NUR 111
Course Review
A nurse who functions in the role of client advocate:

a. makes decisions for the client.
b. counsels the client about the appropriate decisions.
c. supports the client’s decisions.
d. shares his or her own preferences with the client.
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The community health nurse is providing tertiary prevention to a client. Which would be an example of this type of prevention?

a. Poison prevention  
b. Self-examination for breast cancer  
c. Marriage counseling  
d. Identifying complications of diabetes
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According to the World Health Organization, the definition of health:

a. is the absence of disease.
b. is the state of complete physical well-being.
c. focuses on categories of disease that may cause illness.
d. places health in the context of environment.
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In Maslow’s hierarchy of needs, which category of needs must be met before a person can focus on safety and security needs?

a. Physiologic
b. Self-esteem
c. Love and belonging
d. Self-actualization
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a. Physiologic
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c. Love and belonging
d. Self-actualization
In Maslow’s hierarchy of needs, the self-actualized person:

a. is other-directed.
b. possesses above-normal intelligence.
c. has a future-time orientation.
d. has realized his/her full potential.
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a. is other-directed.
b. possesses above-normal intelligence.
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d. has realized his/her full potential.
Using Maslow’s framework, which statement characterizes a self-actualized person?

a. “I have a driving need to change the world.”

b. “I don’t want any changes made from the way it has always been.”

c. “I will look like a fool if I admit that my idea is not working.”

d. “I have listened to everyone, but I still have to do what I think is right.”
Using Maslow’s framework, which statement characterizes a self-actualized person?

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Culture is best defined as the:

a. traditions, values and norms transmitted from generation to generation.

b. classification of people according to shared biologic characteristics.

c. group religious or racial characteristics that set it apart from the larger society of which it is a part.

d. assumption of attitudes, values and beliefs of the dominant society.
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Which is the usual order for the components of the nursing process?

a. Assessing, planning, diagnosing, evaluating, implementing
b. Assessing, diagnosing, planning, implementing, evaluating
c. Planning, assessing, diagnosing, implementing, evaluating
d. Diagnosing, implementing, evaluating, assessing, planning
Which is the usual order for the components of the nursing process?

a. Assessing, planning, diagnosing, evaluating, implementing
b. **Assessing, diagnosing, planning, implementing, evaluating**
c. Planning, assessing, diagnosing, implementing, evaluating
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A client comes to the clinic with vomiting and dehydration. The RN takes vital signs. What is this an example of?

a. Assessing
b. Diagnosing
c. Planning
d. Implementing
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Which best describes the nursing process?

a. It is a solution to all client problems.
b. It is useful mainly in the hospital setting.
c. It is linear in nature, progressing in separate, unrelated steps.
d. It is a systematic, problem-solving approach to client care.
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Which is an example of objective data?

a. Nausea
b. Vomiting
c. Joint pain
d. Headache
Which is an example of objective data?

a. Nausea  
b. Vomiting  
c. Joint pain  
d. Headache
Which is an example of subjective data?

a. Temperature of 101°F.
b. Vomiting.
c. Nausea.
d. BP 128/78.
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a. Temperature of 101° F.
b. Vomiting.
c. Nausea.
d. BP 128/78.
What is the primary reason for interviewing a client during the assessment component of the nursing process?

a. Establish rapport
b. Teach needed information
c. Provide emotional therapy
d. Collect data
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The RN asks the client, “Did your husband hit you?” What is this an example of?

a. Closed question.
b. Open-ended question.
c. Leading question.
d. Neutral question.
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The RN examines the wound for changes in appearance and signs of healing during wound care. Which of the nursing process steps is the RN using?

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b. Diagnosis  
c. Implementation  
d. Evaluation
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Which critical thinking activities are conducted during the assessment phase of the nursing process?

a. Making inferences
b. Finding patterns
c. Stating the problem
d. Categorizing data
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During an interview, the client asks the RN for an opinion on the medical treatment provided by the primary care physician. What would be an appropriate response by the RN?

a. “If I were you, I would get a new doctor.”
b. “I wouldn’t be happy either.”
c. “Tell me what is causing you to question the care you’ve received.”
d. “Let’s not discuss that now. How have you been feeling?”
During an interview, the client asks the RN for an opinion on the medical treatment provided by the primary care physician. What would be an appropriate response by the RN?

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What does a nursing diagnosis focus on?

a. The pathophysiology of the client’s illness.

b. Describing the client’s symptoms

c. The client’s strengths or health problems

d. Describing the client’s needs
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A client has a fractured hip. “Fractured hip” is a:

a. Nursing diagnosis
b. Medical diagnosis
c. Collaborative problem
d. Potential problem
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Why is it important to identify the etiology of a nursing diagnosis?

a. It enables the RN to individualize interventions for a particular client.

b. It describes the pathophysiology of the client’s disease.

c. It determines whether the problem is actual or potential.

d. It includes the defining characteristics of the diagnosis.
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When should discharge planning begin?

a. Upon admission
b. The day before discharge
c. 24 hours after admission
d. When the client is well
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What is wrong with the outcome: ‘Client will be able to climb one flight of stairs without shortness of breath’?

a. Nothing is wrong.
b. No target timeframe is given.
c. It is not measurable.
d. Behavioral terms are not used.
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What is part of the implementation step of the nursing process?

a. Putting the care plan into action.
b. Determining whether desired outcomes have been achieved.
c. Assessing the health status of the client.
d. Identifying available nursing resources.
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a. Putting the care plan into action.
b. Determining whether desired outcomes have been achieved.
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In the nursing process, which step comes after planning?

