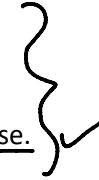


Question 1:

A nurse is caring for a group of clients on a medical-surgical unit. Which client should the nurse prioritize for care?

- a. A client who is postoperative and requires pain medication.
- b. A client newly diagnosed with diabetes who needs diabetic education.
- c. A client with pneumonia who is scheduled for a chest X-ray.
- d. A client admitted for chest pain with a history of coronary artery disease.



Question 2:

The charge nurse is making assignments for the [day shift]. Which assignment is appropriate for the licensed practical nurse (LPN)?

LVNs -

- a. Administering IV medications to a client with heart failure. ✗
- b. Developing a care plan for a client with a new diagnosis of diabetes. ✗
- c. Assisting with postoperative care for a client who had abdominal surgery.
- d. Conducting a group education session on smoking cessation. ✗



Question 3:

A client with a history of hypertension is admitted for a scheduled surgery. The nurse is reviewing the client's preoperative medications. Which medication should the nurse notify the healthcare provider about?

- a. Hydrochlorothiazide (HCTZ). ✓ diuretic
- b. Amlodipine.
- c. Metoprolol.
- d. Lisinopril.

Question 4:

A client diagnosed with major depressive disorder is prescribed fluoxetine. What information should the nurse include in the teaching for this client?

- a. The medication should provide immediate relief of symptoms. ✗
- b. Avoid consuming foods rich in tyramine while taking this medication. ✗
- c. Abrupt discontinuation of the medication may cause withdrawal symptoms.
- d. Take the medication in the evening to enhance its effectiveness. ✗

Question 5:

A nurse is caring for a client who has just been diagnosed with HIV. What is the priority nursing intervention?

- a. Administering antiretroviral medications. ✗
- b. Providing emotional support and counseling.
- c. Initiating airborne precautions. ✗
- d. Notifying the local health department.

↓
HIV does not have any kind of cure.

(A) → (B) ✓

- c. Initiating airborne precautions. X
- d. Notifying the local health department.

Question 6:

A client with heart failure is prescribed furosemide (Lasix). What is the nurse's priority assessment before administering the medication?

- a. Blood pressure.
- b. Serum potassium level.
- c. Respiratory rate.
- d. Urine output.

excretion of water,
sodium and potassium.

↳ hypokalemia (low potassium)

Question 7:

A client admitted with pneumonia is prescribed oxygen therapy. What should the nurse assess before starting oxygen administration?

- a. Hemoglobin level.
- b. Blood glucose level.
- c. Respiratory rate.
- d. Serum sodium level.

Question 8:

A postoperative client is experiencing severe pain despite receiving pain medication. What action should the nurse take first?

- a. Administer an additional dose of pain medication.
- b. Notify the healthcare provider.
- c. Assess the client's pain using a pain scale.
- d. Encourage the client to rest.

Question 9:

A client with a history of chronic kidney disease is scheduled for a CT scan with contrast. What is the nurse's priority action?

- a. Administering the prescribed contrast dye.
- b. Ensuring the client is NPO (nothing by mouth) for 4 hours before the procedure.
- c. Assessing the client's creatinine level.
- d. Providing preoperative teaching about the CT scan. X

Question 10:

A client is receiving intravenous (IV) antibiotics for a severe infection. The nurse observes redness, warmth, and swelling at the IV site. What is the nurse's priority action?

- a. Apply a warm compress to the site. X
- b. Discontinue the IV infusion.
- c. Administer an analgesic for pain. X
- d. Document the findings in the client's chart. ↗

Question 11:

A client with diabetes is scheduled for a lower extremity amputation. What is the nurse's priority action in the preoperative phase?

- a. Assessing the client's blood glucose level.
- b. Administering insulin as ordered.
- c. Providing emotional support and education.
- d. Preparing the client for surgery.

Question 12:

A client with a history of chronic obstructive pulmonary disease (COPD) is prescribed nebulized albuterol. What should the nurse monitor during the administration of albuterol?

- a. Blood pressure.
- b. Oxygen saturation.
- c. Serum potassium level.
- d. Blood glucose level.

Question 13:

A client admitted with gastrointestinal bleeding is prescribed a nasogastric (NG) tube. What is the nurse's priority action before inserting the NG tube?

- a. Administering an antiemetic.
- b. Obtaining informed consent.~~x~~
- c. Auscultating bowel sounds.
- d. Checking the client's gag reflex.

Question 14:

A client is receiving continuous tube feedings. The nurse observes the feeding to be slow, and the client complains of abdominal discomfort. What is the nurse's priority action?

- a. Increase the rate of the feeding.~~x~~
- b. Stop the feeding and notify the healthcare provider.
- c. Administer an antiemetic.
- d. Document the findings.

Question 15:

A postoperative client is prescribed heparin for deep vein thrombosis (DVT) prophylaxis. What is the nurse's priority assessment before administering heparin?

- a. Platelet count.
- b. Activated partial thromboplastin time (aPTT).
thrombin
- c. Serum potassium level.
- d. Liver function tests.

Question 16:

A client is admitted with a suspected myocardial infarction. What is the nurse's priority action during the initial assessment?

initial assessment?

