 to 2 ng/mL.
2. **Tachypnea**, an abnormally rapid rate of breathing (usually more than 20 breaths per minute), is not a symptom of digitalis toxicity.

3. Dysrhythmias, not hypertension, are cardiovascular signs of digitalis toxicity.

4. Digoxin does not influence temperature regulation in the body; it is given whether or not the patient has a fever.

**50.** 1. A tube feeding formula usually is hypertonic, which exerts an osmotic force that pulls fluid into the stomach and intestine, resulting in intestinal cramping and diarrhea.

2. This may result in fluid volume deficit and malnutrition, not diarrhea.

3. This may result in vomiting, not diarrhea. If there is still fluid remaining from the previous feeding, failure to test for a residual before administering a tube feeding can result in adding more fluid than the stomach can tolerate.

4. Placing a patient in the high-Fowler's position during the administration of a tube feeding is done to prevent aspiration of the formula and will not cause diarrhea.

**51.** 1. This is unnecessary. This is done when the patient is unconscious.

2. When attempting to clear an airway of an obstruction, the thumb side of the hand should always be against the patient's body regardless of the modification in the maneuver.

3. This is the appropriate modification of the abdominal thrust (Heimlich) maneuver for a pregnant woman. This provides thoracic compression while preventing pressure against the uterus that can result in trauma to the woman or the fetus.

4. Waiting until the person becomes unconscious wastes valuable time and is unsafe. Discontinuing the maneuver before the obstruction is cleared will result in death.

**52.** 1. The lights, noise, and activity in the hospital environment can interfere with napping during the day. However, naps when they do occur are short and rarely reach Stage IV restorative sleep.

2. Hospitalized patients can follow their usual bedtime rituals.

3. Most medications are administered by 10 PM to 11 PM and should not interfere with sleep.

4. Patients frequently find hospital beds unfamiliar and uncomfortable. In addition, therapeutic regimens restrict movement or require patients to assume sleeping positions other than their preference. Studies support the fact that finding a comfortable position is the most common factor that interferes with sleep as reported by hospitalized patients.

**53.** 1. Yogurt, a dairy product, is not included in a vegetarian diet. Pure vegetarians (vegans) eat only plants. Lacto-vegetarians eat vegetables and milk products, lacto-ovo-vegetarians eat vegetables, milk products, and eggs (some may occasionally eat fish or poultry).

2. Cheese, a dairy product, is not included in a vegetarian diet. Pure vegetarians (vegans) eat only plants.

3. Grains and legumes lack different amino acids. When these foods are combined, they substitute for a complete protein. Complete proteins supply all eight essential amino acids. Essential amino acids are those that cannot be manufactured by the human body and must be obtained from food sources.

4. Peanut butter combined with a grain, not jelly, is a substitute for a complete protein.

**54.** 1. Calcium is essential for functioning, but it is unrelated to the risk for drug toxicity in the older adult. Calcium is essential for cell membrane structure, wound healing, synaptic transmission in nervous tissue, membrane excitability, muscle contraction, tooth and bone structure, blood clotting, and glycolysis.

2. The glomerular filtration rate is reduced by as much as 46% at 90 years of age. In addition, decreased cardiac output can reduce the amount of blood flow to the kidneys by as much as 50%. When the glomerular filtration rate declines, the time necessary for half of a drug to be excreted increases by as much as 40%, which places the older adult at risk for drug toxicity.

3. Red blood cells are responsible for delivering oxygen to cells, and are unrelated to the risk for drug toxicity in the older adult.

4. Frequency of voiding is unrelated to the risk for drug toxicity in the older adult.

**55.** 1. This is done to straighten the ear canal of an infant or a young child, not an adult.

2. This can injure the eardrum. Drops should be directed along the wall of the ear canal.

3. Pressing gently on the tragus facilitates the flow of medication toward the eardrum.

4. This can result in medication flowing out of the ear. The side-lying position with the involved ear on the uppermost side should
be maintained for 2 to 3 minutes after the medication is instilled.

56. 1. Preschoolers (3 to 5 years—Initiative versus Guilt) learn to separate from parents and develop a sense of initiative. Negative resolution will result in guilt, rigidity, and a hesitancy to explore new skills or challenge abilities.

