33. The Blueprint includes nursing care addressing medications the client is taking. These values must be normal for the client’s disease process or must be able to determine if the laboratory value is normal for the client’s disease process or medications the client is taking.

34. Correct Answer: 3, 4, 1, 5, 2

3. The nurse needs to determine if the client is unresponsive prior to taking any action. If the client is unresponsive, then perform compressions.

4. The American Heart Association recommends 30 compressions followed by two breaths.

1. After completing compressions, open the client’s airway to ensure a patent airway.

5. The nurse should then administer two breaths while the client’s nose is pinched.

2. The nurse then must determine whether the client’s heart is pumping by checking the carotid pulse.

35. The client with end-stage COPD usually prefers a cool climate, with fans to help ease breathing. A warm area would increase the effort the client would require to breathe. This action would warrant intervention by the nurse.

2. The client with end-stage COPD should be maintained on a low oxygen rate, such as 2 L/min to prevent depression of the hypoxic drive. High levels of oxygen will depress the client’s ability to breathe. This action would not warrant intervention by the nurse.

3. The client will usually sit in the orthopneic position, usually slumped over a bedside table, to help ease breathing. This is called the three-point stance. This action would not warrant intervention by the nurse.

4. The client in end-stage COPD has great difficulty breathing; therefore, sleeping in a recliner is sometimes the only way the client can sleep. This action would not warrant intervention by the nurse.

36. 1. The UAP cannot perform sterile dressing changes.

2. The UAP cannot perform sterile procedures.

3. The UAP cannot teach the client.

4. The UAP can transfer the client from the bed to the chair three times a day.

37. The staff member is violating HIPAA, and the nurse should take action immediately.
2. The nurse should first ask the staff member not to discuss the client with a friend. Discussing any information about a client is a violation of HIPAA.
3. The nurse should address the staff member in the restaurant. The nurse could tell the clinical manager, but the nurse must stop the conversation in the restaurant immediately.
4. The nurse should not tell the client about the breach of confidentiality.


MAKING NURSING DECISIONS: There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy; the nurse must be knowledgeable of management issues. The Health Insurance Portability and Accountability Act (HIPAA) passed into law in 1996 to standardize exchange of information between healthcare providers and to ensure patient record confidentiality.

38. 1. This statement warrants intervention because fluids will help prevent dehydration and renal calculi. The nurse should explain the client needs to increase fluids.
2. ROM exercises help prevent deep vein thrombosis (DVT). This statement does not require intervention by the nurse. The UAP can perform skills if taught and performance is evaluated by the nurse.
3. Keeping the client off the buttocks is an appropriate intervention for a client on strict bed rest. This comment does not require intervention by the nurse.
4. Pulling the client across the sheets will cause skin breakdown. Because the UAP is not doing this, no intervention by the nurse is needed.


MAKING NURSING DECISIONS: Delegation means the nurse is responsible for the UAP’s actions and performance. The nurse must correct the UAP’s performance to ensure the client is cared for safely in the hospital or the home.

39. 1. The client’s oxygen should always be placed correctly but it is not the priority intervention for difficulty breathing.
2. Because the client has difficulty breathing while lying in bed, allowing the client to sit in a recliner will help the client; therefore, this is the priority intervention.
3. Often clients report a fan blowing on the face helps with difficulty breathing but this is not a priority intervention.
4. Slow, deep breaths will not help the client with difficulty breathing as much as will sitting in a recliner.


MAKING NURSING DECISIONS: In questions that ask the test taker to identify a priority intervention all the options are something a nurse can implement. The test taker must identify the most important intervention.

40. 1. The body naturally begins to slow down, and clients may not wish to take in liquids or nourishment. This can produce a natural euphoria and make the dying process easier on the client. IV fluids would interfere with this process and would increase secretions the client cannot handle, thus making the client more uncomfortable.
2. A PEG feeding tube would increase the intake of the client and would increase secretions the client cannot handle. This can require suctioning the client and further augmenting the client’s discomfort.
3. Refusal to take in food and liquids produces a natural euphoria and makes the dying process easier on the client. This is an appropriate teaching statement.
4. This is a therapeutic response, but factual information is needed by the wife to accept the process.


