CAS Adult Health Practice Exam (Sample)

Study Guide

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Questions

1. **Which intervention is essential in the postoperative care plan for a client with an NG tube on wall suction?**
   - **A. Discontinue suction when assessing for peristalsis.**
   - **B. Irrigate the NG tube with 0.9% sodium chloride irrigation solution.**
   - **C. Place sequential compression devices on the bilateral lower extremities.**
   - **D. Encourage the use of an incentive spirometer every 2 hr while the client is awake.**

2. **For a client with a new diagnosis of myasthenia gravis, which manifestation should the nurse monitor for?**
   - **A. Confusion**
   - **B. Weakness**
   - **C. Increased intracranial pressure**
   - **D. Increased urinary output**

3. **In the event of a tonic-clonic seizure, what should the nurse do first?**
   - **A. Check the client's motor strength.**
   - **B. Turn the client's head to the side.**
   - **C. Loosen the clothing around the client's waist.**
   - **D. Document the time the seizure began.**

4. **What is a common effect of unmanaged hypertension?**
   - **A. Enhanced kidney function**
   - **B. Increased risk of stroke**
   - **C. Improved cardiovascular health**
   - **D. Reduction in heart rate**

5. **What type of exercise is often recommended for patients recovering from respiratory issues?**
   - **A. Aerobic exercise**
   - **B. Heavy weight lifting**
   - **C. High-intensity interval training**
   - **D. Bed rest**

6. After removing an NG tube from a client who is 9 days post total laryngectomy, which statement is appropriate for the nurse to make?

A. "Tuck your chin when you swallow so you won't choke."

B. "It is no longer possible for you to choke on or aspirate food."

C. "You should have no trouble swallowing fluids."

D. "I will add a thickener to your liquids to prevent aspiration."

7. How can a nurse effectively promote optimal respiratory function in a hospitalized patient?

A. By providing oxygen therapy exclusively

B. By encouraging deep breathing exercises

C. By placing the patient in a prone position

D. By limiting patient mobility

8. Which lab value should a nurse expect to be elevated in a client with acute pancreatitis?

A. Calcium

B. RBC count

C. Magnesium

D. Amylase

9. What is the priority risk for a client with extensive burns of the head, neck, and chest?

A. Infection

B. Fluid imbalance

C. Airway obstruction

D. Paralytic ileus

10. What nursing assessment is crucial before starting opioid administration?

A. Assessing the patient’s blood pressure

B. Checking for medication allergies

C. Assessing respiratory rate and sedation level

D. Counting the patient’s pulse

Answers

1. A
2. B
3. B
4. B
5. A
6. B
7. B
8. D
9. C
10. C

Explanations

1. Which intervention is essential in the postoperative care plan for a client with an NG tube on wall suction?

A. Discontinue suction when assessing for peristalsis.

B. Irrigate the NG tube with 0.9% sodium chloride irrigation solution.

C. Place sequential compression devices on the bilateral lower extremities.

D. Encourage the use of an incentive spirometer every 2 hr while the client is awake.

Discontinuing suction when assessing for peristalsis is essential because it allows for an accurate evaluation of the gastrointestinal (GI) function. After surgery, particularly abdominal surgery, assessing peristalsis is critical for monitoring recovery. If the suction is left on, it can impede the natural movement of the intestines and mask any signs of peristalsis. By temporarily discontinuing suction, a clinician can effectively listen for bowel sounds and observe any movement or changes that indicate whether the intestines are starting to function properly again. The other interventions, while beneficial in certain contexts, do not directly pertain to assessing GI function and are therefore secondary considerations. For instance, irrigating the NG tube can be necessary for maintaining patency, but it does not directly contribute to assessing peristalsis. Placing sequential compression devices helps prevent venous thromboembolism, and encouraging the use of an incentive spirometer supports respiratory function, but neither of these actions is specific to evaluating bowel movement and function, which is why the first option stands out as most critical in this situation.

2. For a client with a new diagnosis of myasthenia gravis, which manifestation should the nurse monitor for?

A. Confusion

B. Weakness

C. Increased intracranial pressure

D. Increased urinary output

In myasthenia gravis, the primary manifestation that a nurse should monitor for is weakness. This neuromuscular disorder is characterized by weakness in the voluntary muscles due to the inability of nerve impulses to trigger muscle contractions effectively. The hallmark symptom of myasthenia gravis is fluctuating muscle weakness that typically worsens with activity and improves with rest. Monitoring for this specific weakness is crucial as it can affect major muscle groups, including those controlling eye movements, facial expressions, chewing, swallowing, and even respiratory function. Identifying changes in the pattern and severity of weakness can help in the timely adjustment of treatment and interventions to enhance the client's safety and quality of life. Other potential manifestations like confusion or signs of increased intracranial pressure are not characteristic of myasthenia gravis, as this condition primarily affects the neuromuscular junction. Increased urinary output is also unrelated to the effects of myasthenia gravis, and while it may be observed in various other conditions, it is not a direct concern for a client diagnosed with this disorder.