- a. Obtain a detailed health history. ✓
- b. Administer nitroglycerin as ordered. ✗
- c. Monitor the client's cardiac rhythm. ✓
- d. Check the client's blood pressure. ✗

Question 17:

A client is receiving intravenous (IV) chemotherapy. What is the nurse's priority intervention to prevent complications?

- a. Administer antiemetic medications. ✗
 - b. Use a central venous access device. ✓
 - c. Monitor the client's platelet count. ✗
 - d. Encourage a high-fiber diet. ✗
- catheter
PICC.

Question 18:

A client diagnosed with schizophrenia refuses to take prescribed antipsychotic medication. What is the nurse's initial action?

- a. Administer the medication covertly.
- b. Document the client's refusal in the chart. ✓
- c. Obtain a court order for medication administration.
- d. Convince the client about the importance of the medication.

Question 19:

A client is admitted with acute kidney injury. What is the nurse's priority assessment?

- a. Blood pressure. ✗
 - b. Intake and output. ✓
 - c. Serum creatinine level. ✗
 - d. Dietary preferences. ✗
1. changes in urine output.
↳ oliguria / anuria.

Question 20:

A client with heart failure is prescribed a low-sodium diet. What is the nurse's priority teaching point for the client?

- a. Avoiding foods high in potassium. ✗
- b. Restricting fluid intake. ✗
- c. Reading food labels for sodium content. ✓
- d. Increasing protein intake. ✗

Question 21:

A client with a history of asthma is admitted for shortness of breath. What is the nurse's priority action during the initial assessment? ^{1st.}

- a. Administering a bronchodilator ✗
- b. Checking the client's oxygen saturation. ✓
- c. Obtaining a sputum culture ✗

- a. Administering a bronchodilator ~~X~~
- b. Checking the client's oxygen saturation.
- c. Obtaining a sputum culture. ~~X~~
- d. Assessing lung sounds. ~~X~~

Question 22:

A postoperative client is at risk for deep vein thrombosis (DVT). What is the nurse's priority intervention? 1/2

- a. Applying compression stockings.
- b. Administering low-molecular-weight heparin. ✓
- c. Encouraging ambulation.
- d. Monitoring platelet count.

Question 23:

A client is scheduled for a colonoscopy. What is the nurse's priority pre-procedure teaching?

- a. Discussing dietary restrictions.
- b. Explaining the procedure details.
- c. Providing information about post-procedure care.
- d. Ensuring the client is NPO for 8 hours.

Question 24:

A client diagnosed with heart failure is prescribed a diuretic. What should the nurse monitor closely?

- a. Serum sodium levels.
- b. Serum potassium levels.
- c. Blood glucose levels.
- d. White blood cell count.

↓
Lasix (furosemide)
 hypokalemia.

Question 25:

A client is receiving total parenteral nutrition (TPN). What is the nurse's priority intervention to prevent infection?

- a. Changing the TPN tubing every 48 hours.
- b. Administering TPN through a central venous catheter.
- c. Checking blood glucose levels every 6 hours.
- d. Using aseptic technique during TPN administration.

Homework

Question 26:

A client is prescribed warfarin (Coumadin) for anticoagulation. What is the nurse's priority teaching point?

- a. Increase intake of green leafy vegetables.
- b. Avoid activities that may cause injury or bleeding.
- c. Take the medication with a glass of grapefruit juice.
- d. Discontinue the medication if experiencing headaches.

Question 27:

A client is receiving enteral feedings through a nasogastric tube. What is the nurse's priority intervention to prevent complications?

- a. Elevate the head of the bed to 45 degrees during feedings.
- b. Use a small-bore feeding tube for administration.
- c. Administer feedings at room temperature.
- d. Check residual volume before each feeding.

Question 28:

A client with a history of seizure disorder is admitted for surgery. What is the nurse's priority preoperative assessment?

- a. Respiratory rate.
- b. Blood pressure.
- c. Serum glucose level.
- d. Frequency of recent seizures.

Question 29:

A client with chronic obstructive pulmonary disease (COPD) is prescribed oxygen therapy. What is the nurse's priority assessment before starting oxygen?

- a. Respiratory rate.
- b. Blood pressure.
- c. Serum potassium level.
- d. Oxygen saturation.

Question 30:

A client with diabetes is admitted for a foot ulcer. What is the nurse's priority intervention for wound care?

- a. Apply a dry sterile dressing.
- b. Cleanse the wound with hydrogen peroxide.
- c. Use a wet-to-dry dressing.
- d. Apply a topical antibiotic ointment.

Question 31:

A client is receiving intravenous (IV) antibiotics for a urinary tract infection. The client reports itching, rash, and difficulty breathing. What is the nurse's immediate action?

- a. Administer an antihistamine.
- b. Discontinue the IV antibiotics.
- c. Increase the rate of the IV infusion.
- d. Notify the healthcare provider.

Question 32:

A client is admitted with suspected meningitis. What is the nurse's priority intervention?

- a. Administering antibiotics.
- b. Placing the client in isolation.
- c. Performing a lumbar puncture.
- d. Monitoring blood glucose levels.

Question 33:

A postoperative client is prescribed patient-controlled analgesia (PCA) for pain management. What is the nurse's priority assessment?

- a. Respiratory rate.
- b. Pain intensity.
- c. Urinary output.
- d. Blood pressure.

.....

Question 34:

A client is diagnosed with tuberculosis (TB). What precautionary measures should the nurse take when caring for this client?