a. Assessment  
b. Diagnosis  
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a. Assessment  
b. Diagnosis  
c. Implementation  
d. Evaluation
What is a purpose of the evaluation step of the nursing process?

a. Identify the client’s strengths  
b. Carry out the nursing interventions  
c. Identify effective nursing actions  
d. Determine if client goals have been met
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a. Identify the client’s strengths
b. Carry out the nursing interventions
c. Identify effective nursing actions
d. Determine if client goals have been met
Which is part of the evaluation phase of the nursing process?

a. Planning nursing strategies
b. Reexamining the client’s care plan
c. Identifying available resources
d. Carrying out the nursing interventions
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a. Planning nursing strategies
b. Reexamining the client’s care plan
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d. Carrying out the nursing interventions
What is the next step after the RN determines that a client outcome has not been met?

a. Notify the position
b. Discontinue the care plan
c. Continue current nursing interventions until the outcome has been met
d. Reexamine the care plan to see if it needs to be revised
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Which nursing action would be appropriate to delegate to an unlicensed nursing assistant?

a. Giving regularly scheduled intravenous medications.
b. Analyzing the lab results of a client.
c. Evaluating the desired outcomes for a postoperative client.
d. Taking the temperature of all clients on one side of the hall.
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The RN is preparing to place an indwelling urinary catheter in a client. What is the next step after explaining the procedure to the client?

a. Document the client’s response to the explanation.
b. Provide for client privacy.
c. Offer the client something for pain.
d. Delegate the task to a nursing assistant.
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b. **Provide for client privacy.**
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In which category of SOAP charting would the RN look to find out whether a client had complained of nausea?

a. Subjective data  
b. Objective data  
c. Assessment  
d. Plan
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a. Subjective data
b. Objective data
c. Assessment
d. Plan
After charting your nurses’ notes, you discover you have made an error. How should you correct it?

a. Use whiteout on the incorrect entry.
b. Recopy that page of nurses’ notes.
c. Erase the error and fill in the correct information.
d. Draw a line through the error and write ‘error’, your initials and the date above it.
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Which is a charting error?

a. Using a black ballpoint pen.
b. Handprinting your nurses’ note because your cursive writing is hard to read.
c. Signing the nurses’ note that another nurse wrote about her client and forgot to sign.
d. Including the date and time in each of the chart entries.
Which is a charting error?

a. Using a black ballpoint pen.
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c. Signing the nurses’ note that another nurse wrote about her client and forgot to sign.
d. Including the date and time in each of the chart entries.
The order reads to give the medication ‘tid’. Which schedule meets the ordered interval?

a. 9 AM and 9 PM  
b. 9 AM, 5 PM and 1 AM  
c. 9 AM, 3 PM, 9 PM and 3 AM  
d. 9 AM every third day
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In order to listen attentively to a client, the RN needs to:

a. Maintain good eye contact
b. Lean back in the chair
c. Sit with legs crossed
d. Respond quickly to the client’s statements.
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The RN violates a client’s intimate space when:

a. Sitting in a chair at the client’s bedside.

b. Adjusts the client’s IV flow rate.

c. Removes the client’s abdominal dressing.

d. Enters the client’s hospital room.
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Why is the thumb is not used by the RN to palpate a pulse?

a. The index finger is more sensitive to touch.
b. The thumb pressure may obliterate the pulse.
c. It is more awkward.
d. The RN might feel his/her own thumb pulse.
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When measuring blood pressure, what does the first sound you hear indicate?

a. Systolic pressure
b. Diastolic pressure
c. Pulse pressure
d. Auscultatory gap
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b. Diastolic pressure  
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The RN has assessed the pulse rate of a 44 year old client to be 110 and not regular. Which terms should be used to describe this client’s pulse?

a. Bradycardic and normal rhythm
b. Tachycardic and decreased pulse volume
c. Bradycardic and dysrhythmic
d. Tachycardic and dysrhythmic
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What is the technique called in which the RN listens to sounds produced in the body?

a. Auscultation
b. Inspection
c. Palpation
d. Percussion
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What is skin turgor a measurement of?

a. Hydration  
b. Strength  
c. Motor function  
d. Pain
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An entry in the client’s chart describes wound drainage as ‘sanguineous’. What does this mean?

a. Drainage is watery in appearance.
b. Drainage varies in color from green tinged to yellow.
c. Drainage contains large amount of red blood cells.
d. Drainage is foul smelling and comprised mostly of serum.
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What term describes immunity obtained as a result of experiencing an illness?

a. Active natural immunity
b. Passive natural immunity
c. Active acquired immunity
d. Passive acquired immunity
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As a result of sharing a needle with an HIV positive person (Person A), Person B becomes infected. In the chain of infection, before Person B became infected, what was the reservoir?

a. Person A  
b. Person B  
c. The dirty needle  
d. The hole made by inserting the needle into Person’s B skin.
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As a result of sharing a needle with an HIV positive person (Person A), Person B becomes infected. In the chain of infection, before Person B became infected, what was the portal of exit?

a. Person A’s needle puncture site  
b. Person B’s needle puncture site  
c. Person A’s blood  
d. The needle
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d. The needle
Microorganisms are transmitted to a client when a contaminated stethoscope touches the skin. The stethoscope is a:

a. Vector (vehicle)
b. Portal of exit
c. Portal of entry
d. Reservoir
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a. Vector (vehicle)
b. Portal of exit
c. Portal of entry
d. Reservoir
Which is an example of surgical asepsis?

a. Considering only objects above arm-level to be sterile.

b. Treating any item of uncertain sterility as contaminated.

c. Considering the surgeon’s judgment of breach of technique to be the most accurate.

