NERVOUS SYSTEM TEST

1. Following a craniotomy, a client has been admitted to the neurologic intensive care unit. The nurse has established a goal to maintain intracranial pressure (ICP) within the normal range. What should the nurse do? Select all that apply.

a. Encourage the client to cough and take deep breaths.
b. Elevate the head of the bed 15 to 30 degrees.
c. Contact the health care provider if ICP is greater than 20 mm Hg.
d. Monitor neurologic status using the Glasgow Coma Scale.
e. Stimulate the client with active range-of-motion exercises.

2. The nurse is monitoring a client with increased intracranial pressure (ICP). What indicators are the most critical for the nurse to monitor? Select all that apply.

a. Systolic blood pressure.
b. Urine output.
c. Breath sounds.
d. Cerebral perfusion pressure.
e. Level of pain.

3. A nurse is assessing a client with increasing intracranial pressure. What is a client's mean arterial pressure (MAP) in mm Hg when blood pressure (BP) is 120/60 mm Hg?

a. ___80_____ mm Hg.

4. A client with a contusion has been admitted for observation following a motor vehicle accident when he was driving his wife to the hospital to deliver their child. The next morning, instead of asking about his wife and baby, he asked to see the football game on television that he thinks is starting in 5 minutes. He is agitated that the nurse will not turn on the television. What should the nurse do next? Select all that apply.

a. Find a television so the client can view the football game.
b. Determine if the client's pupils are equal and react to light.
c. Ask the client if he has a headache.
d. Arrange for the client to be with his wife and baby.
e. Administer a sedative.

5. An unconscious client with multiple injuries arrives in the emergency department. Which nursing intervention receives the highest priority?

a. Establishing an airway.
b. Replacing blood loss.
c. Stopping bleeding from open wounds.
d. Checking for a neck fracture.

6. A client is at risk for increased intracranial pressure (ICP). Which of the following would be the priority for the nurse to monitor?

a. Unequal pupil size.
b. Decreasing systolic blood pressure.
c. Tachycardia.
d. Decreasing body temperature.

7. What should the nurse do first when a client with a head injury begins to have clear drainage from his nose?
   a. Compress the nares.
   b. Tilt the head back.
   c. Give the client tissues to collect the fluid.
   d. Administer an antihistamine for postnasal drip.

8. Which of the following respiratory patterns indicates increasing intracranial pressure in the brain stem?
   a. Slow, irregular respirations.
   b. Rapid, shallow respirations.
   c. Asymmetric chest excursion.
   d. Nasal flaring.

9. Which of the following nursing interventions is appropriate for a client with an increased intracranial pressure (ICP) of 20 mm Hg?
   a. Give the client a warming blanket.
   b. Administer low-dose barbiturates.
   c. Encourage the client to hyperventilate.
   d. Restrict fluids.

10. The nurse is assessing a client with increasing intracranial pressure (ICP). The nurse should notify the health care provider about which of the following changes in the client's condition?
   a. Widening pulse pressure.
   b. Decrease in the pulse rate.
   c. Dilated, fixed pupils.
   d. Decrease in level of consciousness (LOC).

11. The client has a sustained increased intracranial pressure (ICP) of 20 mm Hg. Which client position would be most appropriate?
   a. The head of the bed elevated 30 to 45 degrees.
   b. Trendelenburg's position.
   c. Left Sims position.
   d. The head elevated on two pillows.

12. The nurse administers mannitol (Osmitrol) to the client with increased intracranial pressure. Which parameter requires close monitoring?
   a. Muscle relaxation.
   b. Intake and output.
   c. Widening of the pulse pressure.
   d. Pupil dilation.

13. A client is being admitted with a spinal cord transection at C7. Which of the following assessments take priority upon the client's arrival? Select all that apply.
   a. Reflexes.
   b. Bladder function.
   c. Blood pressure.
   d. Temperature.
   e. Respirations.

14. The nurse is assessing a client for movement after halo traction placement for a C8 fracture. The nurse should document which of the following?
    a. The client's shoulders shrug against downward pressure of the examiner's hands.
    b. The client's arm pulls up from a resting position against resistance.
    c. The client's arm straightens out from a flexed position against resistance.
    d. The client's hand-grasp strength is equal.

15. Four days after surgery for internal fixation of a C3 to C4 fracture, a nurse is moving a client from the bed to the wheelchair. The nurse is checking the wheelchair for correct features for this client. Which of the following features of the wheelchair are appropriate for the needs of this client? Select all that apply.
    a. Back at the level of the client's scapula.
    b. Back and head that are high.
    c. Seat that is lower than normal.
    d. Seat with firm cushions.
    e. Chair controlled by the client's breath.