MAKING NURSING DECISIONS: The NCLEX-RN® addresses questions concerned with end of life care. This is included in the Psychosocial Integrity section of the test blueprint.

41. 1. The home health nurse may be a possibility if a hospice organization is not available, but hospice is the best referral.
2. The nurse would not refer the client to his or her own pastor. The nurse could place a call to notify the pastor at the client’s request, but this would not be considered a referral.
3. One of the guidelines for admission to a hospice agency is a terminal process with a life expectancy of 6 months or less.
These organizations work to assist the client and family to live life to its fullest while providing for comfort measures and a peaceful, dignified death.

4. The hospital social worker is not an appropriate referral at this time.


MAKING NURSING DECISIONS: The nurse must be knowledgeable about appropriate referrals and implement the referral to the most appropriate person/agency.

42. 1. This is advising and crossing professional boundaries. The nurse should not try to influence the client in these types of concerns.

2. This is advising and crossing professional boundaries. The nurse should not try to influence the client in these types of concerns.

3. This response allows the client to make his or her own decision. It validates that the nurse heard the concern but does not advise the client.

4. This is advising and crossing professional boundaries. The nurse should not try to influence the client in these types of concerns.


MAKING NURSING DECISIONS: The nurse must always remember that nurses have positions of authority in a healthcare environment. Nurses must maintain professional boundaries at all times and refuse to cross professional boundaries.

43. 1. Women tend to see the big picture and seek solutions based on what makes people feel comfortable rather than on logic.

2. Men often see the world from a logical perspective and focus on a specific intervention.

3. Men tend to ask fewer questions than women, especially if the man perceives that asking the question will make him look foolish or ignorant.

4. Men and women communicate very differently. The female manager of a male employee should recognize the difference when attempting to arrive at a common goal.


MAKING NURSING DECISIONS: There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy; the nurse must be knowledgeable of management issues.

44. 1. The attitude of the staff member changes from one day to the next. The “why” is not important for the manager to know. The important thing for the manager to know is whether the staff member can control the attitude.

2. The first step is an informal meeting with the staff member to discuss the inappropriate attitude and how it affects the staff. The manager should document the conversation informally with the date and time (the staff member does not need to see this documentation) for future reference. If the situation is not resolved, a formal counseling must take place.

3. This step would follow the informal discussion if the attitude did not improve.

4. This is a step sometimes used to get the attention of the staff member when formal counseling has not been effective. This step occurs just before termination.


MAKING NURSING DECISIONS: There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy; the nurse must be knowledgeable of management issues.

45. 1. E-mails should be easy to read and concise. Individuals may not take the time to read and understand poorly worded, lengthy e-mails.

2. Some communication is appropriate by e-mail, but when discussing a problem with an individual, it is best to use face-to-face communication in which both parties can give and receive feedback.

3. Capital letters in e-mails may be interpreted as shouting or yelling at the receiver.

4. E-mail communication should be concise and easy to read. If the e-mail requires a lot of information, then the writer should use bullets to separate information.

**MAKING NURSING DECISIONS:** There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy; the nurse must be knowledgeable of management issues.

46. **1. The problem is not a nursing problem.**
   The HCP should be discussing the problem with an individual from the department that “owns” the problem.
2. This is not a nursing problem.
3. This is not a nursing problem.
4. This will only make the HCP angrier. The HCP should be directed to discuss the problem with the department that can “fix” the problem.


**MAKING NURSING DECISIONS:** There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy; the nurse must be knowledgeable of management issues.

47. **Correct Answer: 1, 4, 3, 2, 5**

1. The nurse should begin the care by assessing the client. Remember the nursing process.
2. The last part of the chest tube drainage system to assess is the suction system.
3. The nurse then follows the chest tube to the drainage system and assesses the system.
4. The nurse should have the client’s chest and dressing exposed and should check to make sure the chest tube is securely taped at this time.
5. The nurse should make sure that emergency supplies are at the bedside last.


**MAKING NURSING DECISIONS:** This is an alternate type of question included in the NCLEX-RN® blueprint. The nurse must be able to perform skills in the correct order. Assessment should always be the first intervention if the client is not in distress.