- a. Standard precautions.
- b. Airborne precautions.
- c. Contact precautions.
- d. Droplet precautions.

Question 35:

A client with a history of alcohol use disorder is admitted for detoxification. What is the nurse's priority intervention during the initial assessment?

- a. Assessing for signs of withdrawal.
- b. Implementing suicide precautions.
- c. Obtaining a urine drug screen.
- d. Monitoring liver function tests.

The nurse should prioritize the client admitted for chest pain with a history of coronary artery disease (CAD).

Explanation:

Clients with chest pain and a history of coronary artery disease are at a higher risk for cardiac events. Chest pain may indicate angina or a myocardial infarction (heart attack), which requires prompt assessment and intervention. The nurse should prioritize this client to assess the severity and characteristics of the chest pain, monitor vital signs, initiate cardiac monitoring, and administer any prescribed medications or interventions to manage the cardiac condition.

While all clients require attention, those with potential life-threatening conditions take precedence. In this case, the client with chest pain and a history of coronary artery disease needs immediate assessment and intervention to ensure timely and appropriate care for a potential cardiac event.

The other options, while important, do not present an immediate life-threatening situation. Postoperative pain management, diabetic education, and a chest X-ray for pneumonia are important aspects of care but can be addressed in a more routine and scheduled manner compared to a potential cardiac emergency.

.....

The appropriate assignment for a licensed practical nurse (LPN) is:

c. Assisting with postoperative care for a client who had abdominal surgery.

Explanation:

LPNs, also known as licensed vocational nurses (LVNs) in some regions, have training and skills suitable for providing hands-on patient care. Assisting with postoperative care aligns with their skill set, as it involves tasks such as monitoring vital signs, wound care, administering oral medications, and assisting with activities of daily living.

Administering IV medications (option a) is typically within the scope of registered nurses (RNs) or advanced practice nurses. Developing a care plan for a client with a new diagnosis of diabetes (option b) involves critical thinking and comprehensive assessment, tasks often performed by RNs. Conducting a group education session on smoking cessation (option d) may also be more aligned with the broader scope of an RN, especially if it involves comprehensive health education and assessment.

.....

The medication that the nurse should notify the healthcare provider about for a client with a history of hypertension scheduled for surgery is:

a. Hydrochlorothiazide (HCTZ).

Explanation:

Hydrochlorothiazide is a diuretic that can lead to electrolyte imbalances, particularly affecting potassium levels. It is important for the healthcare provider to be aware of the client's use of

hydrochlorothiazide before surgery because surgical procedures and anesthesia can impact fluid and electrolyte balance. The healthcare provider may choose to adjust the medication regimen or provide specific instructions regarding its administration on the day of surgery.

While other medications (b. Amlodipine, c. Metoprolol, and d. Lisinopril) are commonly used for hypertension, hydrochlorothiazide, as a diuretic, has specific implications related to fluid and electrolyte balance that need attention in the perioperative period. The nurse should communicate with the healthcare provider to ensure optimal management of the client's medications during the perioperative phase.

.....

The correct answer is:

c. Abrupt discontinuation of the medication may cause withdrawal symptoms.

Explanation:

When providing education to a client prescribed fluoxetine, a selective serotonin reuptake inhibitor (SSRI) used to treat major depressive disorder, it is important to emphasize that abrupt discontinuation of the medication can lead to withdrawal symptoms. Withdrawal symptoms may include dizziness, nausea, headache, fatigue, irritability, and sleep disturbances. Clients should be instructed to taper the medication under the guidance of their healthcare provider to minimize the risk of withdrawal.

The other options are incorrect:

a. The medication should provide immediate relief of symptoms.

- This statement is not accurate. Antidepressant medications, including fluoxetine, typically take several weeks to show therapeutic effects. Clients should be informed about the delayed onset of action.

b. Avoid consuming foods rich in tyramine while taking this medication.

- This statement is more relevant to monoamine oxidase inhibitors (MAOIs), not SSRIs like fluoxetine. Fluoxetine does not have the same dietary restrictions associated with MAOIs.

d. Take the medication in the evening to enhance its effectiveness.

- The timing of fluoxetine administration is not necessarily tied to a specific time of day. It can be taken in the morning or evening, depending on the client's preference and how it affects their sleep. The timing does not significantly impact its effectiveness.

.....

The priority nursing intervention for a client who has just been diagnosed with HIV is:

b. Providing emotional support and counseling.

Explanation:

Receiving a diagnosis of HIV can be emotionally overwhelming for the client. The initial priority is to address the client's emotional needs and provide support. The nurse should offer a safe and non-judgmental environment for the client to express their feelings, fears, and concerns. Counseling and emotional support are crucial at this stage to help the client cope with the diagnosis, understand the implications, and make informed decisions about their care.

While antiretroviral medications (option a) are essential for managing HIV, addressing the client's emotional well-being comes first. Initiating airborne precautions (option c) is not necessary for HIV as it is not transmitted through the air. Notifying the local health department (option d) is important for public health reporting but is not the immediate priority when compared to providing emotional support to the newly diagnosed client.

.....

The nurse's priority assessment before administering furosemide (Lasix) to a client with heart failure is:

b. Serum potassium level.