2. Adolescents (12 to 20 years—Identity versus Role Confusion) strive to develop a personal identity and autonomy. This is a turbulent time as the adolescent internalizes the dramatic physical changes and the psychological stressors of new social conflicts. It is common for adolescents to experience mood swings, make decisions without having all the facts, challenge authority, and assert the self. However, these behaviors are left behind when the developmental tasks of adolescence are positively resolved. Negative resolution results in assertive, rebellious, and antisocial behavior.

3. School-aged children (6 to 12 years—Industry versus Inferiority) learn to compete, compromise, and cooperate, develop relationships with peers, and win recognition through productivity. Negative resolution results in feelings of inadequacy, low self-esteem, and a reluctance to explore the environment.

4. Infants (birth to 18 months—Trust versus Mistrust) learn to depend on others to meet their needs, thereby developing trust and a beginning sense of self. Negative resolution of this task results in mistrust, dependency, lack of self-confidence, and shallow relationships in later stages of development.

57. 1. This will cover the brachial artery and may interfere with the accurate assessment of blood pressure. The lower edge of the cuff should be approximately 1 inch (2.5 cm) above the antecubital space.

2. This will result in a false low blood pressure reading.

3. The sphygmomanometer should be pumped up 30 mm Hg, not 60 mm Hg, above the palpatory blood pressure reading. This ensures an accurate systolic reading without exerting undue pressure on the tissues of the arm.

4. Releasing the valve slowly ensures that all 5 Korotkoff’s sounds are heard accurately. Deflating the cuff too rapidly, can result in a false low systolic reading and deflating the cuff too slowly can result in a false high diastolic reading.

58. 1. Unconscious patients often bite down when something is placed in the mouth. Therefore, a padded tongue blade should be placed between the upper and lower teeth to help keep the mouth open during oral care. Other padded tongue blades, wetted with a small amount of saline, should be used to clean the oral cavity.

2. Toothpaste should be avoided because it requires flushing the mouth with adequate amounts of water to prevent leaving an irritating residue on the mucous membranes. An unconscious patient usually has a diminished gag reflex and is at risk for aspiration.

3. Although this is used, it is not the best intervention because mouthwash contains ingredients that can be irritating to the mucous membranes.

4. Glycerin swabs are not effective in cleaning the oral cavity.

59. 1. Although this historical information eventually may be obtained, it is not the immediate priority.

2. This invites the patient to expand on and develop a topic of importance that relates to the current problem.

3. Although this historical information eventually may be obtained, it is not the immediate priority.

4. This question is too focused.

60. 1. Eleven AM is too soon. The drug will not be at its lowest concentration in the blood.

2. Thirty minutes before, and up to, the next scheduled dose is the most appropriate time for a trough blood level to be obtained. The serum level of the drug will be at its lowest.

3. Peak, not trough, levels are obtained thirty minutes after completion of drug administration.

4. The blood level of the drug rises once the drug is administered. A value taken at this time will no longer reflect the lowest serum level, which is the purpose of identifying a trough level.

61. 1. During adolescence, the individual is beginning to question life-guiding values such as spirituality. However, it is not uncommon for the adolescent to turn away from religious practices as part of dealing with role confusion and exploration of self-identity. Faith becomes centered around the peer group and away from the parents. This stage is called
Synthetic-Conventional Faith by James Fowler.

2. Although older adults often refine spiritual beliefs in response to life events, beliefs generally are expanded upon at an earlier stage of development. Some unique adults are able to achieve Universalizing Faith identified by James Fowler, which is a worldview stressing living out the vision of justice, love, and compassion.

3. Young adults are just beginning to think about spirituality more introspectively at this age. Young adults generally enter a reflective period of time as discovery of values in relation to social goals are explored within their own frame of reference rather than the peer group frame of reference as during adolescence. This stage is called Individuative-Reflective Faith by James Fowler.

4. Middle-aged adults tend to engage in refining and expanding spiritual beliefs through questioning. Middle-aged adults are reported to have greater faith, more reliance on personal spiritual strength, and be less inflexible in spiritual beliefs. Middle-aged adults integrate other viewpoints about faith which introduces tension while working toward resolution of spiritual beliefs. This stage is called Conjunctive Faith by James Fowler.