d. Holding the gloved hands below the elbows.
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d. Holding the gloved hands below the elbows.
The RN has multiple cuts and scratches on his/her hands. What should the RN do to prevent the spread of infection?

a. Wash hands between clients.
b. Wear gloves all day.
c. Wash hands, wear gloves and change gloves between clients.
d. Apply dressings to wounds and wear heavy gloves.
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When helping an elderly client bathe, the RN assesses the skin. Which finding is unexpected?

a. When pinched, the skin returns to place quickly.
b. The skin of the face, arms and legs is intact.
c. The skin on the arms is smooth with some hair.
d. The client has several abrasions on the chest and back.
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b. The skin of the face, arms and legs is intact.
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d. The client has several abrasions on the chest and back.
Which is correct when giving oral care to an unconscious patient?

a. Put the bed in high Fowler’s position before beginning.

b. Lower the head of the bed and place the client in the side lying position.

c. Put the client in Fowler’s position then turn the head to the side.

d. Place the client supine with head lowered.
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What is the name given to a drug by the drug manufacturer?

a. Generic name  
b. Chemical name  
c. Brand name  
d. Official name
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a. Generic name
b. Chemical name
c. Brand name
d. Official name
What is a sweetened solution of alcohol used as a vehicle for medicinal agents called?

a. Elixir
b. Extract
c. Syrup
d. Suspension
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a. Elixir
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What is administration of a medication under the tongue called?

a. Buccal
b. Oral
c. Sublingual
d. Lacrimal
What is administration of a medication under the tongue called?

a. Buccal
b. Oral
c. Sublingual
d. Lacrimal
What is the technique of administering medication just under the skin called?

a. Intramuscular  
b. Z track  
c. Subcutaneous  
d. Intravenous
What is the technique of administering medication just under the skin called?

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b. Z track
c. **Subcutaneous**
d. Intravenous
Which term describes local medication applied to the skin or mucous membranes?

a. Subcutaneously
b. Parenterally
c. Topically
d. By inhalation
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The order for a medication is for 40 mg. The PDR states the normal dose is 10 mg. What should the RN do?

a. Administer 40 mg.
b. Administer 10 mg.
c. Contact the prescriber concerning the order.
d. Ask another nurse if it is safe to administer the ordered amount.
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a. Administer 40 mg.
b. Administer 10 mg.
c. Contact the prescriber concerning the order.
d. Ask another nurse if it is safe to administer the ordered amount.
The order reads, “Drug A 35 mg. IM every 3 hours”. The available prefilled syringe is labeled “Drug A 50 mg. per ml.” How much would you administer?

a. 0.35 ml  
b. 0.5 ml  
c. 0.7 ml  
d. 1 ml
The order reads, “Drug A 35 mg. IM every 3 hours”. The available prefilled syringe is labeled “Drug A 50 mg. per ml.” How much would you administer?

a. 0.35 ml  
b. 0.5 ml  
c. 0.7 ml  
d. 1 ml
Ordered: Penicillin 50,000 units
Available: Penicillin 100,000 units/ml
What would you administer?

a. 0.05 ml
b. 0.5 ml
c. 1 ml
d. 2 ml
Ordered: Penicillin 50,000 units
Available: Penicillin 100,000 units/ml
What would you administer?

a. 0.05 ml
b. 0.5 ml
c. 1 ml
d. 2 ml
A client is 5’6” tall and weighs 160 lbs. What size needle should be used for an intramuscular injection?

a. 22 gauge, 1-1.5 inch  
b. 25 gauge, 1 inch  
c. 22 gauge, ½ inch  
d. 25 gauge, 5/8 inch
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a. 22 gauge, 1-1.5 inch
b. 25 gauge, 1 inch
c. 22 gauge, ½ inch
d. 25 gauge, 5/8 inch
What is the rationale for using the Z track method for injection?

a. The client has insufficient muscle for this type of injection.
b. It is the only method to use for intramuscular injection.
c. The medication is highly irritating to subcutaneous tissues.
d. It is the safest and least painful way to give an injection.
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Which abbreviation means ‘before meals’?

a. OD  
b. Ad lib  
c. AC  
d. PC
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a. OD
b. Ad lib
c. AC
d. PC
Which route of medication administration provides the quickest onset of action?

a. Oral
b. Subcutaneous
c. Intramuscular
d. Intravenous
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b. Subcutaneous  
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d. Intravenous
Which action should the RN perform when giving an antibiotic through a nasogastric tube?

a. Put the small tablets in the tube and flush with water.
b. Crush the table and dissolve it in hot water.
c. Check for tube placement after giving the medication.
d. Flush the tube with 10-30 ml water after giving the medication.
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b. Crush the table and dissolve it in hot water.

c. Check for tube placement after giving the medication.

d. Flush the tube with 10-30 ml water after giving the medication.
The RN is preparing a subcutaneous injection for a client who is 5’4” tall and weighs 102 lbs. Which technique is best for this client?

a. Pinch the skin and inject at 90 degree angle.
b. Stretch the skin and inject at 90 degree angle.
c. Pinch the skin and inject at a 45 degree angle.
d. Stretch skin taut and inject at a 45 degree angle.
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b. Stretch the skin and inject at 90 degree angle.
c. Pinch the skin and inject at a 45 degree angle.
d. Stretch skin taut and inject at a 45 degree angle.
Select 3 of the 6 ‘rights’ of medication administration.