16. A male client with a head injury regains consciousness after several days. Which of the following nursing statements is most appropriate as the client awakens?
    a. "I'll get your family."
    b. "Can you tell me your name and where you live?"
    c. "I'll bet you're a little confused right now."
    d. "You are in the hospital. You were in an accident and unconscious."

17. A client who is regaining consciousness after a craniotomy becomes restless and attempts to pull out the I.V. line. Which nursing intervention protects the client without increasing her increased intracranial pressure (ICP)?
    a. Place her in a jacket restraint.
    b. Wrap her hands in soft "mitten" restraints.
    c. Tuck her arms and hands under the draw sheet.
    d. Apply a wrist restraint to each arm.

18. Which activity should the nurse encourage the client to avoid when there is a risk for increased intracranial pressure (ICP)?
    a. Deep breathing.
    b. Turning.
    c. Coughing.
    d. Passive range-of-motion (ROM) exercises.

19. Which of the following is most effective in assessing the client suspected of developing diabetes insipidus?
    a. Taking vital signs every 2 hours.
    b. Measuring urine output hourly.
    c. Assessing arterial blood gas values every other day.
    d. Checking blood glucose levels.

20. A client who had a serious head injury with increased intracranial pressure is to be discharged to a rehabilitation facility. Which of the following rehabilitation outcomes would be appropriate for the client? The client will:
    a. Exhibit no further episodes of short-term memory loss.
    b. Be able to return to his construction job in 3 weeks.
    c. Actively participate in the rehabilitation process as appropriate.
    d. Be emotionally stable and display pre-injury personality traits.

21. Which of the following describes Decerebrate posturing?
    a. Internal rotation and adduction of arms with flexion of elbows, wrists, and fingers.
    b. Back hunched over, rigid flexion of all four extremities with supination of arms and plantar flexion of feet.
    c. Supination of arms, Dorsiflexion of the feet.
    d. Back arched rigid extension of all four extremities.

22. A client receiving vent-assisted mode ventilation begins to experience cluster breathing after recent intracranial occipital bleeding. The nurse should:
    a. Count the rate to be sure that ventilations are deep enough to be sufficient.
    b. Notify the physician of the client's breathing pattern.
    c. Increase the rate of ventilations.
    d. Increase the tidal volume on the ventilator.

23. In planning the care for a client who has had a posterior fossa (infratentorial) craniotomy, which of the following is contraindicated when positioning the client?
    a. Keeping the client flat on one side or the other.
    b. Elevating the head of the bed to 30 degrees.
    c. Logrolling or turning as a unit when turning.
    d. Keeping the neck in a neutral position.

24. The nurse sees a client walking in the hallway who begins to have a seizure. The nurse should do which of the following in priority order?
    a. Record the seizure activity observed.(2)
    b. Ease the client to the floor.(3)
    c. Obtain vital signs.(4)
    d. Maintain a patent airway.(1)

25. Which of the following is contraindicated for a client with seizure precautions?
    a. Encouraging him to perform his own personal hygiene.
    b. Allowing him to wear his own clothing.
    c. Assessing oral temperature with a glass thermometer.
    d. Encouraging him to be out of bed.

26. Which of the following will the nurse observe in the client in the ictal phase of a generalized tonic-clonic seizure?
    a. Jerking in one extremity that spreads gradually to adjacent areas.
    b. Vacant staring and abruptly ceasing all activity.
    c. Facial grimaces, patting motions, and lip smacking.
    d. Loss of consciousness, body stiffening, and violent muscle contractions.

27. It is the night before a client is to have a computed tomography (CT) scan of the head without contrast. The nurse should tell the client?
    a. "You must shampoo your hair tonight to remove all oil and dirt."
    b. "You may drink fluids until midnight, but after that drink nothing until the scan is completed."
    c. "You will have some hair shaved to attach the small electrode to your scalp."
    d. "You will need to hold your head very still during the examination."

28. For breakfast on the morning a client is to have an electroencephalogram (EEG), the client is served a soft-boiled egg, toast with butter and marmalade, orange juice, and coffee. Which of the following should the nurse do?
    a. Remove all the food.
    b. Remove the coffee.
    c. Remove the toast, butter, and marmalade only.

d. Substitute vegetable juice for the orange juice.

29. A 20-year-old who hit his head while playing football has a tonic-clonic seizure. Upon awakening from the seizure, the client asks the nurse, "What caused me to have a seizure? I've never had one before." Which cause should the nurse include in the response as a primary cause of tonic-clonic seizures in adults older than age 20?

a. Head trauma.
b. Electrolyte imbalance.
c. Congenital defect.
d. Epilepsy.

