Learning Systems Med Surg Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

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Questions

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1. When monitoring a patient in anaphylactic shock, what should be prioritized?

- **A. Fluid resuscitation**
- **B. Airway management**
- **C. Monitoring heart rate**
- **D. Administering antihistamines**

2. What nursing intervention is critical in managing a patient with a respiratory infection?

- **A. Limiting fluid intake**
- **B. Encouraging hydration**
- **C. Administering sedatives**
- **D. Reducing physical activity**

3. Which of the following is a critical sign that a nurse must monitor in a client receiving anticoagulation therapy?

- **A. Increased appetite**
- **B. Bleeding or bruising**
- **C. Improved energy levels**
- **D. Weight loss**

4. What sign might indicate a systemic infection?

- **A. Localized swelling**
- **B. Increased blood pressure**
- **C. Fever and tachycardia**
- **D. Low blood sugar**

5. What defines a 'hypertension crisis'?

- **A. A slight increase in blood pressure**
- **B. A reading of 140/90 mmHg or higher**
- **C. A severe increase in blood pressure, typically over 180/120 mmHg**
- **D. A transient increase in blood pressure**

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6. What is an appropriate nursing response to an AP inquiring about the contagious nature of herpes zoster?

A. "Herpes zoster is contagious to those who have had chickenpox"

B. "Herpes zoster is not contagious to people who have had chickenpox"

C. "Herpes zoster requires isolation at all times"

D. "Herpes zoster is only contagious if blisters are present"

7. What is the first action a nurse should take when a client begins having a tonic-clonic seizure?

A. Call for help

B. Lower the client to the floor

C. Place a bite block in the client's mouth

D. Position the client on their side

8. When planning dietary teaching for a client with diabetes mellitus, what should the nurse do first?

A. Ask the client to identify the types of foods she prefers

B. Provide a list of recommended foods

C. Explain the importance of carbohydrate counting

D. Discuss the impact of diabetes on nutrition

9. What can be a consequence of untreated hypertension?

A. Kidney stones

B. Heart failure

C. Chronic headache

D. Visual disturbances

10. How should a nurse react to a patient experiencing a seizure?

A. Place something in the patient's mouth to prevent biting

B. Restrict the patient's movement to prevent injury

C. Protect the patient from injury and ensure a clear airway

D. Leave the patient alone until the seizure ends

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Answers

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

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Explanations

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1. When monitoring a patient in anaphylactic shock, what should be prioritized?

A. Fluid resuscitation

B. Airway management

C. Monitoring heart rate

D. Administering antihistamines

In the context of anaphylactic shock, airway management is of utmost priority because this condition can lead to severe and rapid obstruction of the airway due to swelling and bronchoconstriction. During an anaphylactic reaction, the release of histamines and other inflammatory mediators can cause the throat and airways to swell, making it difficult for the patient to breathe. When a patient is experiencing anaphylaxis, they can develop stridor, wheezing, or even complete loss of airway patency, which necessitates immediate intervention to secure the airway. If the airway is not established promptly, the patient could suffer from hypoxia, leading to respiratory failure and potential death. While fluid resuscitation, monitoring heart rate, and administering antihistamines are all important components of treating anaphylactic shock, they are secondary to ensuring that the patient has a clear and open airway. Administering epinephrine is also critical, as it helps counteract the allergic reaction quickly, but airway management should always be prioritized to prevent life-threatening complications.

2. What nursing intervention is critical in managing a patient with a respiratory infection?

A. Limiting fluid intake

B. Encouraging hydration

C. Administering sedatives

D. Reducing physical activity

Encouraging hydration is a critical nursing intervention for managing a patient with a respiratory infection because adequate fluid intake helps to maintain effective mucus production, which is essential for clearing secretions from the airways. Proper hydration also supports overall bodily functions and can help in thinning mucus, making it easier to cough up and expel from the lungs. This is particularly important in respiratory infections, where mucus production is often increased and can lead to coughing and difficulty breathing when it is thickened or excessive. In contrast, limiting fluid intake would potentially worsen the patient's condition by leading to dehydration and thicker mucus, which can exacerbate respiratory symptoms. Administering sedatives may not be appropriate as they can depress the respiratory system and diminish the patient's ability to effectively clear secretions through coughing. Reducing physical activity, while sometimes necessary in certain situations to prevent exhaustion, should not be overly restrictive as light activity might actually aid in keeping the lungs functioning better when the patient is capable.

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3. Which of the following is a critical sign that a nurse must monitor in a client receiving anticoagulation therapy?

A. Increased appetite

B. Bleeding or bruising

C. Improved energy levels

D. Weight loss

Monitoring for bleeding or bruising is critical for a client receiving anticoagulation therapy because these medications are designed to inhibit blood clot formation, which increases the risk of excessive bleeding. Anticoagulants, such as warfarin or heparin, are used in various conditions to prevent thromboembolic events, but they also require careful monitoring to avoid complications. Signs of bleeding might include visible bruising, petechiae (small red or purple spots), or excessive bleeding from cuts, nosebleeds, and unusual menstrual bleeding. Internally, bleeding might manifest as dark stools or hematuria (blood in urine). Therefore, vigilant observation for any signs of bleeding is essential in preventing serious health issues and ensuring the patient's safety. In contrast, while changes like increased appetite, improved energy levels, or weight loss are important for overall patient management, they do not constitute immediate health risks or complications associated with anticoagulation therapy. These factors should be noted, but they are not as critical as monitoring for signs of bleeding.