62. 1. Walkers surround a person on three sides and provide 4 points of contact with the floor. This wide base provides the best support available for assisted ambulation.

2. This follows the principle: *An object with wheels that are locked will remain stationary.*

3. This follows the principle: *The closer an object is held to the center of gravity, the greater the stability and the easier the object is to move.*

4. This follows the principle: *Balance is maintained and muscle strain is limited as long as the line of gravity passes through the base of support.*

63. 1. Back massage is the therapeutic manipulation of muscles and tissues that relaxes tense muscles, relieves muscle spasms, and induces rest or sleep. However, it may be contraindicated, and some people do not like a back rub or consider it an invasion of their personal space.

2. Music can be relaxing or stimulating depending on the music and the individual.

3. Although milk contains the amino acid L-tryptophan that promotes sleep, many people do not like milk or avoid fluids before bedtime to limit nocturia.

4. Following routines provides consistency and comfort in an unfamiliar environment. Bedtime rituals meet basic physiologic needs and usually include physically and emotionally relaxing behaviors.

64. An X in any part of the shaded area across the abdomen is a correct answer. The nurse should auscultate all four quadrants of the abdomen to determine the presence of borborygmi. Borborygmi are audible high-pitched, loud, gurgling sounds that occur frequently. Borborygmi are hyperactive bowel sounds that indicate increased intestinal motility usually related to diarrhea, early bowel obstruction, or the use of laxatives.

65. 1. This is unsafe. An over-bed table has wheels and therefore cannot provide a firm base of support. Over-bed tables are physical hazards that often contribute to falls if used inappropriately.

2. This provides for the safety of patients, staff, and visitors within a hospital. Inadequate lighting causes shadows, a dark environment, and the potential for misinterpreting stimuli (illusions), and is
CHAPTER 7 COMPREHENSIVE FINAL BOOK EXAM

a major cause of accidents in the hospital setting.
3. Although this should be done, this is not a physical hazard.
4. Although this should be done, and reaching for a phone can result in a loss of balance and a fall, it is not the most important intervention to prevent injury in a hospital.

66. 1. The knees are extended, not flexed, when in the supine position.
2. The supine position is a back-lying position that results in pressure on the heels (calcaneus), which have minimal tissue between the bone and skin, making them vulnerable to the development of pressure ulcers.
3. There is no pressure on either greater trochanter when in the supine position. Pressure on a greater trochanter occurs when the patient is in a lateral (side-lying) position.
4. External, not internal, rotation of the hips terry occurs when a patient is in the supine position.

67. 1. Setting limits will make the patient more anxious and demanding. Demanding behavior generally is an attempt to gain control over events in an effort to protect the Ego.
2. Alternating care with another nurse can be confusing to the patient and increase anxiety. Maintaining continuity in the nurse assignment will support the development of a trusting relationship, enable the nurse to explore the patient’s feelings, as well as plan and implement interventions that encourage choices, all of which support feeling in control.
3. Pointing out demanding behavior is too confrontational at this time. Demanding behavior generally is a defense mechanism that reduces anxiety generated by powerlessness. To confront the behavior and take away the patient’s coping mechanism will cause the patient to become more anxious.
4. This is an example of empathy, which is understanding a patient’s emotional point of view. An empathic response communicates that the nurse is listening and cares.

68. 1. This information includes a nursing intervention and an evaluation of the outcome, which is the most specific and complete of all the options.
2. No data are given to support the assumption that the patient is happy.
3. The words “less anxious” are relative and do not clearly evaluate the patient’s status.
4. Every patient has his or her own baseline. Indicating that a blood pressure is stable is unclear.

69. 1. Clean, not sterile, gloves are required during this procedure to protect the nurse because the nurse may be exposed to body fluids.
2. This action is related to a patient’s comfort and elimination needs, rather than asepsis.
3. A bath blanket promotes privacy and prevents heat loss during a bath and is unrelated to asepsis. If not soiled, a patient’s bath blanket can be reused.
4. The eye should always be washed from the inner to the outer canthus to prevent secretions from entering the lacrimal ducts, which may result in an infection.