30. Which of the following should the nurse include in the teaching plan for a client with seizures who is going home with a prescription for gabapentin (Neurontin)?

a. Take all the medication until it is gone.
b. Notify the physician if vision changes occur.
c. Store gabapentin in the refrigerator.
d. Take gabapentin with an antacid to protect against ulcers.

31. What is the priority nursing intervention in the postictal phase of a seizure?

a. Reorient the client to time, person, and place.
b. Determine the client's level of sleepiness.
c. Assess the client's breathing pattern.
d. Position the client comfortably.

32. Which intervention is most effective in minimizing the risk of seizure activity in a client who is undergoing diagnostic studies after having experienced several episodes of seizures?

a. Maintain the client on bed rest.
b. Administer butabarbital sodium (phenobarbital) 30 mg P.O., three times per day.
c. Close the door to the room to minimize stimulation.
d. Administer carbamazepine (Tegretol) 200 mg P.O., twice per day.

33. What nursing assessments should be documented at the beginning of the ictal phase of a seizure?

a. Heart rate, respirations, pulse oximeter, and blood pressure.
b. Last dose of anticonvulsant and circumstances at the time.
c. Type of visual, auditory, and olfactory aura the client experienced.
d. Movement of the head and eyes and muscle rigidity.

34. The nurse is assessing a client in the postictal phase of generalized tonic-clonic seizure. The nurse should determine if the client has?

a. Drowsiness.
b. Inability to move.
c. Paresthesia.
d. Hypotension.

35. When preparing to teach a client about phenytoin sodium (Dilantin) therapy, the nurse should urge the client not to stop the drug suddenly because:

a. Physical dependency on the drug develops over time.
b. Status epilepticus may develop.
c. A hypoglycemic reaction develops.
d. Heart block is likely to develop.

36. A client states that she is afraid she will not be able to drive again because of her seizures. Which response by the nurse would be best?
   a. A person with a history of seizures can drive only during daytime hours.
   b. A person with evidence that the seizures are under medical control can drive.
   c. A person with evidence that seizures occur no more often than every 12 months can drive.
   d. A person with a history of seizures can drive if he carries a medical identification card.

37. The nurse is teaching a client to recognize an aura. The nurse should instruct the client to note:
   a. A postictal state of amnesia.
   b. An hallucination that occurs during a seizure.
   c. A symptom that occurs just before a seizure.
   d. A feeling of relaxation as the seizure begins to subside.

38. Which statement by a client with a seizure disorder taking topiramate (Topamax) indicates the client has understood the nurse's instruction?
   a. "I will take the medicine before going to bed."
   b. "I will drink 6 to 8 glasses of water a day."
   c. "I will eat plenty of fresh fruits."
   d. "I will take the medicine with a meal or snack."

39. Which clinical manifestation is a typical reaction to long-term phenytoin sodium (Dilantin) therapy?
   a. Weight gain.
   b. Insomnia.
   c. Excessive growth of gum tissue.
   d. Deteriorating eyesight.

40. A 21-year-old female client takes clonazepam (Klonopin). What should the nurse ask this client about? Select all that apply.
   a. Seizure activity.
   b. Pregnancy status.
   c. Alcohol use.
   d. Cigarette smoking.
   e. Intake of caffeine and sugary drinks.

41. A client is being monitored for transient ischemic attacks. She is oriented, can open her eyes spontaneously, and follows commands. What is her Glasgow Coma Scale score?
   a. ___15_____ Points.

42. The nurse is teaching a client about taking prophylactic warfarin sodium (Coumadin). Which statement indicates that the client understands how to take the drug? Select all that apply.
   a. "The drug's action peaks in 2 hours."
   b. "Maximum dosage is not achieved until 3 to 4 days after starting the medication."
   c. "Effects of the drug continue for 4 to 5 days after discontinuing the medication."
   d. "Protamine sulfate is the antidote for warfarin."
   e. "I should have my blood levels tested periodically."

43. Regular oral hygiene is essential for the client who has had a stroke. Which of the following nursing measures is not appropriate when providing oral hygiene?

a. Placing the client on the back with a small pillow under the head.
b. Keeping portable suctioning equipment at the bedside.
c. Opening the client's mouth with a padded tongue blade.
d. Cleaning the client's mouth and teeth with a toothbrush.

44. A client arrives in the emergency department with an ischemic stroke and receives tissue plasminogen activator (t-PA) administration. The nurse should first:

a. Ask what medications the client is taking.
b. Complete a history and health assessment.
c. Identify the time of onset of the stroke.
d. Determine if the client is scheduled for any surgical procedures.