48. **1. Bronchiectasis is a condition in which the lungs’ airways are abnormally stretched and widened. This is caused by mucous blockage, which allows bacteria to grow and leads to infection. Signs/symptoms include coughing, abnormal breath sounds, and clubbing; therefore, the nurse would not assess this client first.**

2. **Byssinosis (brown lung disease) is a lung disease caused by exposure to dust from cotton processing, hemp, and flax. Signs/symptoms include chest tightness, cough, and wheezing; therefore, this client would not be assessed first.**

3. **Cystic fibrosis (CF) is an inherited disease that causes thick, sticky mucus to form in the lungs, pancreas, and other organs. In the lungs, this mucus blocks the airways, causing lung damage and making it hard to breathe. A pulse oximeter reading of 90% equates to approximately a 60% arterial saturation. The nurse should assess this client first.**

4. **Pneumoconiosis, known as black lung disease, is an occupational lung disease caused by inhaling coal dust. The signs/symptoms are shortness of breath and chronic cough; therefore, this client would not be assessed first.**


**MAKING NURSING DECISIONS:** The test taker must determine which sign/symptom is not expected for the disease process. If the sign/symptom is not expected then the nurse should assess the client first. This type of question is determining if the nurse is knowledgeable of signs/symptoms of a variety of disease processes.

49. **1. Activity intolerance is not priority over gas exchange. If gas exchange does not occur, the client will die.**

2. **Coping is a psychosocial problem, and physiological problems are priority.**

3. **Impaired gas exchange is the priority problem for this client. If the client does not have adequate gas exchange, the client will die. Remember Maslow’s Hierarchy of Needs.**

4. **Self-care deficit is not priority over gas exchange.**


**MAKING NURSING DECISIONS:** The NCLEX-RN® integrates the nursing process throughout the
Client Needs categories and subcategories. The nursing process is a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation, and evaluation. The nurse will be responsible for identifying nursing diagnosis for clients.

50. 1. Consolidation indicates fluid or exudates in the lung—pneumonia. This would not indicate the client is improving.
2. Bilateral breath sounds indicate the left lung has re-expanded and the treatment is effective.
3. Vigorous bubbling in the suction chamber indicates that there is a leak in the system, but this does not indicate the treatment is effective.
4. Crepitus (subcutaneous emphysema) indicates that oxygen is escaping into the subcutaneous layer of the skin, but this does not indicate the lung has re-expanded, which is the goal of the treatment.


MAKING NURSING DECISIONS: The nurse should realize a normal finding indicates the medical treatment is effective. If the nurse is vacillating between two options and one option is equipment the nurse should select the client’s body as the correct answer.

51. 1. Jugular vein distention would indicate the client has CHF. This is not a complication of a loop diuretic.
2. Rales and rhonchi are symptoms of pulmonary edema, not a complication of a loop diuretic.
3. Leg cramps may indicate a low serum potassium level, which can occur as a result of the administration of a diuretic.
4. This would indicate the medication is effective and is not a complication of the medication.


MAKING NURSING DECISIONS: The nurse must be aware of expected actions of medications. The nurse must be aware of assessment data indicating the medication is effective or the medication is causing a side effect or an adverse effect.

52. 1. Nonmaleance means to do no harm. This statement is letting the client know that the concern has been heard but does not give the client bad news before surgery. The nurse is aware that someone having surgery should be of sound mind, and finding out your child is dead would be horrific.
2. This is an example of veracity.
3. This is an example of paternalism, telling the client what he or she should do.
4. This is a therapeutic response, not an example of nonmaleance.


MAKING NURSING DECISIONS: The NCLEX-RN® blueprint includes nursing care that addresses ethical principles, including autonomy, beneficence, justice, and veracity, to name a few.

53. 1. The Joint Commission is an organization that monitors healthcare facilities for compliance with standards of care. Accreditation is voluntary, but most third-party payers will not reimburse a facility that is not accredited by some outside organization.
2. Accreditation does not guarantee reimbursement, although most third-party payers require some accreditation by an outside organization.
3. Accreditation does not reduce the hospital’s liability.
4. Medicare/Medicaid will not review a facility routinely if the Joint Commission has accredited the facility, but a representative will review the facility in cases of reported problems.