1. Doctor
2. Time
3. Dose
4. Shift
5. Documentation

a. 1,2,3
b. 1,2,4
c. 3,4,5
d. 2,3,5
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2. Time
3. Dose
4. Shift
5. Documentation
   a. 1,2,3
   b. 1,2,4
   c. 3,4,5
   d. 2,3,5
The emaciated client is at high risk for developing which skin integrity problems?

a. Blisters
b. Pressure ulcers
c. Pustules
d. Stasis dermatitis
The emaciated client is at high risk for developing which skin integrity problems?

a. Blisters
b. Pressure ulcers
c. Pustules
d. Stasis dermatitis
In caring for a client with urinary incontinence, what factor should the RN consider?

- a. Moisture promotes skin maceration and causes the epidermis to erode easily.
- b. Digestive enzymes in urine contribute to skin excoriation.
- c. Urine kills the protective microorganisms on the client’s skin, making the person prone to infection.
- d. Bacteria in the urine colonize on the skin, making the skin prone to infection.
In caring for a client with urinary incontinence, what factor should the RN consider?

a. Moisture promotes skin maceration and causes the epidermis to erode easily.

b. Digestive enzymes in urine contribute to skin excoriation.

c. Urine kills the protective microorganisms on the client’s skin, making the person prone to infection.

d. Bacteria in the urine colonize on the skin, making the skin prone to infection.
A client has a non-blanchable red spot on the sacrum. What stage pressure ulcer is this?

a. Stage I  
b. Stage II  
c. Stage III  
d. Stage IV
A client has a non-blanchable red spot on the sacrum. What stage pressure ulcer is this?

a. Stage I
b. Stage II
c. Stage III
d. Stage IV
A client has a pressure ulcer with necrosis of subcutaneous tissue, a deep crater but doesn’t extend deeper than the subcutaneous tissue. What stage does this represent?

a. Stage I  
b. Stage II  
c. Stage III  
d. Stage IV
A client has a pressure ulcer with necrosis of subcutaneous tissue, a deep crater but doesn’t extend deeper than the subcutaneous tissue. What stage does this represent?

a. Stage I
b. Stage II
c. Stage III
d. Stage IV
When assessing a client’s self-concept, the RN should create a quiet environment and minimize interruptions. What else should the RN do?

a. Sit at eye-level with the client.
b. Ask close-ended questions.
c. Ask multiple personal questions.
d. Confide in other family members.
When assessing a client’s self-concept, the RN should create a quiet environment and minimize interruptions. What else should the RN do?

a. Sit at eye-level with the client.
b. Ask close-ended questions.
c. Ask multiple personal questions.
d. Confide in other family members.
Which therapeutic nursing interventions are recommended to assist with a client’s self-concept?

1. Discourage clients from expressing their feelings.
2. Discourage clients from asking questions.
3. Provide accurate information.
4. Listen for changes in the client’s speech.
5. Explore the client’s positive qualities and strengths.

a. 1,2,3  
b. 2,4,5  
c. 3,4,5  
d. 1,3,4
Which therapeutic nursing interventions are recommended to assist with a client’s self-concept?

1. Discourage clients from expressing their feelings.
2. Discourage clients from asking questions.
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4. Listen for changes in the client’s speech.
5. Explore the client’s positive qualities and strengths.

a. 1,2,3  
b. 2,4,5  
c. 3,4,5  
d. 1,3,4
The RN is implementing the ‘P’ portion of the PLISSIT model of intervention to help clients with sexual problems when:

a. Gives an accurate but concise explanation of what is normal and how the client’s present situation or condition may affect sexual functioning.

b. Uses specialized knowledge to suggest specific interventions.

c. Acknowledges the client’s sexual concerns and conveys the attitude that sexual needs are important to health and recovery.

d. Refers the client to a clinical nurse specialist or sex therapist.
The RN is implementing the ‘P’ portion of the PLISSIT model of intervention to help clients with sexual problems when:

a. Gives an accurate but concise explanation of what is normal and how the client’s present situation or condition may affect sexual functioning.

b. Uses specialized knowledge to suggest specific interventions.

c. Acknowledges the client’s sexual concerns and conveys the attitude that sexual needs are important to health and recovery.

d. Refers the client to a clinical nurse specialist or sex therapist.
Which parts of the PLISSIT model can be effectively implemented by the RN having basic knowledge on sexuality and sexual function and ways in which health problems can affect sexual function?

a. Permission giving
b. Permission giving and limited information
c. Permission giving, limited information and specific suggestions
d. Permission giving, limited information, specific suggestions and intensive therapy
Which parts of the PLISSIT model can be effectively implemented by the RN having basic knowledge on sexuality and sexual function and ways in which health problems can affect sexual function?

a. Permission giving
b. Permission giving and limited information
c. Permission giving, limited information and specific suggestions
d. Permission giving, limited information, specific suggestions and intensive therapy
Which is the best definition of religion?

a. An organized system of worship.
b. A belief in some higher power.
c. Harmony with the universe.
d. A focus on the purpose and meaning in life.
Which is the best definition of religion?

a. An organized system of worship.
b. A belief in some higher power.
c. Harmony with the universe.
d. A focus on the purpose and meaning in life.
Which is the best definition of spirituality?

a. An organized system of worship.
b. The acceptance of specific rituals.
c. Being committed to something.
d. A belief in or relationship with some higher power.
Which is the best definition of spirituality?

a. An organized system of worship.
b. The acceptance of specific rituals.
c. Being committed to something.
d. A belief in or relationship with some higher power.
Selye’s general adaptation syndrome is an example of conceptualizing stress as a(n):

a. Stimulus
b. Response
c. Transaction
d. Interaction
Selye’s general adaptation syndrome is an example of conceptualizing stress as a(n):

a. Stimulus  
b. **Response**  
c. Transaction  
d. Interaction
A student preparing to take the final exam in NUR 111 feels tense and nervous with increased respiratory and heart rates. Which level of anxiety is being experienced?