Explanation:

Furosemide is a loop diuretic that promotes the excretion of water, sodium, and potassium. It can lead to hypokalemia (low potassium levels), which can be particularly concerning for clients with heart failure. Hypokalemia can exacerbate cardiac arrhythmias and increase the risk of adverse cardiovascular events.

Monitoring the serum potassium level before administering furosemide allows the nurse to assess the client's baseline potassium status. If the potassium level is already low, the healthcare provider may need to adjust the medication regimen or prescribe potassium supplements to prevent further depletion.

While other assessments (a. Blood pressure, c. Respiratory rate, and d. Urine output) are important in the overall care of a client with heart failure, assessing the serum potassium level is the priority when administering furosemide due to its potential impact on potassium balance.

.....

Before starting oxygen therapy for a client admitted with pneumonia, the nurse should assess:

c. Respiratory rate.

Explanation:

Assessing the client's respiratory rate is crucial before initiating oxygen therapy. Pneumonia is characterized by inflammation and infection in the lungs, often leading to impaired gas exchange and respiratory distress. Monitoring the respiratory rate helps determine the severity of respiratory distress and guides the appropriate administration of oxygen.

While other assessments such as hemoglobin level (a), blood glucose level (b), and serum sodium level (d) are important in various clinical situations, they are not the immediate

priorities when initiating oxygen therapy for a client with pneumonia. The primary concern is to ensure adequate oxygenation and relieve respiratory distress.

The nurse's first action when a postoperative client is experiencing severe pain despite receiving pain medication should be:

c. Assess the client's pain using a pain scale.

Explanation:

Before administering additional pain medication or taking further actions, the nurse should first assess the client's pain using a pain scale. Pain is a subjective experience, and the nurse needs to understand the intensity and characteristics of the pain to determine the appropriate intervention.

Assessing the pain scale helps the nurse gather information about the client's pain level, location, and any factors that may be influencing the pain experience. This assessment guides the nurse in making informed decisions about the need for additional pain relief measures, such as adjusting the dosage or type of pain medication, notifying the healthcare provider, or implementing non-pharmacological interventions.

While options a (Administer an additional dose of pain medication) and b (Notify the healthcare provider) may be necessary based on the pain assessment, the initial step is to assess the client's pain to tailor the intervention appropriately. Encouraging the client to rest (option d) may be a part of the overall pain management plan but is not the first action when the client is experiencing severe pain.

The nurse's priority action for a client with a history of chronic kidney disease scheduled for a CT scan with contrast is:

c. Assessing the client's creatinine level.

Explanation:

Administering contrast dye during imaging procedures, such as a CT scan, can pose a risk to individuals with impaired kidney function. Contrast agents are excreted by the kidneys, and if kidney function is compromised, there is an increased risk of contrast-induced nephropathy.

Assessing the client's creatinine level before the procedure provides important information about kidney function. If the creatinine level is elevated, it may indicate impaired renal function, and the healthcare provider may need to reconsider the use of contrast or take additional precautions to minimize the risk of kidney injury.

While administering the prescribed contrast dye (option a) is part of the procedure, assessing the client's creatinine level takes precedence to ensure the safety of the contrast administration. Ensuring the client is NPO (option b) and providing preoperative teaching (option d) are important aspects of preparation for the CT scan but are not the immediate priority for a client with a history of chronic kidney disease.

.....
The nurse's priority action for a client receiving intravenous (IV) antibiotics with redness, warmth, and swelling at the IV site is:

b. Discontinue the IV infusion.

Explanation:

The symptoms of redness, warmth, and swelling at the IV site may indicate a potential infection or inflammation known as phlebitis. The nurse's priority is to discontinue the IV infusion immediately to prevent further complications and ensure the client's safety.

Continuing the infusion could exacerbate the condition, leading to the spread of infection or more severe complications. Once the IV is discontinued, the nurse can assess the site, document the findings in the client's chart (option d), and notify the healthcare provider for further instructions. Applying a warm compress (option a) or administering an analgesic for pain (option c) may be appropriate interventions after discontinuing the IV, depending on the severity of symptoms and healthcare provider recommendations.

.....
The nurse's priority action in the preoperative phase for a client with diabetes scheduled for a lower extremity amputation is:

a. Assessing the client's blood glucose level.

Explanation:

In the preoperative phase, it is crucial to assess the client's blood glucose level, especially for individuals with diabetes. Hyperglycemia can significantly impact wound healing and increase the risk of postoperative complications. Assessing and managing the client's blood glucose level before surgery is essential to optimize conditions for healing and reduce the risk of infection.

While administering insulin as ordered (option b) is important for glycemic control, assessing the blood glucose level is the priority to determine the appropriate insulin dose. Providing emotional support and education (option c) and preparing the client for surgery (option d) are essential components of preoperative care but should occur after addressing immediate concerns related to blood glucose levels.

.....
The nurse should monitor:

b. Oxygen saturation.

Explanation:

Nebulized albuterol is a bronchodilator commonly used to relieve bronchoconstriction in clients with conditions such as chronic obstructive pulmonary disease (COPD). The nurse should monitor the client's oxygen saturation during the administration of albuterol to assess the effectiveness of the medication in improving airflow and oxygenation.

While blood pressure (option a) is generally not significantly affected by nebulized albuterol, monitoring oxygen saturation is more relevant in assessing respiratory function. Serum potassium level (option c) and blood glucose level (option d) are not directly influenced by nebulized albuterol administration.