45. During the first 24 hours after thrombolytic treatment for an ischemic stroke, the primary goal is to control the client's:

a. Pulse.
b. Respirations.
c. Blood pressure.
d. Temperature.

46. What is a priority nursing assessment in the first 24 hours after admission of the client with a thrombotic stroke?

a. Cholesterol level.
b. Pupil size and pupillary response.
c. Bowel sounds.
d. Echocardiogram.

47. A client with a hemorrhagic stroke is slightly agitated, heart rate is 118, respirations are 22, bilateral rhonchi are auscultated, SpO2 is 94%, blood pressure is 144/88, and oral secretions are noted. What order of interventions should the nurse follow when suctioning the client to prevent increased intracranial pressure (ICP) and maintain adequate cerebral perfusion?

a. Hyperoxygenate.(2)
b. Suction the mouth.(3)
c. Provide sedation.(4)
d. Suction the airway(1)

48. In planning care for the client who has had a stroke, the nurse should obtain a history of the client's functional status before the stroke because?

a. The rehabilitation plan will be guided by it.
b. Functional status before the stroke will help predict outcomes.
c. It will help the client recognize his physical limitations.
d. The client can be expected to regain much of his functioning.

49. Which of the following techniques does the nurse avoid when changing a client's position in bed if the client has hemiparalysis?

a. Rolling the client onto the side.
b. Sliding the client to move up in bed.
c. Lifting the client when moving the client up in bed.

d. Having the client help lift off the bed using a trapeze.

50. Which nursing intervention has been found to be the most effective means of preventing plantar flexion in a client who has had a stroke with residual paralysis?

a. Place the client's feet against a firm footboard.
b. Reposition the client every 2 hours.
c. Have the client wear ankle-high tennis shoes at intervals throughout the day.
d. Massage the client's feet and ankles regularly.

51. The nurse is planning the care of a hemiplegic client to prevent joint deformities of the arm and hand. Which of the following positions are appropriate?

a. Placing a pillow in the axilla so the arm is away from the body.
b. Inserting a pillow under the slightly flexed arm so the hand is higher than the elbow.
c. Immobilizing the extremity in a sling.
d. Positioning a hand cone in the hand so the fingers are barely flexed.
e. Keeping the arm at the side using a pillow.

52. For the client who is experiencing expressive aphasia, which nursing intervention is most helpful in promoting communication?

a. Speaking loudly.
b. Using a picture board.
c. Writing directions so client can read them.
d. Speaking in short sentences.

53. The nurse is teaching the family of a client with dysphagia about decreasing the risk of aspiration while eating. Which of the following strategies is not appropriate?

a. Maintaining an upright position.
b. Restricting the diet to liquids until swallowing improves.
c. Introducing foods on the unaffected side of the mouth.
d. Keeping distractions to a minimum.

54. Which food-related behaviors are expected in a client who has had a stroke that has left him with homonymous hemianopia?

a. Increased preference for foods high in salt.
b. Eating food on only half of the plate.
c. Forgetting the names of foods.
d. Inability to swallow liquids.

55. A nurse is teaching a client who had a stroke about ways to adapt to a visual disability. Which does the nurse identify as the primary safety precaution to use?

a. Wear a patch over one eye.
b. Place personal items on the sighted side.
c. Lie in bed with the unaffected side toward the door.
d. Turn the head from side to side when walking.

56. A client is experiencing mood swings after a stroke and often has episodes of tearfulness that are distressing to the family. Which is the best technique for the nurse to instruct family members to try when the client experiences a crying episode?

a. Sit quietly with the client until the episode is over.
b. Ignore the behavior.

c. Attempt to divert the client's attention.
d. Tell the client that this behavior is unacceptable.

57. The client who has had a stroke with residual physical handicaps becomes discouraged by his physical appearance. What approach to the client is best for the nurse to use to help the client overcome his negative self-concept? Select all that apply.

a. Helpfulness.
b. Charity.
c. Firmness.
d. Encouragement.
e. Patience.

58. When communicating with a client who has aphasia, which of the following nursing interventions is not appropriate?

a. Present one thought at a time.
b. Encourage the client not to write messages.
c. Speak with normal volume.
d. Make use of gestures.

59. What is the expected outcome of thrombolytic drug therapy for stroke?

a. Increased vascular permeability.
b. Vasoconstriction.
c. Dissolved emboli.
d. Prevention of hemorrhage.

60. A health care provider has ordered carbidopa- levodopa (Sinemet) four times per day for a client with Parkinson's disease. The client states that he wants "to end it all now that the Parkinson's disease has progressed." What should the nurse do? Select all that apply.

a. Explain that the new prescription for Sinemet will treat his depression.
b. Encourage the client to discuss his feelings as the Sinemet is being administered.
c. Contact the health care provider before administering the Sinemet.
d. Determine if the client is on antidepressants or monoamine oxidase (MAO) inhibitors.
e. Determine if the client is at risk for suicide.

