Name: _____ Class: _____ Date: _____ ID: B

Nursing Process 2 Exam 2

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. Which statement by the patient about an upcoming computed tomography (CT) scan indicates a need for further teaching?
a. "I'm allergic to shrimp, so I should monitor myself for an allergic reaction."
b. "I will complete my bowel prep program the night before the scan."
c. "I will be anesthetized so that I lie perfectly still during the procedure."
d. "I will ask the technician to play music to ease my anxiety."

____ 2. Although isometric contractions do not result in muscle shortening, the nurse understands that isometric contractions
a. Result in decreased energy expenditure.
b. Are always desirable regardless of patient condition.
c. Are necessary for the active movement of muscles.
d. Result in increased energy expenditure.

____ 3. The nurse is caring for a patient with *Clostridium difficile*. Which of the following nursing actions will have the greatest impact in preventing the spread of bacteria?
a. Monthly in-services about contact precautions
b. Placing all contaminated items in biohazard bags
c. Mandatory cultures on all patients
d. Proper hand hygiene techniques

____ 4. The nurse would expect the least formed stool to be present in which portion of the digestive tract?
a. Ascending
b. Descending
c. Transverse
d. Sigmoid

____ 5. Which of the following is not a function of the large intestine?
a. Absorbing nutrients
b. Absorbing water
c. Secreting bicarbonate
d. Eliminating waste

____ 6. A nurse is caring for a patient who just underwent intravenous pyelography that revealed a renal calculus obstructing the left ureter. What is the nurse's first priority in caring for this patient?
a. Turn the patient on the right side to alleviate pressure on the left kidney.
b. Encourage the patient to increase fluid intake to flush the obstruction.
c. Administer narcotic medications to alleviate pain.
d. Monitor the patient for fever, rash, and difficulty breathing.

____ 7. The nurse would anticipate inserting a Coudé catheter for which patient?
a. An 8-year-old male undergoing anesthesia for a tonsillectomy
b. A 24-year-old female who is going into labor
c. A 56-year-old male admitted for bladder irrigation
d. An 86-year-old female admitted for a urinary tract infection.

____ 8. A patient expresses concerns over having black stool. The fecal occult test is negative. Which response by the nurse is most appropriate?
a. "This is probably a false negative; we should rerun the test."
b. "Do you take iron supplements?"
c. "You should schedule a colonoscopy as soon as possible."
d. "Sometimes severe stress can alter stool color."

____ 9. The nurse is working on an orthopedic rehabilitation unit that requires lifting and positioning of patients. The nurse is aware that the rate of occupational injury and illness in the hospital setting
a. Is the same as in the private industry sector.
b. Is higher than in the nursing home setting.
c. Is about 4.4%.
d. Has decreased in recent years.

____ 10. The patient is unable to move himself and needs to be pulled up in bed. For this repositioning to be done safely, the nurse must understand that
a. The procedure can be done by one person if the bed is in the flat position.
b. Side rails should be in the up position to prevent the patient from falling out.
c. The pillow should be placed under the patient's head and shoulders.
d. Assistive devices or additional nurses should be used.

____ 11. In developing an individualized plan of care for a patient, it is important for the nurse to
a. Set goals that are a little beyond the capabilities of the patient.
b. Use his or her judgment and not be swayed by family desires.
c. Establish goals that are measurable and realistic.
d. Explain that without taking alignment risks, there can be no progress.

____ 12. When caring for a patient with urinary retention, the nurse would anticipate an order for
a. Limited fluid intake.
b. A urinary catheter.
c. Diuretic medication.
d. A renal angiogram.

____ 13. Which assessment question should the nurse ask if stress incontinence is suspected?
a. "Does your bladder feel distended?"
b. "Do you empty your bladder completely when you void?"
c. "Do you experience urine leakage when you cough or sneeze?"
d. "Do your symptoms increase with consumption of alcohol or caffeine?"

____ 14. Many individuals have difficulty voiding in a bedpan or urinal while lying in bed because they
a. Are embarrassed that they will urinate on the bedding.
b. Would feel more comfortable assuming a normal voiding position.
c. Feel they are losing their independence by asking the nursing staff to help.
d. Are worried about acquiring a urinary tract infection.

____ 15. The nurse knows that which indwelling catheter procedure places the patient at greatest risk for acquiring a urinary tract infection?
a. Emptying the drainage bag every 8 hours or when half full
b. Kinking the catheter tubing to obtain a urine specimen
c. Placing the drainage bag on the side rail of the patient's bed
d. Failing to secure the catheter tubing to the patient's thigh

____ 16. The nurse would question an order to insert a urinary catheter on which patient?
a. A 26-year-old patient with a recent spinal cord injury at T2
b. A 30-year-old patient requiring drug screening for employment
c. A 40-year-old patient undergoing bladder repair surgery
d. An 86-year-old patient requiring monitoring of urinary output for renal failure

____ 17. Patients on bed rest or otherwise immobile are at risk for
a. Increased metabolic rate.
b. Increased diarrhea (peristalsis).
c. Altered metabolic function.
d. Increased appetite.