In summary, assessing oxygen saturation helps the nurse evaluate the respiratory response to the bronchodilator and ensures appropriate oxygenation for the client with COPD.

.....
The nurse's priority action before inserting the NG tube is:

d. Checking the client's gag reflex.

Explanation:

Before inserting a nasogastric (NG) tube, it is crucial to check the client's gag reflex. This assessment ensures that the client can protect their airway during the insertion procedure. If the gag reflex is absent or compromised, there is an increased risk of the tube entering the trachea instead of the esophagus, which can lead to respiratory distress.

Administering an antiemetic (option a) may be considered in certain situations, but checking the gag reflex takes precedence as it directly impacts the safety of the NG tube insertion. Obtaining informed consent (option b) is an important step in the procedure but is not the immediate priority. Auscultating bowel sounds (option c) is not directly related to the insertion of an NG tube and can be assessed afterward.

.....
The nurse's priority action is:

b. Stop the feeding and notify the healthcare provider.

Explanation:

If a client receiving continuous tube feedings experiences a slow rate of feeding and complains of abdominal discomfort, it may indicate complications such as feeding intolerance or the development of gastrointestinal issues. Stopping the feeding allows the nurse to assess the situation further and prevent potential harm to the client.

Increasing the rate of the feeding (option a) without understanding the cause of the issue could

exacerbate the problem. Administering an antiemetic (option c) addresses symptoms but does not address the underlying cause. Documenting the findings (option d) is important, but stopping the feeding and notifying the healthcare provider take precedence to ensure appropriate and timely intervention.

.....
The nurse's priority assessment before administering heparin is:

b. Activated partial thromboplastin time (aPTT).

Explanation:

Heparin is an anticoagulant that works by inhibiting clotting factors, particularly thrombin and factor Xa. The aPTT is a laboratory test that measures the time it takes for blood to clot, and it is used to monitor the effectiveness of heparin therapy. The nurse should assess the aPTT before administering heparin to ensure that the client is within the therapeutic range.

While other laboratory values, such as platelet count (option a), may be monitored during heparin therapy, the aPTT is the most specific test for assessing heparin's anticoagulant effects. Serum potassium level (option c) and liver function tests (option d) are not directly related to monitoring heparin therapy. The aPTT reflects the clotting time and guides adjustments to heparin dosage to prevent bleeding or thrombosis.

.....
The nurse's priority action during the initial assessment for a client admitted with a suspected myocardial infarction is:

c. Monitor the client's cardiac rhythm.

Explanation:

When a client is admitted with a suspected myocardial infarction (MI), the initial priority is to assess and monitor the cardiac rhythm. This is crucial because an MI can lead to arrhythmias, which can be life-threatening. Monitoring the cardiac rhythm allows the nurse to detect any abnormalities or signs of arrhythmias promptly.

While obtaining a detailed health history (option a) is important, monitoring the cardiac rhythm takes precedence in this acute situation. Administering nitroglycerin as ordered (option b) and checking the client's blood pressure (option d) are important interventions, but assessing the cardiac rhythm is the immediate priority to identify any life-threatening arrhythmias.

.....
The nurse's priority intervention to prevent complications for a client receiving intravenous (IV) chemotherapy is:

b. Use a central venous access device.

Explanation:

Chemotherapy medications are potent and can cause irritation to peripheral veins. Using a

central venous access device, such as a central venous catheter or a peripherally inserted central catheter (PICC), is a common practice in chemotherapy administration. This central access allows for the delivery of chemotherapy directly into larger veins, reducing the risk of extravasation and irritation to peripheral veins.

While administering antiemetic medications (option a) is important to manage nausea and vomiting associated with chemotherapy, using a central venous access device takes precedence to prevent complications related to peripheral vein irritation. Monitoring the client's platelet count (option c) is relevant but does not directly address the prevention of complications during chemotherapy administration. Encouraging a high-fiber diet (option d) is not directly related to the prevention of complications associated with chemotherapy administration.

.....
The nurse's initial action when a client diagnosed with schizophrenia refuses to take prescribed antipsychotic medication is:

b. Document the client's refusal in the chart.

Explanation:

In cases where a client refuses medication, it is essential for the nurse to document this refusal accurately and thoroughly in the client's medical chart. Documentation should include the client's statements, any observed behaviors, and the nurse's attempts to educate and encourage medication adherence. Documenting refusals provides a clear record of the client's choices and the nursing interventions taken.

Administering medication covertly (option a) is not ethically appropriate and violates the client's autonomy. Obtaining a court order for medication administration (option c) is a legal process that is generally pursued if all other efforts to obtain informed consent have been exhausted. Attempting to convince the client about the importance of the medication (option d) is a valid intervention, but the immediate action should involve accurate documentation of the refusal.

.....
The nurse's priority assessment for a client admitted with acute kidney injury is:

b. Intake and output.

Explanation:

Acute kidney injury (AKI) is characterized by a sudden decline in kidney function, leading to the accumulation of waste products and fluids in the body. Monitoring intake and output (I&O) is crucial in assessing renal function and fluid balance. Changes in urine output, such as oliguria or anuria, can indicate impaired kidney function. It helps the nurse identify trends, assess response to interventions, and prevent complications related to fluid overload or dehydration.