a. Mild  
b. Moderate  
c. Severe  
d. Panic
A student preparing to take the final exam in NUR 111 feels tense and nervous with increased respiratory and heart rates. Which level of anxiety is being experienced?

a. Mild  
b. Moderate  
c. Severe  
d. Panic
After a client has died, the physician agreed that the family could stay with the body until rigor mortis sets in. The RN should inform the family that they may stay for how long?

a. 30-60 minutes
b. 60-90 minutes
c. 2-4 hours
d. 4-6 hours
After a client has died, the physician agreed that the family could stay with the body until rigor mortis sets in. The RN should inform the family that they may stay for how long?

a. 30-60 minutes
b. 60-90 minutes
c. 2-4 hours
d. 4-6 hours
According to Elizabeth Kubler-Ross, the five stages or phases of dying include denial, bargaining, depression, acceptance and what else?

a. Shock  
b. Restitution  
c. Protest  
d. Anger
According to Elizabeth Kubler-Ross, the five stages or phases of dying include denial, bargaining, depression, acceptance and what else?

a. Shock  
b. Restitution  
c. Protest  
d. Anger
What is movement of a limb away from the midline of the body called?

a. Abduction  
b. Adduction  
c. Flexion  
d. Extension
What is movement of a limb away from the midline of the body called?

a. Abduction
b. Adduction
c. Flexion
d. Extension
What should an assessment of a client’s ADL include?

a. Vital signs
b. Intake and output
c. Laboratory reports
d. Ability to bathe and dress
What should an assessment of a client’s ADL include?

a. Vital signs
b. Intake and output
c. Laboratory reports
d. Ability to bathe and dress
To what point should passive range of motion be performed?

a. To the point of discomfort
b. To the point of slight resistance
c. With the client sitting up
d. On limbs that the client can exercise unassisted
To what point should passive range of motion be performed?

a. To the point of discomfort
b. To the point of slight resistance
c. With the client sitting up
d. On limbs that the client can exercise unassisted
The head of the client’s bed is elevated approximately 60° and the knees are slightly bent. What position is this?

a. Supine  
b. Fowler’s  
c. Sims’  
d. Prone
The head of the client’s bed is elevated approximately 60° and the knees are slightly bent. What position is this?

a. Supine  
b. Fowler’s  
c. Sims’  
d. Prone
The RN is preparing to perform passive range of motion on the hinge joints. Which are hinge joints?

a. Elbow, knee, ankle
b. Wrist, fingers, feet
c. Neck, elbow, thumb
d. Hip, toes, trunk
The RN is preparing to perform passive range of motion on the hinge joints. Which are hinge joints?

a. Elbow, knee, ankle
b. Wrist, fingers, feet
c. Neck, elbow, thumb
d. Hip, toes, trunk
Since being in the hospital, a client has taken a bath each morning, however at home, the client took a warm bath each evening before bed. The client now has difficulty sleeping. What should the RN do?

a. Provide a back rub for 15 minutes before bed.
b. Offer warm milk and crackers at 9 PM.
c. Allow the client to bathe in the evening.
d. Ask the physician for an order for a sleeping medication.
Since being in the hospital, a client has taken a bath each morning, however at home, the client took a warm bath each evening before bed. The client now has difficulty sleeping. What should the RN do?

a. Provide a back rub for 15 minutes before bed.
b. Offer warm milk and crackers at 9 PM.
c. Allow the client to bathe in the evening.
d. Ask the physician for an order for a sleeping medication.
What is the first therapeutic nursing intervention to implement when a client has a problem sleeping?

a. Check the physician orders to see if a sleeping medication is ordered.
b. Provide the client a back rub.
c. Determine the client’s normal bedtime routine.
d. Reduce environmental noise.
What is the first therapeutic nursing intervention to implement when a client has a problem sleeping?

a. Check the physician orders to see if a sleeping medication is ordered.
b. Provide the client a back rub.
c. **Determine the client’s normal bedtime routine.**
d. Reduce environmental noise.
Which nutrient provides the major source of energy for the body?

a. Fats  
b. Carbohydrates  
c. Proteins  
d. Vitamins
Which nutrient provides the major source of energy for the body?

a. Fats
b. Carbohydrates
c. Proteins
d. Vitamins
Which is the best indicator of iron deficiency?

a. Low hemoglobin level
b. Low serum albumin
c. Decreased creatinine excretion
d. Decreased pre-albumin level
Which is the best indicator of iron deficiency?

a. Low hemoglobin level
b. Low serum albumin
c. Decreased creatinine excretion
d. Decreased pre-albumin level
How does a carminative enema work?

a. Distends the intestine with a large volume of fluid.
b. Lubricates the rectum and anal canal to make defecation easier.
c. Distends the rectum and colon with gas released from the enema solution.
d. Alternating flow of fluid into and out of the large intestine.
How does a carminative enema work?

a. Distends the intestine with a large volume of fluid.

b. Lubricates the rectum and anal canal to make defecation easier.

c. Distends the rectum and colon with gas released from the enema solution.

d. Alternating flow of fluid into and out of the large intestine.
What client teaching is important to include for clients on a low residue diet to prevent constipation?

a. Use an over-the-counter laxative every other day.
b. Increase daily fluid intake.
c. Increase the amount of rice eaten daily.
d. Decrease physical activity.
What client teaching is important to include for clients on a low residue diet to prevent constipation?

a. Use an over-the-counter laxative every other day.
b. Increase daily fluid intake.
c. Increase the amount of rice eaten daily.
d. Decrease physical activity.
The RN encounters resistance at the internal sphincter during insertion of an enema tube. What is the next nursing action?

a. Raise the height of the container holding the solution to increase flow.
b. Withdraw the tube and report resistance to charge nurse.
c. Instruct the client to take a deep breath and run a small amount of fluid through the tube.
d. Withdraw the tube and then reinsert.
The RN encounters resistance at the internal sphincter during insertion of an enema tube. What is the next nursing action?