70. 1. Water is ineffective against a grease fire. It will scatter the flames and the fire will spread.
2. The lid of the frying pan deprives the fire of oxygen. Without oxygen to support combustion, the fire will go out.
3. Although this will help to contain the fire to the kitchen, there is a more appropriate intervention to contain the fire to the frying pan.
4. This is inappropriate. A class A fire extinguisher is designed for fires consisting of paper, wood, upholstered furnishings, and ordinary rubbish.

71. 1. This will not prevent the problem from occurring in the first place.
2. This will ensure that the medication is dispersed throughout solution in the cartridge. It will not change the taste of the medication.
3. Oral hygiene should be performed after the procedure.
4. The aerosolized medication enters the aerosol chamber where the larger droplets fall to the bottom of the chamber. The smaller droplets are inhaled deep into the lungs rather than falling on the patient’s tongue.

72. 1. A beginning rapport must be established before information can be collected.
2. The orientation phase (also called the introductory or prehelping phase) of a therapeutic relationship sets the tone for the rest of the relationship. A rapport develops when the patient recognizes that the nurse is willing and able to help and can be trusted.
3. Problems are identified, explored, and dealt with during the working, not orientation, phase of a therapeutic relationship.
4. Priority needs are identified and interventions planned and implemented during the working, not orientation, phase of a therapeutic relationship.

73. 1. Feeling cold, chills, and shivering are adaptations associated with the onset (chill, initiation) stage of a fever. During this stage, the body responds to pyrogens by conserving heat to raise body temperature and reset the body's thermostat.

2. Profuse diaphoresis (sweating) occurs during the defervescence (flush) stage of a fever. During this stage, the fever abates and body temperature returns to the expected range.

3. Dehydration can occur during both the febrile (course, plateau) and defervescence (flush) stages of a fever.

4. The patient will have warm, flushed skin during the defervescence (flush) stage of a fever. During this stage, the fever abates and body temperature returns to the expected range.

74. 1. The feet can be washed thoroughly when taking a shower.

2. Extra care with the feet is unnecessary because paper slippers provide a barrier between the feet and the floor.

3. The warm water used to soak the feet promotes vasodilation, which improves circulation to the most distal portions of the feet. Soaking the feet loosens dirt and limits scrubbing, which prevent trauma to the skin. Soaking the feet should be done for just several minutes because prolonged soaking removes natural skin oils, which dries the skin and makes it prone to cracking.

4. When on bed rest, the feet do not get soiled with dirt. Bed rest does not necessitate soaking the feet during the bed bath.

75. 1. This is an expected integumentary change in the older adult. Brown spots (lentigo senilis) on the skin are caused by a clustering of melanocytes, pigment-producing cells.

2. A loss of subcutaneous fat and a reduced thickness and vascularity of the dermis that occur with aging result in thin, translucent skin in the older adult.

3. Tenting occurs when the skin of a dehydrated person remains in a peak or tent position after the skin is pinched together. This is a sign of a fluid volume deficit. Care must be taken when assessing an older person because some degree of tenting may occur, even when hydrated, because of the decrease in skin elasticity and decrease in tissue fluid associated with aging; however, in the hydrated patient tenting will slowly resolve.

4. A decrease in tissue fluid and sebaceous gland activity associated with aging commonly result in dry, flaky skin.

76. 1. This is the correct way to inhale when using an incentive spirometer; it helps to keep the airways open.

2. The patient is using the incentive spirometer incorrectly and needs further teaching. An incentive spirometer must be held in an upright position. A tilted flow-oriented device requires less effort to reach the desired inspiratory volume. A tilted volume-oriented device will not function correctly.

3. This is an acceptable practice. Inspiratory goals should be progressively increased daily or more frequently depending on the patient's ability to continually maximize the inspiratory volume, which promotes alveoli ventilation.

4. This is a desirable practice because it prevents hyperventilation and respiratory alkalosis.

77. 1. Effleurage involves long, smooth strokes sliding over the skin that have a relaxing, sedative effect. When performed slowly with light pressure at the end of a back massage, it is called "feathering off."

2. Firm, not deep, circular motions are used with back massage.

3. Kneading (petrissage) is not performed over the vertebrae because it is stimulating and traumatic for the vertebral column and spinal cord.

4. Massage over the vertebrae is contraindicated because it is traumatic to the vertebral column and spinal cord. Massage should be performed on either side of the vertebrae.