While blood pressure (option a) is important in assessing overall cardiovascular and renal health, it may not provide immediate information about kidney function. Serum creatinine level (option c) is an important laboratory parameter for assessing kidney function, but it may not provide real-time information about fluid balance. Dietary preferences (option d) are relevant but not the priority in the initial assessment of a client with acute kidney injury.

.....
The nurse's priority teaching point for a client with heart failure prescribed a low-sodium diet is:

c. Reading food labels for sodium content.

Explanation:

Clients with heart failure often benefit from a low-sodium diet to manage fluid balance and reduce the risk of exacerbations. Reading food labels for sodium content is crucial for making informed choices about food consumption. Many processed and packaged foods contain high levels of sodium, and being able to identify and choose low-sodium options is essential for maintaining dietary restrictions.

While restricting fluid intake (option b) is a common recommendation for heart failure management, the emphasis on sodium restriction is more pertinent in this context. Avoiding foods high in potassium (option a) is not the primary concern in a low-sodium diet. Increasing protein intake (option d) may have its considerations, but it is not the priority teaching point in the context of heart failure and sodium restriction.

.....
The nurse's priority action during the initial assessment for a client with a history of asthma admitted for shortness of breath is:

b. Checking the client's oxygen saturation.

Explanation:

Assessing oxygen saturation is a critical and immediate step to determine the client's respiratory status and the effectiveness of oxygen exchange. It helps in understanding the severity of respiratory distress and guides the nurse in making decisions about the need for supplemental oxygen or other interventions.

While administering a bronchodilator (option a) is an important intervention for asthma, checking oxygen saturation takes precedence to assess the immediate respiratory status. Obtaining a sputum culture (option c) may be done later in the assessment process but is not the initial priority. Assessing lung sounds (option d) is relevant but does not provide immediate information about the client's oxygenation status, which is crucial in the initial assessment.

.....
The nurse's priority intervention for a postoperative client at risk for deep vein thrombosis (DVT) is:

b. Administering low-molecular-weight heparin.

Explanation:

Administering low-molecular-weight heparin (LMWH) is a crucial intervention for DVT prophylaxis in postoperative clients. LMWH helps prevent the formation of blood clots by inhibiting the clotting process.

While applying compression stockings (option a) and encouraging ambulation (option c) are important measures in preventing DVT, administering LMWH is often a more direct and immediate pharmacological intervention for postoperative clients at risk. Monitoring platelet count (option d) is not a primary intervention for preventing DVT.

.....
The nurse's priority pre-procedure teaching for a client scheduled for a colonoscopy is:

a. Discussing dietary restrictions.

Explanation:

Discussing dietary restrictions is a crucial aspect of preparing a client for a colonoscopy. Adequate bowel preparation is essential for a successful colonoscopy, and specific dietary restrictions help ensure a clear visualization of the colon during the procedure. Typically, clients are instructed to follow a clear liquid diet and avoid certain foods or substances that could impact the clarity of the colonoscopy.

While explaining the procedure details (option b) and providing information about post-procedure care (option c) are important, ensuring the client understands and complies with dietary restrictions is a critical component of the preparation process. Being NPO (nothing by mouth) for 8 hours (option d) is more relevant for procedures requiring sedation but may not be the primary focus for colonoscopy preparation.

.....
The nurse should monitor closely:

b. Serum potassium levels.

Explanation:

When a client with heart failure is prescribed a diuretic, particularly loop diuretics like furosemide (Lasix), monitoring serum potassium levels is crucial. Loop diuretics can lead to potassium loss, which may result in hypokalemia. Hypokalemia can have serious consequences, including cardiac dysrhythmias.

While monitoring other electrolytes such as sodium is also important, potassium is particularly critical in clients taking diuretics. Blood glucose levels (option c) and white blood cell count (option d) are generally not directly affected by diuretic use for heart failure.

The nurse's priority intervention to prevent infection when a client is receiving total parenteral nutrition (TPN) is:

d. Using aseptic technique during TPN administration.

Explanation:

TPN is a specialized form of nutrition delivered directly into the bloodstream through a central venous catheter to provide nutrients when the client cannot tolerate oral or enteral feedings. Infection is a significant risk because TPN is administered through a central venous line, which provides a direct route for bacteria to enter the bloodstream.

Using aseptic technique during TPN administration, including proper hand hygiene, wearing sterile gloves, and maintaining a sterile field, is crucial to prevent infection. Changing the TPN tubing every 48 hours (option a) is a standard practice to reduce the risk of contamination. Administering TPN through a central venous catheter (option b) is a common route for TPN delivery. Checking blood glucose levels every 6 hours (option c) is essential for monitoring the client's response to TPN but is not primarily focused on infection prevention.

The nurse's priority teaching point for a client prescribed warfarin (Coumadin) for anticoagulation is:

b. Avoid activities that may cause injury or bleeding.

Explanation:

Warfarin is an anticoagulant that works by inhibiting the synthesis of vitamin K-dependent clotting factors. It reduces the risk of blood clots but also increases the risk of bleeding. Therefore, it is crucial to educate the client about activities that may cause injury or bleeding and to take precautions to minimize this risk. This includes:

- Using a soft toothbrush to prevent gum bleeding.
- Using an electric razor instead of a manual razor to avoid nicks and cuts.
- Avoiding contact sports or activities that carry a high risk of injury.