61. Which of the following is an initial sign of Parkinson's disease?

a. Rigidity.
b. Tremor.
c. Bradykinesia.
d. Akinesia.

62. The nurse develops a teaching plan for a client newly diagnosed with Parkinson's disease. Which of the following topics that the nurse plans to discuss is the most important?

a. Maintaining a balanced nutritional diet.
b. Enhancing the immune system.
c. Maintaining a safe environment.
d. Engaging in diversional activity.

63. The nurse observes that a client's upper arm tremors disappear as he unbuttons his shirt. Which statement best guides the nurse's analysis of this observation about the client's tremors?

a. The tremors are probably psychological and can be controlled at will.
b. The tremors sometimes disappear with purposeful and voluntary movements.
c. The tremors disappear when the client's attention is diverted by some activity.
d. There is no explanation for the observation; it is probably a chance occurrence.

64. At what time of day should the nurse encourage a client with Parkinson's disease to schedule the most demanding physical activities to minimize the effects of hypokinesia?
    a. Early in the morning, when the client's energy level is high.
    b. To coincide with the peak action of drug therapy.
    c. Immediately after a rest period.
    d. When family members will be available.

65. Which goal is the most realistic and appropriate for a client diagnosed with Parkinson's disease?
    a. To cure the disease.
    b. To stop progression of the disease.
    c. To begin preparations for terminal care.
    d. To maintain optimal body function.

66. What is the primary goal collaboratively established by the client with Parkinson's disease, nurse, and physical therapist?
    a. To maintain joint flexibility.
    b. To build muscle strength.
    c. To improve muscle endurance.
    d. To reduce ataxia.

67. A client with Parkinson's disease is prescribed levodopa (L-dopa) therapy. Improvement in which of the following indicates effective therapy?
    a. Mood.
    b. Muscle rigidity.
    c. Appetite.
    d. Alertness.

68. A client is being switched from levodopa (L-dopa) to carbidopa-levodopa (Sinemet). The nurse should monitor for which of the following possible complications during medication changes and dosage adjustment?
    a. Euphoria.
    b. Jaundice.
    c. Vital sign fluctuation.
    d. Signs and symptoms of diabetes.

69. A new medication regimen is ordered for a client with Parkinson's disease. At which time should the nurse make certain that the medication is taken?
    a. At bedtime.
    b. All at one time.
    c. Two hours before mealtime.
    d. At the time scheduled.

70. A client with Parkinson's disease needs a long time to complete her morning hygiene, but she becomes annoyed when the nurse offers assistance and refuses all help. Which action is the nurse's best initial response in this situation?
    a. Tell the client firmly that she needs assistance and help her with her care.
    b. Praise the client for her desire to be independent and give her extra time and encouragement.
    c. Tell the client that she is being unrealistic about her abilities and must accept the fact that she needs help.
    d. Suggest to the client that if she insists on self care, she should at least modify her routine.

71. A client with Parkinson's disease asks the nurse to explain to his nephew "what the doctor said the pallidotomy would do." The nurse's best response includes stating that the main goal for the client after pallidotomy is improved:
    a. Functional ability.
    b. Emotional stress.
    c. Alertness.
    d. Appetite.

72. The nurse is reviewing the care plan of a client with Multiple Sclerosis. Which of the following nursing diagnoses should receive further validation?
    a. Impaired mobility related to spasticity and fatigue.
    b. Risk for falls related to muscle weakness and sensory loss.
    c. Risk for seizures related to muscle tremors and loss of myelin.
    d. Impaired skin integrity related bowel and bladder incontinence.

73. The nurse is teaching a client with bladder dysfunction from multiple sclerosis (MS) about bladder training at home. Which instructions should the nurse include in the teaching plan? Select all that apply.
    a. Restrict fluids to 1,000 mL/24 hours.
    b. Drink 400 to 500 mL with each meal.
    c. Drink fluids midmorning, mid afternoon, and late afternoon.
    d. Attempt to void at least every 2 hours.
    e. Use intermittent catheterization as needed.

74. Which of the following is not a typical clinical manifestation of multiple sclerosis (MS)?
    a. Double vision.
    b. Sudden bursts of energy.
    c. Weakness in the extremities.
    d. Muscle tremors.

75. A client with multiple sclerosis (MS) is receiving baclofen (Lioresal). The nurse determines that the drug is effective when it achieves which of the following?
    a. Induces sleep.
    b. Stimulates the client's appetite.
    c. Relieves muscular spasticity.
    d. Reduces the urine bacterial count.