MAKING NURSING DECISIONS: The NCLEX-RN® blueprint includes nursing care that is ruled by legal requirements as well as Joint Commission, Medicare & Medicaid Services, Centers for Disease Control and Prevention, and Occupational Safety and Health Administration rules and regulations. The nurse must be knowledgeable of these standards.

54. 1. The nurse should “offer self” to the significant other. Ignoring the needs of the significant other at this time makes the significant other feel that the nurse does not care, and if the nurse does not care
for “me,” then did the nurse provide adequate care to my loved one? This action is very important to assist in the grieving process.
2. The UAP can gather the deceased client’s belongings.
3. The UAP can perform post-mortem care.
4. The representative of the organ donation team will make this request. Organ banks think it is best for specially trained individuals to discuss organ donation with the significant others.


MAKING NURSING DECISIONS: The NCLEX-RN® addresses questions concerned with end-of-life care. This is included in the Psychosocial Integrity section of the test blueprint. If unsure of the correct option, selecting an option addressing an individual is a better choice.

55. 1. Coumadin is an oral, not intravenous, medication.
2. The therapeutic PTT results should be 1.5 to 2 times the control, or 51 to 68 seconds. The client’s value of 53 is within the therapeutic range. The nurse should continue the heparin drip as is.
3. The INR is not up to therapeutic range yet, so warfarin (Coumadin) should be administered.
4. These lab values do not provide any information about aspirin administration, but the nurse should ask the HCP whether aspirin (an antiplatelet) should be discontinued because the client is receiving two anticoagulants—heparin and warfarin.


MAKING NURSING DECISIONS: This is an alternate type of question included in the NCLEX-RN® blueprint. The test taker must be able to read a chart, must be knowledgeable of laboratory data, and must be able to make appropriate decisions as to the nurse’s most appropriate action.

56. 1. A Rapid Response Team (RRT) is called when the nurse assesses a client whose condition is deteriorating. The purpose of an RRT is to intervene to prevent a code. In the scenario described, the situation has not progressed to an arrest. The nurse should call an RRT, but administering oxygen is the first intervention.
2. The first action is to increase the client’s oxygen to 100%.
3. The nurse could check the ABG results, but the client is in distress and the nurse should implement an intervention to relieve the distress.
4. A fast-acting inhaler should be used, but not until after the oxygen has been increased and an RRT called.


MAKING NURSING DECISIONS: The nurse should remember: If a client is in distress and the nurse can do something to relieve the distress, that should be done first, before assessment. The test taker should select an option that directly helps the client’s condition.

57. 1. The client may eventually need to be transferred to a facility that accepts long-term ventilator-dependent clients, but the nurse would not anticipate this at this time.
2. The client on a ventilator will have blood gases ordered more often than daily.
3. The stem does not indicate that the client is ready to be removed from the ventilator.
4. A client who has been intubated for 10 to 14 days and still requires mechanical ventilation should have a surgically placed tracheostomy to prevent permanent vocal cord damage.


MAKING NURSING DECISIONS: The nurse must be knowledgeable of expected medical treatment for the client. This is a knowledge-based question.

58. 1. The child’s skin will normally taste salty, but this is not the priority intervention to teach.
2. The parents should be asked about the client’s stools during an assessment because the effectiveness of the pancreatic enzymes is evaluated by the consistency of the stool. This is not the priority intervention because the child must take the enzymes before monitoring the consistency of the stool.
3. Cystic fibrosis is a genetic condition that results in blockage of the pancreatic ducts. The child needs pancreatic
enzymes to be administered with every meal and snack so the enzymes will be available when the food gets to the small intestine.

4. Cystic fibrosis is one of the few diseases that requires salt replacement, but salt replacement is not more important than taking the pancreatic enzymes.


MAKING NURSING DECISIONS: The nurse must be knowledgeable of expected medical treatment for the client. This is a knowledge-based question.

59. 1. The UAP should be sensitive to the client’s preferences and not insist that the client miss the program.
2. The UAP should arrange an acceptable time for the client, and the UAP can return to complete the task at the agreed-on time.
3. This is the best instruction for the nurse to give to the UAP.
4. The bath has not been refused. The client does not want the program interrupted.