While maintaining a consistent intake of green leafy vegetables is important for clients on warfarin (option a), it is not the priority teaching point. Taking warfarin with a glass of grapefruit juice (option c) is not a relevant consideration, and discontinuing the medication if experiencing headaches (option d) is not appropriate without consulting the healthcare provider.

The nurse's priority intervention to prevent complications while a client is receiving enteral feedings through a nasogastric tube is:

a. Elevate the head of the bed to 45 degrees during feedings.

Explanation:

Elevating the head of the bed to 45 degrees during feedings helps prevent aspiration, which is a potential complication of enteral feedings. Aspiration occurs when stomach contents reflux into the lungs, leading to respiratory complications, including pneumonia. Keeping the head of the bed elevated helps minimize the risk of regurgitation and aspiration.

While the other options may also be relevant considerations in enteral feeding care:

- *Using a small-bore feeding tube for administration (option b)*: The choice of feeding tube depends on the client's condition and nutritional needs, but preventing aspiration with proper positioning is a more immediate concern.
- *Administering feedings at room temperature (option c)*: This is generally a good practice to enhance tolerance, but it is not as critical as preventing aspiration.
- *Checking residual volume before each feeding (option d)*: Checking residual volume is part of the enteral feeding management protocol to assess gastric emptying and tolerance. However, maintaining the head of the bed elevated is more directly related to preventing aspiration during feedings.

The nurse's priority preoperative assessment for a client with a history of seizure disorder is:

d. Frequency of recent seizures.

Explanation:

Assessing the frequency of recent seizures is crucial in determining the client's seizure control and the potential risk for perioperative seizures. This information helps guide the anesthesia and surgical teams in planning and implementing appropriate perioperative care to minimize the risk of seizures during and after surgery.

While all the options (a, b, c, and d) are relevant considerations in the preoperative assessment, assessing the frequency of recent seizures is particularly important for individuals with a seizure disorder to ensure their safety and well-being during the surgical process. This information helps the healthcare team make informed decisions about anesthesia, antiseizure medications, and postoperative monitoring.

The nurse's priority assessment before starting oxygen therapy for a client with chronic obstructive pulmonary disease (COPD) is:

a. Respiratory rate.

Explanation:

Assessing the respiratory rate is crucial before initiating oxygen therapy, especially for clients with COPD. These individuals may rely on hypoxic drive (low oxygen levels) to stimulate their respiratory effort. Administering high levels of supplemental oxygen can suppress the hypoxic drive, leading to respiratory depression. Therefore, monitoring the respiratory rate helps ensure that the client is not at risk of respiratory depression when receiving oxygen therapy.

While blood pressure, serum potassium level, and oxygen saturation are important assessments in the care of a client with COPD, the respiratory rate takes precedence in this specific context to prevent potential complications related to the administration of oxygen.

The nurse's priority intervention for wound care in a client with diabetes and a foot ulcer would be:

a. Apply a dry sterile dressing.

Explanation:

1. ***Dry Sterile Dressing:*** Applying a dry sterile dressing helps to create a clean and protective environment for the wound. It promotes healing by preventing contamination and infection. People with diabetes are at an increased risk of developing infections, and proper wound care is crucial in preventing complications.

2. ***Hydrogen Peroxide:*** Hydrogen peroxide can be too harsh on the wound and may impede the healing process. It can cause damage to healthy tissue and delay wound healing. Therefore, it is generally not recommended for routine wound care.

3. ***Wet-to-Dry Dressing:*** While wet-to-dry dressings were once commonly used, they are now less favored due to their potential to cause trauma to the wound bed during dressing changes. They can remove healthy tissue along with the debris, leading to delayed healing.

4. ***Topical Antibiotic Ointment:*** While topical antibiotic ointments can be beneficial in certain situations, they are not always the first-line treatment. Overuse of antibiotics can contribute to antibiotic resistance, and the choice of antibiotic should be based on the specific characteristics of the wound and any signs of infection.

In summary, applying a dry sterile dressing is the priority intervention as it provides a suitable environment for wound healing and helps prevent infection without causing unnecessary trauma to the wound bed.

The nurse's immediate action when a client receiving intravenous (IV) antibiotics for a urinary tract infection reports itching, rash, and difficulty breathing would be:

b. Discontinue the IV antibiotics.

Explanation:

1. ***Discontinue IV Antibiotics:*** The symptoms described (itching, rash, and difficulty breathing) are indicative of an allergic reaction, which can be serious and potentially life-threatening. The immediate priority is to stop the administration of the suspected offending agent, which, in this case, is the IV antibiotics. This helps prevent the escalation of the allergic reaction.
2. ***Administer an Antihistamine:*** While an antihistamine might be considered to manage symptoms, discontinuing the IV antibiotics takes precedence as it directly addresses the cause of the allergic reaction.
3. ***Increase the Rate of the IV Infusion:*** Increasing the rate of the IV infusion is not an appropriate action in the context of an allergic reaction. It may exacerbate the symptoms and further compromise the client's respiratory status.
4. ***Notify the Healthcare Provider:*** While notifying the healthcare provider is important, the immediate action should be discontinuing the IV antibiotics. Afterward, the nurse should promptly inform the healthcare provider about the allergic reaction and seek further guidance regarding alternative treatments.