76. A client has had multiple sclerosis (MS) for 15 years and has received various drug therapies. What is the primary reason why the nurse has found it difficult to evaluate the effectiveness of the drugs that the client has used?
    a. The client exhibits intolerance to many drugs.
    b. The client experiences spontaneous remissions from time to time.
    c. The client requires multiple drugs simultaneously.
    d. The client endures long periods of exacerbation before the illness responds to a particular drug.

77. When the nurse talks with a client with multiple sclerosis who has slurred speech, which nursing intervention is contraindicated?
    a. Encouraging the client to speak slowly.
    b. Encouraging the client to speak distinctly.
    c. Asking the client to repeat indistinguishable words.
    d. Asking the client to speak louder when tired.

78. The right hand of a client with multiple sclerosis trembles severely whenever she attempts a voluntary action. She spills her coffee twice at lunch and cannot get her dress fastened securely. Which is the best legal documentation in nurses' notes of the chart for this client assessment?

a. "Has an intention tremor of the right hand."
b. "Right-hand tremor worsens with purposeful acts."
c. "Needs assistance with dressing and eating due to severe trembling and clumsiness."
d. "Slight shaking of right hand increases to severe tremor when client tries to button her clothes or drink from a cup."

79. A client with multiple sclerosis (MS) is experiencing bowel incontinence and is starting a bowel retraining program. Which strategy is inappropriate?

a. Eating a diet high in fiber.
b. Setting a regular time for elimination.
c. Using an elevated toilet seat.
d. Limiting fluid intake to 1,000 mL/day.

80. Which of the following is not a realistic outcome to establish with a client who has multiple sclerosis (MS)? The client will:

a. Develop joint mobility.
b. Develop muscle strength.
c. Develop cognition.
d. Develop mood elevation.

81. The nurse is preparing a client with multiple sclerosis (MS) for discharge from the hospital to home. The nurse should tell the client:

a. "You will need to accept the necessity for a quiet and inactive lifestyle."
b. "Keep active, use stress reduction strategies, and avoid fatigue."
c. "Follow good health habits to change the course of the disease."
d. "Practice using the mechanical aids that you will need when future disabilities arise."

82. Which of the following should the nurse include in the discharge plan for a client with multiple sclerosis who has an impaired peripheral sensation? Select all that apply.

a. Carefully test the temperature of bath water.
b. Avoid kitchen activities because of the risk of injury.
c. Avoid hot water bottles and heating pads.
d. Inspect the skin daily for injury or pressure points.
e. Wear warm clothing when outside in cold temperatures.

83. Which intervention should the nurse suggest to help a client with multiple sclerosis avoid episodes of urinary incontinence?

a. Limit fluid intake to 1,000 mL/day.
b. Insert an indwelling urinary catheter.
c. Establish a regular voiding schedule.
d. Administer prophylactic antibiotics, as ordered.

84. A client with multiple sclerosis (MS) lives with her daughter and 3-year-old granddaughter. The daughter asks the nurse what she can do at home to help her mother. Which of the following measures would be most beneficial?

a. Psychotherapy.
b. Regular exercise.
c. Day care for the granddaughter.
d. Weekly visits by another person with MS.

85. A client is brought to the emergency department unconscious. An empty bottle of aspirin was found in his car, and a drug overdose is suspected. Which of the following medications should the nurse has available for further emergency treatment?

a. Vitamin K.
b. Dextrose 50%.
c. Activated charcoal powder.
d. Sodium thiosulfate.

86. Which clinical manifestations should the nurse expect to assess in a client diagnosed with an overdose of a cholinergic agent? Select all that apply.

a. Dry mucous membranes.
b. Urinary incontinence.
c. Central nervous system (CNS) depression.
d. Seizures.
e. Skin rash.

87. The wife and sister of a client who had attempted suicide with an overdose are distraught about his comatose condition and the possibility that he took an intentional drug overdose. Which of the following would be an appropriate initial nursing intervention with this family?

a. Explain that because the client was found on hospital property, he was probably asking for help and did not intentionally overdose.
b. Give the wife and sister a big hug and assure them that the client is in good hands.
c. Encourage the wife and sister to express their feelings and concerns, and listen carefully.
d. Allow the wife and sister to help care for the client by rubbing his back when he is turned.

88. Which of the following is a priority during the first 24 hours of hospitalization for a comatose client with suspected drug overdose?

a. Educate regarding drug abuse.
b. Minimize pain.
c. Maintain intact skin.
d. Increase caloric intake.