MAKING NURSING DECISIONS: Delegation means the nurse is responsible for the UAP’s actions and performance. The nurse must provide guidance to the UAP.

60. 1. Effective group process involves all members of the group.
2. Unanimous decisions may indicate group-think, which can be a problem in a group process.
3. Effective group process involves all members of the group, not just two.
4. Not allowing deviation from the agenda is an autocratic style and limits the creativity and involvement of the group.


MAKING NURSING DECISIONS: There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy; the nurse must be knowledgeable of management issues.

61. 1. The ventilator should be checked to determine which alarm is sounding. This is the first step in assessing the client’s problem.
2. The nurse should assess the ventilator and the client and then notify the respiratory therapist, if needed.
3. The client should be assessed, but the ventilator may require only a simple adjustment to fix the problem and turn off the alarm. This is one instance in which the nurse should assess the machine prior to assessing the client because the machine is breathing for the client.
4. The client should be manually ventilated if the nurse cannot determine the cause of the ventilator alarm.


MAKING NURSING DECISIONS: The nurse must determine if the client is in distress. Remember: If in distress, do not assess. The nurse must intervene to help the client. In most situations, the nurse should not select equipment over the client’s body; however, when the equipment is breathing for the client the equipment should be assessed first.

62. 1. Acute respiratory distress syndrome is diagnosed when the client has an arterial blood gas of less than 50% while receiving oxygen at 10 LPM. The nurse should prepare for the client to be intubated.
2. The nurse should intervene while the client is breathing by calling the HCP and assisting in the intubation and setup of the mechanical ventilator. If the client has an arrest before this can be arranged, the client would be ventilated with a bag/mask device.
3. If the nurse does not intervene immediately, an arrest situation will occur, at which time a Code Blue would be called and CPR started.
4. If the client does not have a patent IV, the nurse should start one, but not before preparing for intubation.


MAKING NURSING DECISIONS: The nurse must be knowledgeable of expected medical treatment for the client. This is a knowledge-based question.
63. 1. These blood gases indicate respiratory acidosis that could be caused by ineffective cough, with resulting air trapping. The nurse should encourage the client to turn, cough, and deep breathe.

2. The PaO₂ level is within normal limits, 80 to 100. Administering oxygen is not the first intervention.

3. The nurse knows the arterial blood gas oxygen level, which is an accurate test. The pulse oximeter only provides an approximate level.

4. This is not the first intervention. The nurse can intervene to treat the client before notifying the HCP.


MAKING NURSING DECISIONS: The nurse must be knowledgeable of expected medical treatment for the client. This is a knowledge-based question.

64. 1. The nurse should first prevent circulatory collapse by starting two IVs and initiating normal saline or Ringer’s lactate. The cross-match may be needed if the shock condition is caused by hemorrhage.

2. The client is exhibiting symptoms of shock. The nurse should start IV lines to prevent the client from progressing to circulatory collapse.

3. All clients have a history taken and physical examination performed as part of the admission process to the emergency department, but this is not the first intervention.

4. Checking the client’s allergies to medications is important, but it is not the first intervention in a client exhibiting signs of shock.


MAKING NURSING DECISIONS: The nurse should remember if a client is in distress and the nurse can do something to relieve the distress, that should be done first, before assessment. The test taker should select an option that directly helps the client’s condition.

65. 1. This client is nearing discharge status. Postoperative clients are progressed rapidly. A medical-surgical nurse could take care of this client.

2. Chest tubes are frequently cared for on a medical-surgical unit, the medical-surgical nurse can care for this client.

3. This client’s status is uncertain. The ICU nurse would be an appropriate assignment for this client since the patient will be moved to ICU soon.

4. A medical-surgical nurse can care for this client.

5. The intensive care nurse should care for this client requiring titration of multiple medications simultaneously.


MAKING NURSING DECISIONS: The charge nurse must decide which clients need a higher level of expertise to make this decision. Those clients requiring a higher level of expertise should be assigned to the nurse with the greatest knowledge in certain areas.

66. 1. This position allows for access to the client’s back area. The chest tube for a hemothorax is positioned low and posterior to allow for gravity to assist in the removal of fluid from the thoracic area.