In summary, discontinuing the IV antibiotics is the immediate and priority action to address the allergic reaction and prevent further complications.

The nurse's priority intervention for a client admitted with suspected meningitis is:

c. Performing a lumbar puncture.

Explanation:

1. ***Performing a Lumbar Puncture:*** Meningitis is an inflammation of the meninges (protective membranes) surrounding the brain and spinal cord. A lumbar puncture (also known as a spinal tap) is a diagnostic procedure to obtain cerebrospinal fluid (CSF) for analysis. It helps to confirm the diagnosis of meningitis and identify the causative organism, guiding appropriate treatment.
2. ***Administering Antibiotics:*** While administering antibiotics is an essential intervention in the treatment of bacterial meningitis, the priority is to confirm the diagnosis through a lumbar puncture before initiating specific antibiotic therapy. The choice of antibiotics may vary based on the causative organism.
3. ***Placing the Client in Isolation:*** Isolation precautions may be necessary once the diagnosis is confirmed, especially if the meningitis is caused by bacteria or viruses that can be spread to others. However, confirming the diagnosis is the initial priority.

4. ***Monitoring Blood Glucose Levels:*** While monitoring blood glucose levels is an important aspect of overall patient care, it is not the priority when meningitis is suspected. The focus at this stage is on diagnostic procedures and identifying the cause of the symptoms.

In summary, performing a lumbar puncture is the priority intervention to confirm the diagnosis of meningitis, allowing for appropriate and timely treatment.

The nurse's priority assessment for a postoperative client prescribed patient-controlled analgesia (PCA) for pain management is:

a. Respiratory rate.

Explanation:

1. ***Respiratory Rate:*** With the use of opioid analgesics, such as those delivered through patient-controlled analgesia (PCA), there is a risk of respiratory depression. Monitoring the respiratory rate is crucial to identify any signs of respiratory compromise. If the respiratory rate decreases significantly, it may indicate opioid overdose or respiratory suppression, requiring prompt intervention.
2. ***Pain Intensity:*** While pain intensity is important to assess, it is secondary to respiratory rate in this context. Respiratory depression is a potentially serious complication associated with opioid use, and prompt identification is crucial for patient safety.
3. ***Urinary Output:*** Urinary output is a relevant assessment, especially in the postoperative period, but it is not the top priority when the client is on PCA. Respiratory depression takes precedence due to the risk associated with opioid administration.
4. ***Blood Pressure:*** Monitoring blood pressure is important, but it is not the immediate priority when assessing a client on PCA. Respiratory rate is a more sensitive indicator of potential opioid-related respiratory depression.

In summary, the nurse's priority assessment when caring for a postoperative client on PCA is to monitor the respiratory rate to promptly identify any signs of respiratory depression and ensure patient safety.

The precautionary measures that the nurse should take when caring for a client diagnosed with tuberculosis (TB) are:

b. Airborne precautions.

Explanation:

1. ***Airborne Precautions:*** TB is primarily transmitted through the air via respiratory droplets. Airborne precautions are designed to prevent the transmission of infectious agents that remain infectious over long distances when suspended in the air. For TB, this involves placing the client in a negative-pressure room, using an N95 respirator or higher-level respiratory protection, and ensuring proper ventilation.
2. ***Standard Precautions:*** Standard precautions involve the use of personal protective equipment (PPE) and infection control practices to prevent the transmission of infectious agents. While standard precautions are important in general patient care, they may not be sufficient for highly contagious diseases like TB.
3. ***Contact Precautions:*** Contact precautions are used for diseases that spread by direct or indirect contact with the patient or their environment. TB is primarily transmitted through the air, so contact precautions are not the most appropriate for TB.
4. ***Droplet Precautions:*** Droplet precautions are for diseases spread by respiratory droplets that are larger and do not remain suspended in the air for long distances. TB transmission occurs through smaller airborne particles, so droplet precautions are not sufficient for TB.

In summary, airborne precautions are essential when caring for a client with TB to minimize the risk of transmission to healthcare workers and other patients.

The nurse's priority intervention during the initial assessment of a client with a history of alcohol use disorder admitted for detoxification is:

a. Assessing for signs of withdrawal.

Explanation:

1. ***Assessing for Signs of Withdrawal:*** When a client with a history of alcohol use disorder is admitted for detoxification, the initial priority is to assess for signs and symptoms of alcohol withdrawal. Alcohol withdrawal can be a serious and potentially life-threatening condition, with symptoms ranging from mild anxiety and tremors to more severe manifestations such as hallucinations, seizures, and delirium tremens. Early identification and management of withdrawal symptoms are crucial for patient safety.
2. ***Implementing Suicide Precautions:*** While suicide risk is an important consideration, assessing for withdrawal symptoms is more immediate and directly related to the client's admission for detoxification. Suicidal ideation and behavior can be assessed as part of the overall assessment, but it may not be the initial priority.
3. ***Obtaining a Urine Drug Screen:*** While obtaining a urine drug screen can provide

information about recent substance use, including drugs other than alcohol, the primary focus during the initial assessment is on alcohol withdrawal symptoms.

4. *Monitoring Liver Function Tests:* Monitoring liver function tests is important in assessing the overall health of an individual with a history of alcohol use disorder, but it may not be the priority during the initial assessment for detoxification. Immediate attention is needed to address potential withdrawal symptoms.