89. An unconscious intubated client does not have increased intracranial pressure. Which nursing intervention would be essential?

a. Monitoring the oral temperature, keep the room temperature at 70° F (21.1° C), and place the client on a cooling blanket if the client's temperature is higher than 101° F (38.3° C).
b. Cleaning the mouth carefully, applying a thin coat of petroleum jelly, and moving the endotracheal tube to the opposite side daily.
c. Positioning the client in the supine position with the head to the side and slightly elevated on two pillows.
d. Turning the client with a draw sheet and placing a pillow behind the back and one between the legs.

90. The client is to be placed in a right side-lying position. The nurse should intervene when observing a client in which of the following positions?

a. The head is placed on a small pillow.
b. The right leg is extended without pillow support.
c. The left arm is rested on the mattress with the elbow flexed.
d. The left leg is supported on a pillow with the knee flexed.

91. The nursing team has been performing passive range-of-motion (ROM) exercises on an unconscious client? Which of the following indicate the exercises have been successful?
    a. Preservation of muscle mass.
    b. Prevention of bone demineralization.
    c. Increase in muscle tone.
    d. Maintenance of joint mobility.

92. When the nurse performs oral hygiene for an unconscious client, which nursing intervention is the priority?
    a. Keep a suction machine available.
    b. Place the client in a prone position.
    c. Wear sterile gloves while brushing the client's teeth.
    d. Use gauze wrapped around the fingers to clean the client's gums.

93. The nurse observes that the right eye of an unconscious client does not close completely. Which nursing intervention is most appropriate?
    a. Have the client wear eyeglasses at all times.
    b. Lightly tape the eyelid shut.
    c. Instill artificial tears once every shift.
    d. Clean the eyelid with a washcloth every shift.

94. Which sign is an early indicator of hypoxia in the unconscious client?
    a. Cyanosis.
    b. Decreased respirations.
    c. Restlessness.
    d. Hypotension.

95. When administering intermittent enteral feeding to an unconscious client, the nurse should:
    a. Heat the formula in a microwave.
    b. Place the client in a semi-Fowler's position.
    c. Obtain a sterile gavage bag and tubing.
    d. Weigh the client before administering the feeding.

96. The client is to receive 200 mL of tube feeding every 4 hours. The nurse checks for the client's gastric residual before administering the next scheduled feeding and obtains 40 mL of gastric residual. The nurse should:
    a. Withhold the tube feeding and notify the physician.
    b. Dispose of the residual and continue with the feeding.
    c. Delay feeding the client for 1 hour and then recheck the residual.
    d. Re-administer the residual to the client and continue with the feeding.

97. Of the following nursing interventions for catheter care, which should have the highest priority?
    a. Cleaning the area around the urethral meatus.
    b. Clamping the catheter periodically to maintain muscle tone.
    c. Irrigating the catheter with several ounces of normal saline solution.
    d. Changing the location where the catheter is taped to the client's leg.

98. A client has been pronounced brain dead. Which findings should the nurse document? Select all that apply.
    a. Decerebrate posturing.
    b. Nonreactive dilated pupils.

c. Deep tendon reflexes.
d. Absent corneal reflex.
e. Blink reflex.

Medication Record

Time	Pain Level	Intervention
7 AM	8	Morphine 4 mg IV
9 AM	4	Morphine 2 mg IV
10 AM	1	

99. The physician orders Morphine Sulfate 2-4 mg IV push every 2 hours prn pain for a client who has postoperative pain following abdominal surgery. Prior to performing an abdominal dressing change with packing at 10 AM, the nurse assesses the client's pain level as 1 on a scale of 0 = no pain to 10 = the worst pain. The client is awake and oriented and vital signs are within normal limits. The nurse reviews the pain medication record (see chart). The nurse should:

a. Perform the dressing change.
b. Administer Morphine 2 mg IV before the dressing change.
c. Administer Morphine 4 mg IV after the dressing change.
d. Call the physician for a new medication order.

100. A 34-year-old Chinese man is admitted with multiple injuries from a motor vehicle accident. He complains of severe pain and requests frequent medication. One of the assistive nursing personnel expresses surprise, saying, "I thought Asian people were very stoic about pain." Which is the nurse's best response about pain?

a. Expression and perception of pain vary widely from person to person.
b. Tolerance of pain is the same in all people.
c. Tolerance of pain is determined by a person's genetic makeup.
d. Pain perception is the same in all people.

101. The nurse finds it difficult to relieve a client's pain satisfactorily. Which of the following measures should the nurse take next when continuing efforts to promote comfort?

a. Improve the nurse-client relationship.
b. Enlist the help of the client's family.
c. Allow the client additional time to work through his or her own responses to pain.
d. Arrange to have the client share a room with a client who has little pain.