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b. Withdraw the tube and report resistance to charge nurse.
c. Instruct the client to take a deep breath and run a small amount of fluid through the tube.
d. Withdraw the tube and then reinsert.
Which is a characteristic of normal urine?

a. It appears transparent.
b. It has a musty odor.
c. It contains mucus.
d. It is dark amber in color.
Which is a characteristic of normal urine?

a. It appears transparent.
b. It has a musty odor.
c. It contains mucus.
d. It is dark amber in color.
A client has an indwelling catheter. To decrease embarrassment, the RN should:

a. Provide privacy and use proper draping procedures.
b. Ask the client to tell you why they are embarrassed.
c. Work quickly in order to decrease the client’s discomfort.
d. Tell the client this is routine care and not to be embarrassed.
A client has an indwelling catheter. To decrease embarrassment, the RN should:

a. Provide privacy and use proper draping procedures.

b. Ask the client to tell you why they are embarrassed.

c. Work quickly in order to decrease the client’s discomfort.

d. Tell the client this is routine care and not to be embarrassed.
An ambulatory client with an indwelling catheter is scheduled for an x-ray today. What instructions should the RN give to the person transporting the client to the radiology department?

a. The client may feel abdominal discomfort while ambulating.
b. The drainage bag should be disconnected before leaving the client’s room.
c. The drainage bag should be kept below waist level at all times.
d. The drainage bag should be placed on the x-ray table next to the client’s hips.
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Which is a purpose of urinary catheterization?

a. Prevent urinary tract infection.
b. Assessing the amount of residual urine.
c. Keeping a client’s bed dry.
d. Obtaining a specimen to examine for protein.
Which is a purpose of urinary catheterization?

a. Prevent urinary tract infection.
b. Assessing the amount of residual urine.
c. Keeping a client’s bed dry.
d. Obtaining a specimen to examine for protein.
Which therapeutic nursing intervention should be done to prevent a catheter associated urine infection in a client with an indwelling catheter?

a. Encourage fluid limits to 1000 mL per day.
b. Change the catheter every 7-10 days.
c. Maintain a closed drainage system.
d. Cleanse the urinary meatus daily with alcohol.
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What would the RN expect the urine specific gravity to be on a dehydrated client?

a. Normal
b. Higher than normal
c. Lower than normal
d. Related to the urinary pH
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a. Normal  
b. Higher than normal  
c. Lower than normal  
d. Related to the urinary pH
The wife of an elderly man asks why he is wearing a condom catheter instead of a ‘tube inside him’. What is the best response for the RN to give?

a. “There’s less of a chance for infection with a condom catheter.”

b. “I couldn’t get the tube inside of him.”

c. “I didn’t want to hurt him.”

d. “I didn’t want him to pull it out.”
The wife of an elderly man asks why he is wearing a condom catheter instead of a ‘tube inside him’. What is the best response for the RN to give?

a. “There’s less of a chance for infection with a condom catheter.”

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c. “I didn’t want to hurt him.”

d. “I didn’t want him to pull it out.”
Where is the respiratory control center located?

a. Medulla and pons  
b. Hypothalamus  
c. Cerebellum  
d. Pituitary
Where is the respiratory control center located?

a. Medulla and pons
b. Hypothalamus
c. Cerebellum
d. Pituitary
What is the normal respiratory rate for an adult?

a. 8-14 breaths per minute
b. 12-20 breaths per minute
c. 20-40 breaths per minute
d. 15-30 breaths per minute
What is the normal respiratory rate for an adult?

a. 8-14 breaths per minute
b. 12-20 breaths per minute
c. 20-40 breaths per minute
d. 15-30 breaths per minute
A client has dyspnea when lying down and must assume an upright or sitting position in order to breathe more comfortably. What term should the RN use to describe this in charting?

a. Eupnea
b. Hyperpnea
c. Orthopnea
d. Acapnea
A client has dyspnea when lying down and must assume an upright or sitting position in order to breathe more comfortably. What term should the RN use to describe this in charting?

a. Eupnea
b. Hyperpnea
c. Orthopnea
d. Acapnea
A client has a nursing diagnosis of ineffective airway clearance r/t inadequate chest excursion and poor cough effort d/t pain from chest trauma. What is an appropriate therapeutic nursing intervention to help achieve an outcome of patent airway?

a. Provide uninterrupted periods of sleep.
b. Encourage and assist with frequent position changes.
c. Assess for cyanosis.
d. Teach the rationale for a clear liquid diet.
A client has a nursing diagnosis of ineffective airway clearance r/t inadequate chest excursion and poor cough effort d/t pain from chest trauma. What is an appropriate therapeutic nursing intervention to help achieve an outcome of patent airway?

a. Provide uninterrupted periods of sleep.
b. Encourage and assist with frequent position changes.
c. Assess for cyanosis.
d. Teach the rationale for a clear liquid diet.
What must be included in the care of a client receiving oxygen therapy through a nasal cannula system?

a. Remove the cannula when the client is eating or drinking.

b. Assuring that the rebreather bag does not totally deflate.

c. Check the color code on the cannula to determine the precise oxygen concentration.

d. Inspect the nares for encrustation and irritation.
What must be included in the care of a client receiving oxygen therapy through a nasal cannula system?