____ 18. Which observation by the nurse best indicates that bladder irrigation for urinary retention has been effective?
a. Recording an output that is larger than the amount instilled
b. Presence of blood clots or sediment in the drainage bag
c. Reduction in discomfort from bladder distention
d. Visualizing clear urinary catheter tubing

____ 19. A nurse notifies the provider immediately if a patient with an indwelling catheter
a. Complains of discomfort upon insertion of the catheter.
b. Places the drainage bag higher than the waist while ambulating.
c. Has not collected any urine in the drainage bag for 2 hours.
d. Is incontinent of stool and contaminates the external portion of the catheter.

____ 20. In caring for a patient who is immobile, it is important for the nurse to understand that
a. The effects of immobility are the same for everyone.
b. Immobility helps maintain sleep-wake patterns.
c. Changes in role and self-concept may lead to depression.
d. Immobile patients are often eager to help in their own care.

____ 21. The nurse has attempted to administer a tap water enema for a patient with fecal impaction with no success. What is the next priority nursing action?
a. Preparing the patient for a second tap water enema
b. Donning gloves for digital removal of the stool
c. Positioning the patient on the left side
d. Inserting a rectal tube

____ 22. The nurse would expect the urine of a patient with uncontrolled diabetes mellitus to be
a. Cloudy.
b. Discolored.
c. Sweet smelling.
d. Painful.

____ 23. The nurse is devising a plan of care for a patient with the nursing diagnosis of *Constipation related to opioid use.* Which of the following outcomes would the nurse evaluate as successful for the patient to establish normal defecation?
a. The patient reports eliminating a soft, formed stool.
b. The patient has quit taking opioid pain medication.
c. The patient's lower left quadrant is tender to the touch.
d. The nurse hears bowel sounds present in all four quadrants.

____ 24. The nurse is emptying an ileostomy pouch for a patient. Which assessment finding would the nurse report immediately?
a. Liquid consistency of stool
b. Presence of blood in the stool
c. Noxious odor from the stool
d. Continuous output from the stoma

____ 25. A nurse is educating a patient on how to irrigate an ostomy bag. Which statement by the patient indicates the need for further instruction?
a. "I can use a fleet enema to save money because it contains the same irrigation solution."
b. "Sitting on the toilet lets the irrigation sleeve eliminate into the bowl."
c. "I should never attempt to reach into my stoma to remove fecal material."
d. "Using warm tap water will reduce cramping and discomfort during the procedure."

____ 26. The nurse should question which order?
a. A normal saline enema to be repeated every 4 hours until stool is produced
b. A hypertonic solution enema with a patient with fluid volume excess
c. A Kayexalate enema for a patient with hypokalemia
d. An oil retention enema for a patient using mineral oil laxatives

____ 27. Which nursing action best reduces risk of excoriation to the mucosal lining of the nose from a nasogastric tube?
a. Lubricating the nares with water-soluble lubricant
b. Applying a small ice bag to the nose for 5 minutes every 4 hours
c. Instilling Xylocaine into the nares once a shift
d. Changing the tape holding the tube in place once a shift

____ 28. The nurse is preparing to perform a fecal occult blood test. The nurse plans to properly perform the examination by
a. Applying liberal amounts of stool to the guaiac paper.
b. Testing the quality control section before collecting the specimen section.
c. Reporting any abnormal findings to the provider.
d. Applying sterile disposable gloves.

____ 29. The nurse is assessing body alignment for a patient who is immobilized. To do this, the nurse must
a. Place the patient in the supine position.
b. Remove the pillow from under the patient's head.
c. Insert positioning supports to help the patient.
d. Place the patient in a lateral position.

____ 30. In applying for a job on a nursing unit that requires frequent patient positioning, the nurse should be aware that nurses
a. Are at low risk for back injury.
b. Are especially at risk for high back injuries.
c. Should be aware of agency policies.
d. Should not need to use assistive devices.

____ 31. A patient is having difficulty voiding in a bedpan but states that she feels her bladder is full. To stimulation micturition, which nursing intervention should the nurse try first?
a. Exiting the room and informing the patient that the nurse will return in 30 minutes to check on the patient's progress
b. Utilizing the power of suggestion by turning on the faucet and letting the water run
c. Obtaining an order for a Foley catheter
d. Administering diuretic medication

____ 32. The nurse knows that indwelling catheters are placed before a cesarean because
a. The patient may void uncontrollably during the procedure.
b. A full bladder can cause the mother's heart rate to drop.
c. Spinal anesthetics can temporarily disable urethral sphincters.
d. The patient will not interrupt the procedure by asking to go to the bathroom.

____ 33. The nurse is assessing a patient 2 hours after a colonoscopy. Based on the procedure done, what focused assessment will the nurse include?
a. Bowel sounds
b. Presence of flatulence
c. Bowel movements
d. Nausea

____ 34. In preparing to create a nursing diagnosis for a patient who is immobile, it is important for the nurse to understand that
a. Physiological issues should be the major focus.
b. Psychosocial issues should be the major focus.
c. Developmental issues should be the major focus.
d. All dimensions are important to health.