3. In the event of a tonic-clonic seizure, what should the nurse do first?

A. Check the client's motor strength.

B. Turn the client's head to the side.

C. Loosen the clothing around the client's waist.

D. Document the time the seizure began.

Turning the client's head to the side during a tonic-clonic seizure is critical for several reasons. This position helps to maintain an open airway and prevent aspiration. When a person experiences a seizure, they might lose control over their bodily functions, including the ability to breathe normally. By turning the head to the side, it allows any fluids, such as saliva or vomit, to drain out of the mouth rather than becoming a choking hazard. Additionally, protecting the airway is one of the primary concerns in managing a patient during a seizure. Ensuring that the person is not in a position where they could inhale foreign materials can significantly decrease the risk of respiratory complications. It's also important to monitor the duration of the seizure and the client's condition after it, but ensuring their immediate safety by positioning them correctly is the first priority. Other interventions, such as checking motor strength, loosening clothing, and documenting the seizure's onset, are important, but they should come after addressing the immediate needs for airway protection.

4. What is a common effect of unmanaged hypertension?

A. Enhanced kidney function

B. Increased risk of stroke

C. Improved cardiovascular health

D. Reduction in heart rate

Unmanaged hypertension, or high blood pressure that is not adequately controlled, can lead to a variety of serious health complications. One significant effect is an increased risk of stroke. High blood pressure can cause damage to the blood vessels over time, making them less elastic and more susceptible to rupture or blockage. When a blood vessel supplying the brain is affected, it can lead to a stroke, either through hemorrhage or ischemia (a lack of blood flow). In contrast, enhanced kidney function and improved cardiovascular health would be outcomes of well-managed hypertension rather than unmanaged. A reduction in heart rate is not typically a direct result of hypertension; in fact, hypertension can lead to an increased heart rate as the heart works harder to pump blood against elevated pressure. Therefore, the increased risk of stroke is a well-established consequence of prolonged, uncontrolled high blood pressure.

5. What type of exercise is often recommended for patients recovering from respiratory issues?

A. Aerobic exercise

B. Heavy weight lifting

C. High-intensity interval training

D. Bed rest

Aerobic exercise is often recommended for patients recovering from respiratory issues due to its capacity to improve lung function and overall cardiovascular health. Engaging in aerobic activities—such as walking, cycling, or swimming at a comfortable intensity—can facilitate better oxygen exchange, enhance endurance, and promote better respiratory muscle function. These exercises help to gradually increase the patient's physical activity levels without overwhelming their system, making it easier to rebuild stamina and improve respiratory efficiency. While options like heavy weight lifting and high-intensity interval training might be beneficial for healthy individuals or those looking to enhance fitness levels, they can pose significant challenges to patients with respiratory issues, potentially leading to breathlessness or respiratory distress. Bed rest, on the other hand, may hinder recovery by contributing to muscle deconditioning and a decline in functional capacity. Therefore, aerobic exercise strikes a balanced approach by supporting respiratory recovery while minimizing risks.

6. After removing an NG tube from a client who is 9 days post total laryngectomy, which statement is appropriate for the nurse to make?

A. "Tuck your chin when you swallow so you won't choke."

B. "It is no longer possible for you to choke on or aspirate food."

C. "You should have no trouble swallowing fluids."

D. "I will add a thickener to your liquids to prevent aspiration."

In the context of a patient who has undergone a total laryngectomy, the correct statement focuses on the changes in the anatomy and physiology associated with this surgery. After a total laryngectomy, the patient's airway is completely separated from the esophagus due to the removal of the larynx. As a result, aspiration—where food or liquid enters the airway instead of the esophagus—becomes highly unlikely, as the trachea is no longer directly connected to the swallowing pathway. Therefore, the statement indicating it is no longer possible for the patient to choke on or aspirate food reflects this fundamental change in anatomy. While the other statements may suggest strategies for safe swallowing or address concerns about aspiration, they do not accurately reflect the patient's new physiology. For instance, tucking the chin when swallowing is a strategy typically used for clients at risk of aspiration, but it is less relevant in this case. Similarly, stating that the patient should have no trouble swallowing fluids overlooks the fact that they may still experience dysphagia due to other factors, not directly related to the mechanics of choking or aspiration. Adding thickener to liquids is also a management strategy for those at risk of aspiration who still have a functioning airway that can potentially interact with the swallowing process

