Final Quiz with Answers and Hints

1. The client is receiving external radiation (teletherapy) to the neck for laryngeal cancer. The nurse instructs the client that the most likely side affect is:
   A. diarrhea
   B. a sore throat
   C. a headache
   D. blurred vision

Techniques to apply: Priority Words – MOST

Hints: neck, a sore throat
1. Look for the priority word.
2. Find the hint. One word in the question is similar to a word in the answer choices.
4. Also, of course, you should look for the pattern of the anatomical locations i.e., neck and throat.

Correct answer is: B

2. A client is receiving Digoxin for congestive heart failure. The nurse will assess for early signs and symptoms of digoxin toxicity which include:
   A. coma
   B. disorientation
   C. hallucinations
   D. nausea/vomiting

Techniques to apply: Priority Words: EARLY SIGNS AND SYMPTOMS

Hints:
1. Find the priority words “early signs and symptoms” which should guide you to the correct answer.
2. In addition, nausea and vomiting is a common and early side affect for many medications.
3. Answer choices A, B and C would take time to develop.

Correct answer is: D

3. Upon auscultation of bowel sounds the nurse has identified an early sign of an intestinal obstruction which includes:
   A. diminished bowel sounds
   B. high pitched sounds
   C. absent bowel sounds
   D. distention

Techniques to apply: Priority Words: AN EARLY SIGN
Hints: auscultation and high pitched.
1. Two Answer Choices Are Similar: diminished bowel sounds, absent bowel sounds
2. Find the priority words: an early sign
3. Find the hints: One of the choices is something that you can hear, so it is directly linked to the word auscultation.
4. The two answer choices that are similar can be eliminated because, in addition to being incorrect, they are basically the same. If they are basically the same in meaning. Therefore, it would be impossible for only one of them to be the correct answer

Correct answer is: B

A client has been ordered Coumadin (an anticoagulant). The nurse is aware that there is a need for further education when the patient states:

A. I will continue to use a soft bristled toothbrush.
B. I will not eat green leafy vegetables.
C. I will wear a medic alert bracelet.
D. I will continue to shave with a straight razor.

Techniques to apply: False words: A NEED FOR FURTHER EDUCATION

Hint:
1. This question addresses what the nurse WILL NOT do.

Correct answer is: D.

Which action violates medical asepsis when the nurse is performing handwashing?

A. Turning off the faucet with your clean hand.
B. Perform hand washing before and after client care.
C. Use soap and rub your hands to create friction.
D. Wear a limited amount of jewelry.

Techniques to apply:

Hints:
1. This question addresses what the nurse WILL NOT do.
2. You are looking for the negative or wrong nursing action.
3. Touching the faucet could contaminate your hands with microorganisms. The nurse should use a paper towel to turn the faucet off.

Correct answer is: A
6. When providing oral hygiene for patients, what action can nurses take to protect themselves when providing oral hygiene for patients?

A. Encourage patients to perform all of their own mouth care.
B. Wash hands before providing care.
C. Wear clean gloves during mouth care.
D. Always provide mouthwash before tooth brushing.

Techniques to apply: **Absolute Words**: ALL, ALWAYS

*Hints:*
1. The exclusivity of the words all and always makes them very suspicious and most likely, incorrect.
2. The hand washing protects the patient from the nurse but not the nurse from the patient.
3. Gloves would be standard precautions and create a barrier between the nurse and the body secretions.

Correct answer is: **C**

7. The nurse will perform logrolling to keep the patient's spine in proper alignment. The nurse will:

A. always explain procedure to the patient.
B. advise the patient to keep arms at their side.
C. remove draw sheet.
D. elevate head of bed.

Techniques to apply: **Absolute Word**: ALWAYS

*Hints:*
1. There is one absolute word that you must consider.
2. It will be either 100% correct or 100% wrong.

Correct answer is: **A**

8. A hospice patient has many visitors including family, friends and chaplain. The nurse notices the patient's son is angry when the patient does not eat. In response to the son's anger, the nurse should:

A. tell the son that the patient is not hungry.
B. encourage the patient to eat.
C. explore the situation with the son.
D. continue to observe the situation.

Techniques to apply: **Central Person**: THE SON
Hints:
1. There are many people in this situation
2. The phrase when the patient’s son becomes angry SHIFTS the focus to him and the nurse needs to address his anger.