78. 1. This assumes that the patient can read at the reading level of the presented material. Also, it does not provide an opportunity for the nurse to communicate with the patient.

2. If the patient was not participating in the present formal class, it is unlikely that the patient will participate in the next class.

3. Although an audiovisual cassette is an excellent strategy to provide instruction, it does not provide the nurse an opportunity to individualize one-on-one instruction.

4. The nurse identified that the patient was quiet and withdrawn in the group class. Individual instruction provides the nurse
the opportunity to explore the patient’s concerns and address the patient’s individual needs in privacy.

79. 1. This increases the risk of aspiration because it straightens the trachea and anatomically makes it easier for food and fluid to enter the trachea rather than the esophagus.

2. Food and fluid should be consumed separately in the presence of dysphagia. Fluid is more difficult to control with dysphagia and it may flush the solid food toward the trachea where it can cause choking or a partial or total airway obstruction.

3. A patient with dysphagia should concentrate on the acts of chewing and swallowing. Environmental stimuli can be distracting and can result in inadequate chewing or premature swallowing, which in turn can result in choking and aspiration.

4. This will increase the risk for aspiration. Food should be placed in the posterior, not anterior, part of the mouth toward the side. The molars in the back of the mouth are designed for chewing. Placing food to the side keeps it close to the molars for chewing and out of direct line with the trachea. Placing food in the posterior of the mouth limits the need for the tongue to manipulate the bolus of food toward the back of the mouth in preparation for swallowing (deglutition).

80. 1. This may further decrease the consumption of food at mealtimes. Supplements are given in addition to, not to replace, the nutrients that are consumed with meals.

2. Research indicates that exercise decreases appetite and increases the need for calories. Exercise releases beta-endorphin, which results in a state of relaxation and satisfaction with less food.

3. This intervention is premature. It assumes that the inadequate intake is related to discomfort associated with flatus.

4. A person’s cultural, religious, educational, economic, and experiential background influences eating behaviors and food preferences. When familiar, preferred foods are available and personally selected, patients may feel that the care is individualized and that they are in more control, resulting in eating a greater percentage of the meal.

81. 1. This is an example of learning in the affective domain. In the affective domain, learning is concerned with feelings, emotions, values, beliefs, and attitudes.

2. This is not an example of learning in the cognitive domain. In the cognitive domain, learning is concerned with intellectual understanding and includes thinking on many levels, with progressively increasing complexity.

3. There is no learning domain known as physiologic.

4. This is not an example of learning in the psychomotor domain. Learning in the psychomotor domain includes using motor and physical abilities to master a skill. It requires the learner to practice to improve coordination and dexterity manipulating the equipment associated with the skill.

82. 1. Hyperextension of the condyloid joint of the wrist is accomplished by bending the fingers and hand backward as far as possible.

2. Opposition of the thumb, which is a saddle joint, occurs when the thumb touches the top of each finger on the same hand.

3. Abduction of the fingers (metacarpophalangeal joints—condyloid) occurs when the fingers of each hand spread apart.

4. Flexion of the wrist, a condyloid joint, occurs when the fingers of the hand move toward the inner aspect of the forearm.

83. 1. This recognizes the patient’s feelings.

2. This denies the patient’s feelings and gives false reassurance.

3. This denies the patient’s feelings and gives false reassurance.

4. This denies the patient’s feelings.

84. 1. This is done with a medication administered via the sublingual, not buccal, route.

2. Fluid will interfere with the action and absorption of the medication.

3. It should be administered after, or between, meals. Food will interfere with the action and absorption of the medication.

4. Alternating cheeks will limit irritation to the mucous membranes in the buccal area.

85. 1. Pain tolerance is the maximum amount and duration of pain that a person is willing to tolerate. It is influenced by psychosociocultural factors and usually increases with age.

2. This question focuses on an alleviating factor, distraction, rather than on the concept of pain tolerance.

3. This question is determining the patient’s perception of the intensity of pain, not pain tolerance.
4. This question focuses on an alleviating factor, medication, rather than on the concept of pain tolerance.