7. How can a nurse effectively promote optimal respiratory function in a hospitalized patient?

A. By providing oxygen therapy exclusively

B. By encouraging deep breathing exercises

C. By placing the patient in a prone position

D. By limiting patient mobility

Encouraging deep breathing exercises is a fundamental nursing intervention for promoting optimal respiratory function in hospitalized patients. Deep breathing exercises increase lung expansion, enhance alveolar ventilation, and improve gas exchange. They help clear secretions, reduce the risk of atelectasis (partial lung collapse), and promote effective breathing patterns, especially after surgery or during prolonged bed rest. In practice, these exercises can include techniques like diaphragmatic breathing or using incentive spirometry. These strategies not only improve respiratory function but also engage the patient, encouraging participation in their own care, which can lead to better outcomes. While providing oxygen therapy may assist those with difficulty breathing, it does not address the underlying lung mechanics, such as improving lung volume and air exchange. Positioning the patient in a prone position can be beneficial in certain scenarios, such as with patients suffering from severe acute respiratory distress syndrome (ARDS), but it is not a universal approach for all patients. Limiting patient mobility can impair respiratory function by increasing the risk of complications like pneumonia and consequentially, it can negatively affect respiratory health by reducing lung expansion and promoting stagnation in lung secretions. Thus, promoting mobility and deep breathing exercises remains a cornerstone of nursing care for respiratory health.

8. Which lab value should a nurse expect to be elevated in a client with acute pancreatitis?

A. Calcium

B. RBC count

C. Magnesium

D. Amylase

In a client with acute pancreatitis, the lab value that should be expected to be elevated is amylase. Amylase is an enzyme produced primarily by the pancreas and salivary glands, and it plays a crucial role in the digestion of carbohydrates. When the pancreas becomes inflamed, as in the case of acute pancreatitis, the levels of amylase can rise significantly due to the release of this enzyme into the bloodstream from the inflamed pancreatic tissue. Elevated levels of amylase occur shortly after the onset of acute pancreatitis and can remain elevated for several days. This makes amylase a key indicator in determining the presence of pancreatic inflammation. In conjunction with other tests and clinical signs, elevated amylase can assist healthcare professionals in diagnosing acute pancreatitis and monitoring its progression. Other lab values, such as calcium and magnesium, may be affected in the context of pancreatitis but do not typically show the same distinct rise as amylase during an acute episode. Additionally, while the RBC count can fluctuate in various clinical conditions, it is not a specific indicator of acute pancreatitis. Therefore, the elevation of amylase serves as a distinctive and expected laboratory finding in this condition.

9. What is the priority risk for a client with extensive burns of the head, neck, and chest?

A. Infection

B. Fluid imbalance

C. Airway obstruction

D. Paralytic ileus

In the case of a client with extensive burns of the head, neck, and chest, the priority risk is airway obstruction. Burns in these areas can lead to significant swelling and edema, which can quickly compromise the airway. The head and neck are particularly critical because they house the trachea and major blood vessels. Inflammation from the burns can result in narrowing of the airway passages, making it difficult for the client to breathe. Additionally, the risk of airway compromise is heightened due to the potential for smoke inhalation or aspiration of harmful substances, especially in cases of fire-related burns. Therefore, ensuring a patent airway is the top priority in burn management, as airway obstruction can lead to hypoxia and respiratory failure if not addressed promptly. While infection is a serious concern with burns due to skin barrier loss, it typically becomes a more pressing issue after immediate threats to life, such as airway compromise, have been managed. Fluid imbalance is also significant in burn patients, given the risk of hypovolemic shock due to fluid loss. However, without a clear airway, the client cannot adequately receive oxygen, making airway obstruction the most critical priority. Paralytic ileus, while a concern due to stress and decreased bowel perfusion, is not an immediate

10. What nursing assessment is crucial before starting opioid administration?

A. Assessing the patient's blood pressure

B. Checking for medication allergies

C. Assessing respiratory rate and sedation level

D. Counting the patient's pulse

Assessing the respiratory rate and sedation level is crucial before starting opioid administration because these medications have a significant impact on the respiratory system. Opioids can cause respiratory depression, which is a serious and potentially life-threatening side effect. By evaluating the patient's respiratory rate, the nurse can determine if the patient is at risk for inadequate respiratory function. Additionally, assessing the level of sedation helps to gauge the patient's alertness and potential responsiveness to stimuli, which can indicate how opioids may affect them. Ensuring that the patient has an adequate baseline respiratory rate and is not excessively sedated is vital for safe opioid use. In contrast, while blood pressure assessments and checking for medication allergies are important aspects of a comprehensive nursing assessment, they do not directly address the specific risks associated with opioid therapy. Counting the patient's pulse is also a standard part of vital sign assessment but does not focus on the immediate implications of opioid administration related to respiratory function and sedation. Therefore, prioritizing respiratory rate and sedation assessment ensures patient safety in the context of opioid use.