____ 35. A patient with a hip fracture is having difficulty defecating into a bed pan while lying in bed. Which action by the nurse would assist the patient in having a successful bowel movement?
a. Administering laxatives to the patient
b. Raising the head of the bed
c. Preparing to administer a barium enema
d. Withholding narcotic pain medication

____ 36. A patient has constipation and hypernatremia. The nurse prepares to administer which type of enema?
a. Oil retention
b. Carminative
c. Saline
d. Tap water

____ 37. In caring for immobile patients, the nurse understands that back injuries occur
a. Only when lifting patients.
b. Only when transferring patients.
c. Only when providing direct patient care.
d. With many clinical activities.

____ 38. When caring for a hospitalized patient with a urinary catheter, which nursing action best prevents the patient from acquiring an infection?
a. Inserting the catheter using strict clean technique
b. Performing hand hygiene before and after providing perineal care
c. Fully inflating the catheter's balloon according to the manufacturer's recommendation
d. Disconnecting and replacing the catheter drainage bag once per shift

____ 39. A nurse is pouching an ostomy on a patient with an ileostomy. Which action by the nurse is most appropriate?
a. Changing the skin barrier portion of the ostomy pouch daily
b. Selecting a pouch that is able to hold excess output to reduce the frequency of pouch emptying
c. Thoroughly scrubbing the skin around the stoma to remove excess stool and adhesive
d. Measuring the correct size for the barrier device while leaving a 1/8-inch space around the stoma

____ 40. The nurse is evaluating the body alignment of a patient in the sitting position. In this position
a. The body weight is directly on the buttocks only.
b. Both feet are supported on the floor with ankles flexed.
c. The edge of the seat is in contact with the popliteal space.
d. The arms hang comfortably at the sides.

____ 41. The nurse administers a cathartic to a patient. The nurse determines that the cathartic has had a therapeutic effect when the patient
a. Has a decreased level of anxiety.
b. Experiences pain relief.
c. Has a bowel movement.
d. Passes flatulence.

____ 42. The nurse is caring for a patient who has had a stroke causing total paralysis of the right side. To help maintain joint function and to prevent contractures, passive ROM will be initiated. When should therapy begin?
a. After the acute phase of the disease has passed
b. As soon as the ability to move is lost
c. Once the patient enters the rehab unit
d. No ROM is needed.

____ 43. The nurse is aware that patients who are immobile are at increased risk of developing deep vein thromboses (DVTs). Because of this, the nurse should
a. Make sure that elastic stockings are not removed.
b. Measure the calf circumference of both legs.
c. Dorsiflex the foot while assessing for patient discomfort.
d. Measure both ankles to determine size.

____ 44. The nurse must assess the patient for hazards of immobility by performing a head-to-toe physical assessment. When assessing the respiratory system, the nurse should
a. Assess the patient at least every 4 hours.
b. Inspect chest wall movements during the expiratory cycle only.
c. Auscultate the entire lung region to assess lung sounds.
d. Focus auscultation on the upper lung fields.

____ 45. A guaiac test has been ordered. The nurse knows that this is a test for
a. Bright red blood.
b. Dark black blood.
c. Blood that contains mucus.
d. Blood that cannot be seen.

____ 46. A nurse is caring for an older adult patient with fecal incontinence due to cathartic use. The nurse is most concerned about which complication that has the greatest risk for severe injury?
a. Rectal skin breakdown
b. Contamination of existing wounds
c. Falls from attempts to reach the bathroom
d. Cross-contamination into the upper GI tract

____ 47. A patient has fallen several times in the past week when attempting to get to the bathroom. The patient informs the nurse that he gets up 3 or 4 times a night to urinate. Which recommendation by the nurse is most appropriate in correcting this urinary problem?
a. Clear the path to the bathroom of all obstacles before bed.
b. Leave the bathroom light on to illuminate a pathway.
c. Limit fluid and caffeine intake before bed.
d. Practice Kegel exercises to strengthen bladder muscles.

____ 48. When assessing the body alignment of a patient while he or she is standing, the nurse is aware that
a. When observed posteriorly, the hips and shoulders form an "S" pattern.
b. When observed laterally, the spinal curves align in a reversed "S" pattern.
c. The arms should be crossed over the chest or in the lap.
d. The feet should be close together with toes pointed out.

____ 49. When reviewing laboratory results, the nurse should immediately notify the health care provider about which finding?
a. Glomerular filtration rate of 20 mL/min
b. Urine output of 80 mL/hr
c. pH of 6.4
d. Protein level of 2 mg/100 mL

____ 50. Which of the following is the primary function of the kidney?
a. Metabolizing and excreting medications
b. Maintaining fluid and electrolyte balance
c. Storing and excreting urine
d. Filtering blood cells and proteins