86. 1. This imposes on family members. A person must learn to cope with temptation because exposure to desirable foods occurs inside and outside the home.
2. This is degrading and should be avoided. Pictures that reflect a positive outcome are more desirable.
3. The rigidity and limitation of avoiding between-meal snacks may cause periods of hypoglycemia, overeating, and noncompliance. Between-meal snacks should be calculated into the weight-reduction program to meet both physical and emotional needs.
4. Behavior modification strategies are most successful when the person has an internal locus of control and is actively involved in self-care. Research demonstrates that self-monitoring of food intake is the single most helpful strategy in weight reduction.

87. 1. Although there is a predictable sequence to growth and development, there are individual differences in the rate and pace in which developmental milestones are achieved. Therefore, achievement of milestones is measured in ranges of time to allow for individual differences.
2. Task achievement refers to Erikson’s Theory of Personality Development, which is only one aspect of growth and development. Erikson believed that each stage of personality development is characterized by the need to achieve a specific developmental task, and that achievement of each task is affected by the social environment and influence of significant others. The success or failure to achieve a task at one stage will influence task achievement in subsequent stages.
3. Unfortunately, not all families provide safe and supportive environments for the growing child. In addition, the family is only one of many factors that influence the stages of growth and development.
4. This is untrue. Regression is possible at any stage when one attempts to cope with a threat to the Ego.

88. Answer: 2, 1, 4, 3, 6, 5
2. The outside of the catheterization package is contaminated and should be opened with hands that have been washed with soap and water.

1. The inside of the catheterization package is sterile. Sterile gloves are on the top of the supplies included because all subsequent equipment in the package must remain sterile.
4. The nurse’s sterile gloved hands then place the fenestrated drape over the patient’s perineal area to continue with the establishment of a sterile field.
3. The integrity of the balloon (inability to inflate or deflate, presence of leaks) is established before insertion to prevent trauma to the patient.
6. Cleansing the labia moves from areas that are less likely to be contaminated than the urinary meatus as well as reduces the spread of microorganisms toward the urinary meatus.
5. Cleansing the urinary meatus last reduces the possibility of introducing microorganisms into the urinary meatus and bladder.

89. 1. Although a jacket restraint is removed every 2 hours to permit range-of-motion exercises, contractures are not life threatening and therefore are not the most serious complication associated with a vest restraint.
2. The V opening of a jacket restraint should be in the front of the patient to prevent pressure against the neck, particularly the trachea. The rounded side of the restraint goes across the patient’s back.
3. This is too often and unnecessary.
4. Although a jacket restraint is removed every 2 hours to permit inspection of the skin, excoriation and skin compression are not the most serious complications associated with a vest restraint.

90. 1. The diastolic blood pressure decreases, not increases, during shock.
2. The initial stage of shock begins when baroreceptors in the aortic arch and the carotid sinus detect a drop in the mean arterial pressure. The systolic pressure is the pressure in the arteries during ventricular contraction.
3. Korotkoff’s sounds are the 5 distinct sounds that are heard when auscultating a blood pressure (I—faint, clear tapping; II—swishing sound; III—intense, clear tapping; IV—muffled, blowing sounds; V—absence of sounds).
4. During shock, there will be a narrowing, not widening, of pulse pressure. Pulse pressure is the difference between the systolic and diastolic pressures.
91. 1. Elastic stockings provide external pressure on the patient’s legs to prevent pooling of blood in the veins while not interfering with arterial circulation. Inspecting the skin 3 times a day is adequate.
2. This is unsafe because pressure injures fluid-filled tissue. They should be applied before, not after, the legs are dependent.
3. When applying elastic stockings, lotion increases friction that can injure tissue.
4. This is unsafe. Elastic stockings should be removed for 30 minutes 3 times a day; some practitioners’ orders require elastic stockings to be worn only when the patient is out of bed.

92. 1. The DRGs were not designed to increase the quality of health care.
2. DRGs are unrelated to increasing or decreasing reliability of research statistics. Reliability is the degree of consistency with which a research study measures a hypothesis and depends on how well the measurement tool and the research methods are designed.
3. DRGs have increased, not decreased, the acuity of the hospitalized population. Patients, who in the past, were treated in the hospital are now treated in the home, ambulatory care settings, or in less acute care settings, such as rehabilitation or extended-care centers.
4. The DRGs, pretreatment diagnoses reimbursement categories, were designed to decrease the average length of a hospital stay, which in turn reduces costs.