Correct answer is: C

9. The patient has had a portion of their large intestine surgically removed resulting in a colostomy. The patient says to the nurse, “My wife says she prefers not to look at the colostomy bag and leaves the room when I am getting dressed and undressed.” What should be the initial action of the nurse?

A. Refer the wife to a support group or licensed counselor.
B. Meet with the wife to discuss her concerns.
C. Tell the patient that the wife’s feelings are normal.
D. Explore the patient’s feeling about the wife’s comments.

Techniques to apply: **Central Person:** THE PATIENT

Priority Words: initial action

Hints: The quote from the patient directs the nurse’s attention to what the patient may be feeling
1. There are three people in this question: the patient, the wife the nurse.
2. The fact that there is a direct quote from the patient should lead you to find the correct central person.

Correct answer: D

10. In relation to extracellular body fluids, lactated ringers is:

A. isotonic.
B. hypotonic.
C. alkalotic.
D. hypertonic.

Techniques to apply: **Opposites in the Answer:** HYPOTONIC, HYPERTONIC

Hints:
1. Options A and B are opposites. Therefore they signal the need for careful consideration.
2. In this case both are incorrect.
3. The correct answer is A because isotonic means it is equal to body fluids.

Correct answer: A
11. The nurse is to perform passive range of motion exercises for a patient who is paralyzed. When should the nurse perform passive ROM?

A. After the patient is mechanically transferred out of bed.
B. While the patient is still in bed.
C. When the patient’s legs become edematous.
D. Before the patient is placed on a bedpan.

Techniques to apply: Opposites in the Answer: IN BED, OUT OF BED

Hints:
1. A and B are opposites.
2. Technically both are possible, but B is the safest.
3. In this case, one of the opposites does contain the correct answer.

Correct answer: B

12. The nurse instructs the post-operative client to participate in turn, cough, and deep breathing exercises. What is the main purpose for these breathing exercises?

A. To prevent pooling of secretions.
B. To increase respiratory endurance.
C. To strengthen expiratory effort.
D. To maximize inspiratory effort.

Techniques to apply: Priority Words: THE MAIN PURPOSE

Hints: Answer Choices Are Similar: increase, strengthen, maximize
1. B, C, D are not completely similar; however, the verbs are similar.
2. Therefore the answer choice that contains the word “prevent” requires special consideration because it is different.
3. B, C, D are correct, but they are not the main purpose.

Correct answer: A

13. What nursing action is most appropriate for helping meet a patient's physiological needs?

A. Provide assist with ambulation.
B. Put the bedrails up.
C. Put the call bell within reach.
D. Provide sufficient fluid.

Techniques to apply: Priority Words: MOST APPROPRIATE

Hint: Answer Choices Are Similar: A, B, and C
1. A, B, and C all relate to safety and are basically equal as they focus on safety needs and therefore they are not correct.
2. Physiological needs include food, fluid, oxygen and shelter.

Correct answer: D

14. A client with schizophrenia reveals to the nurse that voices have told him he is in danger. The client asks the nurse, "Do you hear the voices?" The nurse’s best response would be:

A. “Don’t worry. You’re safe in the hospital.”
B. “Tell me more about the voices. Are they men or women?”
C. “You need an activity to occupy your mind so you don’t hear the voices.”
D. “I know these voices are very real to you, but I don’t hear them.”

Techniques to apply: **Central Person: THE PATIENT**

Hint: **Client Focused Care**
1. A, B, and C do not focus on what is important to the patient at the time. Therefore, they are incorrect.
2. D validates and focuses on the patient and problem at hand.

Correct answer: D

15. A client diagnosed with a major depressive disorder is eating breakfast in the dining room. However, she is not speaking. The most therapeutic nursing intervention in response to this behavior would be:

A. have her sit with a group of clients who will encourage her to talk.
B. ignore her silence and talk about topics such as the news.
C. plan time with her even though she does not communicate.
D. point out that by not speaking she makes those around her feel uncomfortable.

Techniques to apply: **Central Person: THE PATIENT**

Hint: **Client Focused Care**
1. A, B, and D do not focus on the needs of the patient’s communication, emotional or physical needs.
2. The nurse offering his/her self provides validation of the patient’s needs and helps develop a trusting relationship.

Correct answer: C