a. Remove the cannula when the client is eating or drinking.
b. Assuring that the rebreather bag does not totally deflate.
c. Check the color code on the cannula to determine the precise oxygen concentration.
d. Inspect the nares for encrustation and irritation.
Which is an appropriate safety precaution to observe with the use of oxygen therapy?

a. Use woolen or synthetic blankets on the bed.

b. Be sure that electric equipment is grounded.

c. Keep a fire extinguisher by the bedside.

d. Clean equipment and tubing daily with alcohol.
Which is an appropriate safety precaution to observe with the use of oxygen therapy?

a. Use woolen or synthetic blankets on the bed.
b. Be sure that electric equipment is grounded.
c. Keep a fire extinguisher by the bedside.
d. Clean equipment and tubing daily with alcohol.
During physical assessment, the RN observes that the anteroposterior diameter of the chest is the same as the transverse diameter. How would the RN chart this finding?

a. Pigeon chest
b. Funnel chest
c. Barrel chest
d. Normal chest
During physical assessment, the RN observes that the anteroposterior diameter of the chest is the same as the transverse diameter. How would the RN chart this finding?

a. Pigeon chest
b. Funnel chest
c. Barrel chest
d. Normal chest
Which client is most at risk for fluid imbalance?

a. An infant with diarrhea
b. An adolescent mowing the lawn on a hot day
c. A healthy 70 year old man with a fractured wrist
d. A middle aged woman who is vomiting
Which client is most at risk for fluid imbalance?

a. An infant with diarrhea
b. An adolescent mowing the lawn on a hot day
c. A healthy 70 year old man with a fractured wrist
d. A middle aged woman who is vomiting
What are fluids in the interstitial spaces called?

a. Intracellular fluids
b. Extracellular fluids
c. Electrolytes
d. Intravascular fluids
What are fluids in the interstitial spaces called?

a. Intracellular fluids
b. Extracellular fluids
c. Electrolytes
d. Intravascular fluids
When individuals are in a well or healthy state, what should their fluid output be?

a. Approximately the same as their fluid intake.
b. Correlated very little with their fluid intake.
c. Higher than their fluid intake.
d. Lower than their fluid intake.
When individuals are in a well or healthy state, what should their fluid output be?

a. Approximately the same as their fluid intake.
b. Correlated very little with their fluid intake.
c. Higher than their fluid intake.
d. Lower than their fluid intake.
What should the RN do when weighing a client with a nursing diagnosis of Fluid Volume Excess?

a. Weigh the client at least 2 hours after a meal.
b. Balance the scale daily.
c. Document the type of scale used.
d. Weigh the client without clothing.
What should the RN do when weighing a client with a nursing diagnosis of Fluid Volume Excess?

a. Weigh the client at least 2 hours after a meal.
b. Balance the scale daily.
c. Document the type of scale used.
d. Weigh the client without clothing.
The order reads to infuse 600 ml over 10 hours. The tubing delivers 15 gtt/ml. What is the flow rate?

a. 4 gtt/min  
b. 15 gtt/min  
c. 60 gtt/min  
d. 100 gtt/min
The order reads to infuse 600 ml over 10 hours. The tubing delivers 15 gtt/ml. What is the flow rate?

a. 4 gtt/min  
b. 15 gtt/min  
c. 60 gtt/min  
d. 100 gtt/min
The physician orders Drug A to infuse over 90 minutes. The drug volume is 250 ml. The drop factor is 10. What is the flow rate?

a. 25 gtt/ml  
b. 27 gtt/ml  
c. 28 gtt/ml  
d. 41 gtt/ml
The physician orders Drug A to infuse over 90 minutes. The drug volume is 250 ml. The drop factor is 10. What is the flow rate?

a. 25 gtt/ml
b. 27 gtt/ml
c. 28 gtt/ml
d. 41 gtt/ml
The chemical indicator on the package of sterile towels hasn’t changed color. What should the RN do?

a. Use the package
b. Not use the package
The chemical indicator on the package of sterile towels hasn’t changed color. What should the RN do?

a. Use the package
b. Not use the package
The RN has finished setting up the sterile field for a dressing change. All packages are opened and the contents dropped onto the sterile drape. The RN has sterile gloves on and then notices that not enough sterile 4 X 4’s are open. What should the RN do?

a. Open another package using one hand & consider one hand clean and one hand sterile.
b. Open another package of 4 X 4’s and put on a new pair of sterile gloves.
c. Ask the client to open a package of 4 X 4’s.
d. Open another package of gauze, drop them on the sterile drape and continue the procedure.
The RN has finished setting up the sterile field for a dressing change. All packages are opened and the contents dropped onto the sterile drape. The RN has sterile gloves on and then notices that not enough sterile 4 X 4’s are open. What should the RN do?

a. Open another package using one hand & consider one hand clean and one hand sterile.

b. Open another package of 4 X 4’s and put on a new pair of sterile gloves.

c. Ask the client to open a package of 4 X 4’s.

d. Open another package of gauze, drop them on the sterile drape and continue the procedure.
Julie is 10 years old and has been outside riding her scooter. She falls off the scooter and scrapes the skin on both knees. What kind of wound is this?

a. Abrasion  
b. Laceration  
c. Contusion  
d. Ecchymosis
Julie is 10 years old and has been outside riding her scooter. She falls off the scooter and scrapes the skin on both knees. What kind of wound is this?

a. Abrasion
b. Laceration
c. Contusion
d. Ecchymosis
Michael just cut his finger on one of the pages of his Berman textbook. What kind of wound is this?

a. Puncture
b. Laceration
c. Incision
d. Contusion
Michael just cut his finger on one of the pages of his Berman textbook. What kind of wound is this?