2. This is the position for giving an enema.

3. This is the position used to assist with a lumbar puncture.

4. This is a resting position; it is not preparing for a chest tube placement.


MAKING NURSING DECISIONS: The nurse must have knowledge of basic anatomy and physiology to answer this question. “Hemo” means blood and “thorax” refers to the thoracic cavity. Blood is in the area where the lung needs to expand. Blood is heavier than air so the client should be positioned to access the area where dependent drainage will occur.

67. 1. Starting an intravenous line must be done prior to being able to initiate a piggyback medication.

2. In order to treat the client with the most effective medication and not skew the results of a sputum culture, the specimen must be obtained prior to initiating antibiotics.

3. New orders for intravenous antibiotics must be considered a priority to prevent the client
from going into gram-negative sepsis, a potentially lethal situation. However, in order to initiate the antibiotic the nurse must make sure a correct diagnosis is able to be made.

4. Respiratory treatments are important, but not before starting the antibiotics.

**Content – Medical/Surgical: Category of Health**


**Cognitive Level – Application**

**MAKING NURSING DECISIONS:** To arrive at the correct priority intervention, the test taker must decide if one option must be accomplished prior to initiating other options.

68. 1. Shortness of breath after ambulating is expected for a patient diagnosed with COPD.

2. Patients diagnosed with deep vein thrombosis are at risk for pulmonary embolism (PE). Anxiety is a symptom of PE. The nurse must determine if interventions are needed for PE, a life-threatening emergency.

3. Anyone can take a specimen to the laboratory.

4. An empyema is an abscess in the thoracic cavity. These vital signs would be expected for this patient.

**Content – Medical/Surgical: Category of Health**


**Cognitive Level – Analysis**

**MAKING NURSING DECISIONS:** When deciding which patient to assess first, there are rules. 1. Is the situation life threatening or life altering? 2. Is the information/data presented abnormal or unexpected? 3. Is the information expected for the disease process? Or is the problem a psychosocial one? 4. Are the data within normal limits? The test taker should choose the correct answer based on 1 first, 2 next, 3 next, and 4 last.

69. Answer: 2160 mL intake and 925 mL output.

The urinary output is not used in this calculation. The urine output must add up both intravenous fluids and oral fluids to obtain the total intake for this client; 1500 + 100 = 1500 IV fluids; (1 ounce = 30 mL) 12 ounces ¥ 30 mL = 360 mL, 6 ounces ¥ 30 mL = 180 mL, 4 ounces ¥ 30 mL = 120 mL; 360 + 180 + 120 = 660 oral fluids. Total intake is 1,500 + 660 = 2,160. The urinary output 800 mL plus chest drainage 125 mL equals 925 mLs for shift output.

**Content – Medical/Surgical: Category of Health**


**MAKING NURSING DECISIONS:** The NCLEX-RN® blueprint includes dosage calculations under Pharmacological and Parenteral Therapies. This category is included under Physiological Integrity, which promotes physical health and wellness by providing care and comfort, reducing client risk potential, and managing health alterations.

70. 1. Bronchiolitis is an inflammation of the bronchioles, which are the small airways in the lungs. Signs/symptoms include wheezy cough, rapid breathing, cyanosis, nasal flaring, muscle retactions, and fever. Because the client is exhibiting expected signs/symptoms this client should be assigned to the graduate nurse.

2. Dull percussion and vocal fremitus indicate consolidation. Consolidation is fluid instead of air in the alveolar space. This is a potentially life-threatening situation and should not be assigned to a new graduate.

3. Flail chest describes a situation in which a portion of the rib cage is separated from the rest of the chest wall, usually due to a severe blunt trauma, such as a serious fall or a car accident. This affected portion is unable to contribute to expansion of the lungs. Flail chest is a serious condition that can lead to long-term disability and even death. The charge nurse should assign this client to a more experienced nurse.

4. The client with reactive airway disease, asthma, should be asymptomatic; therefore, when the client is wheezing the client is having an acute exacerbation and should be assigned to a more experienced nurse.

**Content – Medical/Surgical: Category of Health**


**MAKING NURSING DECISIONS:** When the test taker is deciding which client should be assigned to a new graduate, the most stable client should be assigned to the least experienced nurse.