102. The client's physician decides to change the analgesia medication from meperidine hydrochloride (Demerol) 75 mg I.M. every 4 hours as needed to meperidine hydrochloride by the oral route. What dosage of oral meperidine is required to provide an equivalent analgesic dose?

a. 25 to 50 mg.
b. 75 to 100 mg.
c. 125 to 150 mg.
d. 250 to 300 mg.

103. After administering meperidine hydrochloride (Demerol), the nurse determines its effectiveness as an analgesic was related to its ability to:

a. Reduce the perception of pain.
b. Decrease the sensitivity of pain receptors.
c. Interfere with pain impulses traveling along sensory nerve fibers.
d. Block the conduction of pain impulses along the central nervous system.

104. A client is arousing from a coma and keeps saying, "Just stop the pain." The nurse responds based on the knowledge that the human body typically and automatically responds to pain first with attempts to:

a. Tolerate the pain.

b. Decrease the perception of pain.
c. Escape the source of pain.
d. Divert attention from the source of pain.

105. Ergotamine tartrate (Gynergen) is prescribed for a client's migraine headaches. The client's report of which of the following indicates effectiveness?
a. Prevention of the migraine.
b. Reduced severity of the developing migraine.
c. Relief from the sleeplessness experienced in the past after a migraine.
d. Relief from the vision problems experienced in the past after a migraine.

106. The nurse explains to the client with pain that the purpose of biofeedback is to enable him to exert control over his physiologic processes by:
a. Regulating the body processes through electrical control.
b. Shocking himself when an undesirable response is elicited.
c. Monitoring the body processes for the therapist to interpret.
d. Translating the signals of his body processes into observable forms.

107. The nurse explains to the client that the main reason a back rub is used as therapy to relieve pain is because the massage:
a. Blocks pain impulses from the spinal cord to the brain.
b. Blocks pain impulses from the brain to the spinal cord.
c. Stimulates the release of endorphins.
d. Distracts the client's focus on the source of the pain.

108. Nursing responsibilities for the client with a patient-controlled analgesia (PCA) system should include:
a. Reassuring the client that pain will be relieved.
b. Documenting the client's response to pain medication on a routine basis.
c. Instructing the client to continue pressing the system's button whenever pain occurs.
d. Titrating the client's pain medication until the client is free from pain.

109. A client has an epidural catheter inserted for postoperative pain management. The client rates his pain at 4 on a 0-to-5 pain scale. What should the nurse do first?
a. Check the patient-controlled analgesia (PCA) pump function.
b. Adjust the epidural catheter.
c. Assess vital signs.
d. Notify the physician.

110. The nurse using healing touch affects a client's pain primarily through:
a. Energy fields.
b. Touch therapy.
c. Massage.
d. Hypnosis.

111. A nursing assistant is providing care to a client with left-sided paralysis. Which of the following actions by the nursing assistant requires the nurse to provide further instruction?
a. Providing passive range of motion exercises to the left extremities during the bed bath.
b. Elevating the foot of the bed to reduce edema.

c. Pulling up the client under the left shoulder when getting out of bed to a chair.
d. Putting high top tennis shoes on the client after bathing.

112. The nurse notices that a client with Parkinson's disease is coughing frequently when eating. Which one of the following interventions should the nurse consider?

a. Have the client hyperextend the neck when swallowing.
b. Tell the client to place the chin firmly against the chest when eating.
c. Thicken all liquids before offering to the client.
d. Place the client on a clear liquid diet.

113. The nurse has asked the nursing assistant to ambulate a client with Parkinson's disease. The nurse observes the nursing assistant pulling on the client's arms to get the client to walk forward. The nurse should:

a. Have the nursing assistant keep a steady pull on the client to promote forward ambulation.
b. Explain how to overcome a freezing gait by telling the client to march in place.
c. Assist the nursing assistant with getting the client back in bed.
d. Give the client a muscle relaxant.

114. Which pressure point area(s) should the nurse monitor for an unconscious client positioned on the left side? Choose all that apply.

a. Ankles.
b. Ear.
c. Greater trochanter.
d. Heels.
e. Occiput.
f. Sacrum.
g. Shoulder.

115. The nurse ascertains that there is a discrepancy in the records of use of a controlled substance for a client who is taking large doses of narcotic pain medication. The nurse should do which of the following next?

a. Notify the Drug Enforcement Agency (DEA).
b. Contact the Director of Quality and Risk Management/ Legal Department.
c. Notify the pharmacy technician who delivered the controlled substance.
d. Notify the nursing supervisor of the clinical unit.