a. Puncture
b. Laceration
c. Incision
d. Contusion
Mr. Jones needs to have his abdominal dressing changed every 4 hours. What is the best way to secure this dressing?

a. Elastic adhesive tape
b. Nonallergic tape
c. Montgomery straps
d. Transparent adhesive
Mr. Jones needs to have his abdominal dressing changed every 4 hours. What is the best way to secure this dressing?

a. Elastic adhesive tape
b. Nonallergic tape
c. Montgomery straps
d. Transparent adhesive tape
When adding things to a sterile field, it is best to drop them from a distance as close to the sterile field as possible.

a. True
b. False
When adding things to a sterile field, it is best to drop them from a distance as close to the sterile field as possible.

a. True
b. False
What is the most important thing to do when performing a sterile dressing change?

a. Never contaminate anything
b. Realize when you have contaminated something and fix it
c. Assess the wound and document your findings
d. Remove the old dressing without injuring the surrounding tissue.
What is the most important thing to do when performing a sterile dressing change?

a. Never contaminate anything
b. Realize when you have contaminated something and fix it
c. Assess the wound and document your findings
d. Remove the old dressing without injuring the surrounding tissue.
After irrigating a wound, the bed should be thoroughly dried.

a. True
b. False
After irrigating a wound, the bed should be thoroughly dried.

a. True
b. False
Where should a wound culture be taken from?

a. The center of the pool of exudate.
b. The edge where the intact skin meets the open area.
c. Clean areas of granulation tissue.
Where should a wound culture be taken from?

a. The center of the pool of exudate.
b. The edge where the intact skin meets the open area.
c. **Clean areas of granulation tissue.**
How long should ice packs be left on an injured area?

a. 5-10 minutes
b. 15-30 minutes
c. 45-60 minutes
d. As long as the injured area is painful.
How long should ice packs be left on an injured area?

a. 5-10 minutes
b. 15-30 minutes
c. 45-60 minutes
d. As long as the injured area is painful.
Sitting in front of a fan when you are hot is an example of what?

a. Conduction
b. Convection
c. Radiation
Sitting in front of a fan when you are hot is an example of what?

a. Conduction
b. Convection
c. Radiation
How should the tape be pulled when removing an old dressing?

a. Toward the wound to prevent disrupting granulation tissue
b. Away from the wound to prevent introducing bacteria into the wound
c. Quickly to minimize the pain
d. On the count of 3 so the client knows when you are going to pull
How should the tape be pulled when removing an old dressing?

a. Toward the wound to prevent disrupting granulation tissue
b. Away from the wound to prevent introducing bacteria into the wound
c. Quickly to minimize the pain
d. On the count of 3 so the client knows when you are going to pull
Which would most likely result in contamination?

a. Pouring sterile saline out of the side of the bottle without the label.
b. Reaching around the glove package instead of across it.
c. Asking your colleague to go to the supply room for gauze you forgot.
d. Separating the 4 X 4’s by shaking them until one falls onto the sterile field.
Which would most likely result in contamination?

a. Pouring sterile saline out of the side of the bottle without the label.

b. Reaching around the glove package instead of across it.

c. Asking your colleague to go to the supply room for gauze you forgot.

d. Separating the 4 X 4’s by shaking them until one falls onto the sterile field.
What is the term used to describe the loss of underlying red tones or paleness in skin?

a. Pallor  
b. Erythema  
c. Cyanosis  
d. Jaundice
What is the term used to describe the loss of underlying red tones or paleness in skin?

a. Pallor
b. Erythema
c. Cyanosis
d. Jaundice
Which documents normal pulse strength?

a. 1+
b. 2+
c. 3+
d. 4+
Which documents normal pulse strength?

a. 1+

b. 2+  \(\textcolor{green}{\text{Correct!}}\)

c. 3+

d. 4+
Place the 4 steps in physical assessment in order.

1. Auscultation
2. Inspection
3. Palpation
4. Percussion
   a. 1,2,3,4
   b. 2,3,4,1
   c. 3,4,2,1
   d. 2,1,4,3
Place the 4 steps in physical assessment in order.

1. Auscultation
2. Inspection
3. Palpation
4. Percussion
   a. 1,2,3,4
   b. 2,3,4,1
   c. 3,4,2,1
   d. 2,1,4,3
Where would the RN normally expect to hear bronchovesicular breath sounds?

a. Over the trachea  
b. Over the bronchus  
c. Over the periphery of the lungs
Where would the RN normally expect to hear bronchovesicular breath sounds?

a. Over the trachea  
b. Over the bronchus  
c. Over the periphery of the lungs
What term describes the client who is disoriented, has decreased awareness and exhibits inappropriate actions and judgments?

a. Alert
b. Confused
c. Lethargic
d. Stuporous
What term describes the client who is disoriented, has decreased awareness and exhibits inappropriate actions and judgments?

a. Alert
b. Confused
c. Lethargic
d. Stuporous
Which term describes the movement of pointing the toes down toward the floor?

a. Dorsiflexion  
b. Plantar flexion
Which term describes the movement of pointing the toes down toward the floor?

a. Dorsiflexion  
b. Plantar flexion
List the correct order of physical assessment techniques for the abdomen.

1. Auscultation
2. Inspection
3. Palpation
4. Percussion
   a. 1, 2, 3, 4
   b. 2, 3, 4, 1
   c. 3, 4, 2, 1
   d. 2, 1, 4, 3
List the correct order of physical assessment techniques for the abdomen.

1. Auscultation
2. Inspection
3. Palpation
4. Percussion
   a. 1,2,3,4
   b. 2,3,4,1
   c. 3,4,2,1
   d. 2,1,4,3