93. 1. Identifying body landmarks before giving an injection is part of the procedure for administering an injection and, therefore, is an example of the implementation step of the nursing process.
2. Obtaining the medication is part of the procedure associated with giving medication and, therefore, is an example of the implementation step of the nursing process.
3. Determining when medications should be administered requires planning and, therefore, is part of the planning step of the nursing process.
4. Collecting data from a patient involves assessment and, therefore, verifying a patient’s allergies is an example of the assessment step of the nursing process.

94. 1. This is a challenging statement and is inappropriate. It may take away the patient’s coping mechanism, is demeaning, and may cut off communication; the patient is using denial to cope with the diagnosis.
2. This response may take away the patient’s coping mechanism, is demeaning, and may cut off communication; the patient is using denial to cope with the diagnosis.
3. This provides an opportunity to discuss the illness; eventually a developing awareness will occur, and the patient will move on to other coping mechanisms.
4. This response may take away the patient’s coping mechanism, is demeaning, and may cut off communication; the patient is using denial to cope with the diagnosis.

95. 1. The pressure of firm strokes on the skin moving from distal to proximal areas increases venous return. When venous return increases, cardiac output increases.
2. Prolonged soaking removes the protective oils on the skin; the result is dry, cracked skin that is prone to further injury.
3. This prevents chilling, not increases circulation.
4. This is too hot for bath water because it may cause tissue injury. Bath water should be 110°F to 115°F.

96. 1. Although a teaching program must be designed within the patient’s developmental and cognitive abilities, it is not the most relevant factor when predicting success of the options presented.
2. Although this is important, it is not the most relevant factor when predicting success of the options presented.
3. Although family support is important, it is not the most relevant factor when predicting success of the options presented. Not all patients have a family support system.
4. The motivation of the learner to acquire new attitudes, information, or skills is the most important component for successful learning; motivation exists when the learner recognizes the future benefits of learning.

97. 1. After shampooing a patient’s hair, it may be dried or just towed dry until it is free of excess moisture.
2. The appearance of one’s hair is an extension of self-image. Therefore, the patient’s personal preferences should be considered before grooming the hair.
3. Combing or brushing should begin from the ends of the hair, then from the middle to the ends, and finally from the scalp to the ends. This technique limits discomfort and prevents broken ends and damaged hair shafts.
4. The application of alcohol, will help prevent matting and tangles. A small amount of a lubricant, not alcohol, applied to the hair will facilitate the combing out of tangles once they have occurred.

98. 1. This will impede the evacuation of the room if it becomes necessary.
2. This is premature at this time, but it may become necessary eventually.
3. This is unsafe. Rolling the patient from side to side fans the flames, which will increase the intensity of the fire.
4. Smothering the flames with a blanket deprives the fire of oxygen. Without oxygen to support combustion, the fire will go out. Rescuing the patient is the first step of fire safety.

99. 1. It is essential for the nurse to be an informed provider of care, but it is not the priority of care for this patient.
2. Although this should be done, it is not the priority of care for this patient.
3. The practitioner should be notified immediately because the herb may interact with prescribed medications or therapies.
4. Although this should be done, it is not the priority. Medications or therapies may interact with the herb before the physician reads the information in the health history.

100. 1. Hospice care is inappropriate for this patient because the patient is not dying. Hospice programs provide supportive care to dying patients and their family members to promote dying with dignity.
2. This generally is not the best setting to provide extensive rehabilitation services. The acute care setting provides services that medically and emotionally support the patient during the critical and acute phases right after the traumatic event and until the patient is stable and out of danger.
3. An extended-care facility is an inpatient setting where people live while receiving subacute medical, nursing, and rehabilitative care. Extended-care facilities that should meet the needs of this individual include intermediate-care facilities, nursing homes that provide subacute care, and rehabilitation centers.
4. Once stabilized and out of danger, the individual in this scenario needs intensive rehabilitation services that generally cannot be provided in an assisted-living residence. An assisted-living residence (e.g., apartment, villa, or condominium) provides limited assistance with activities of daily living, meal preparation, laundry services, transportation, and opportunities for socialization. Residents are relatively independent.