4. What sign might indicate a systemic infection?

A. Localized swelling

B. Increased blood pressure

C. Fever and tachycardia

D. Low blood sugar

Fever and tachycardia are classic indicators of a systemic infection. When the body is fighting an infection, it often responds with a systemic inflammatory response. This response can lead to an increase in body temperature, known as fever, which occurs as the body attempts to create an environment less favorable for pathogens. Tachycardia, or an elevated heart rate, typically accompanies fever as part of the body's effort to circulate blood more rapidly. This helps deliver immune cells to areas of infection and enhances the overall response to combat the invading organisms. In contrast, localized swelling generally indicates inflammation at a specific site, rather than a systemic response. Increased blood pressure can result from various factors but is not a direct sign of infection. Low blood sugar is not a typical indicator of infection; rather, it can arise from other metabolic issues or complications. Thus, the combination of fever and tachycardia signifies the presence of a systemic infection and reflects the body's immune response rather than localized issues or different physiological changes.

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5. What defines a 'hypertension crisis'?

A. A slight increase in blood pressure

B. A reading of 140/90 mmHg or higher

C. A severe increase in blood pressure, typically over 180/120 mmHg

D. A transient increase in blood pressure

A hypertension crisis is specifically characterized by a severe increase in blood pressure, typically recognized as readings exceeding 180/120 mmHg. This level of hypertension is critical as it can lead to acute complications, including organ damage and other life-threatening conditions. The main concern during a hypertension crisis is the immediate risk it poses to vital organs, such as the heart, brain, kidneys, and eyes. In contrast, a slight increase in blood pressure or a transient increase does not reach the severity necessary to be classified as a crisis. While readings of 140/90 mmHg or higher indicate elevated blood pressure and may warrant attention, they do not represent the high-risk scenario that characterizes a hypertension crisis. The distinction is crucial, as recognizing the signs and symptoms of a hypertension crisis can prompt timely medical interventions, potentially preventing serious health outcomes.

6. What is an appropriate nursing response to an AP inquiring about the contagious nature of herpes zoster?

A. "Herpes zoster is contagious to those who have had chickenpox"

B. "Herpes zoster is not contagious to people who have had chickenpox"

C. "Herpes zoster requires isolation at all times"

D. "Herpes zoster is only contagious if blisters are present"

The appropriate nursing response emphasizes that herpes zoster, also known as shingles, is not contagious to individuals who have previously had chickenpox. This is because herpes zoster arises from the reactivation of the varicella-zoster virus, which remains dormant in the body after a person has experienced chickenpox. Those who have had chickenpox carry immunity to the virus, so they are not at risk of contracting herpes zoster from someone else who has it. Understanding this aspect of the disease is important for public health and infection control measures, as it helps differentiate between vulnerability and immunity. The correct choice reinforces the idea that individuals who are already immune to chickenpox through previous infection or vaccination are not at risk of becoming infected with herpes zoster, thus minimizing unnecessary fears or isolation protocols in a healthcare setting.

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7. What is the first action a nurse should take when a client begins having a tonic-clonic seizure?

A. Call for help

B. Lower the client to the floor

C. Place a bite block in the client's mouth

D. Position the client on their side

The first action a nurse should take when a client begins having a tonic-clonic seizure is to lower the client to the floor. This action is crucial as it helps prevent injury from falls or contact with hard surfaces during the seizure. By ensuring the client is safely lowered, the nurse can minimize the risk of trauma, which is particularly important since tonic-clonic seizures involve violent muscle contractions and loss of consciousness. Lowering the client on the floor allows for a safer environment where the seizure can occur without additional hazards. It provides the opportunity for the nurse to subsequently take other essential actions, such as moving objects away to avoid injury and preparing to implement further measures for the client's safety and care once the seizure has ended. Positioning, calling for help, and providing oral protection, while important, are actions that may follow the immediate need to ensure the client's physical safety during the seizure.

8. When planning dietary teaching for a client with diabetes mellitus, what should the nurse do first?

A. Ask the client to identify the types of foods she prefers

B. Provide a list of recommended foods

C. Explain the importance of carbohydrate counting

D. Discuss the impact of diabetes on nutrition

The first step in planning dietary teaching for a client with diabetes mellitus is to ask the client to identify the types of foods she prefers. This approach is important because it engages the client in the learning process, promotes collaboration, and respects individual preferences and cultural considerations when it comes to diet. Understanding a client's food preferences helps in tailoring dietary recommendations that are realistic and sustainable for the individual, increasing the likelihood of adherence to the dietary plan. When the nurse starts by assessing the client's preferences, it also provides insights into potential challenges the client may face and areas where education may be most effective. For instance, if certain preferred foods are high in sugar or carbohydrates, the nurse can then guide the client in making healthier choices within those preferences or suggest alternatives that would fit their dietary needs without completely eliminating favorite foods. This individualized approach is foundational in diabetes management, as it not only fosters a positive therapeutic relationship but also empowers the client to take an active role in her dietary management, which is crucial for effective diabetes control and overall health.

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9. What can be a consequence of untreated hypertension?

A. Kidney stones

B. Heart failure

C. Chronic headache

D. Visual disturbances

Untreated hypertension can lead to a range of serious health complications, one of the most significant being heart failure. High blood pressure forces the heart to work harder than normal, causing the heart muscle to thicken and stiffen over time. This increased workload can eventually lead to heart failure, where the heart becomes less effective at pumping blood to meet the body's needs. Heart failure can manifest in several ways, including fatigue, fluid retention, shortness of breath, and reduced exercise capacity. Over time, as hypertension remains unaddressed, the cumulative effects on the cardiovascular system can result in significant damage, leading to the heart's inability to function properly, which is a dire consequence of prolonged high blood pressure. While other options like kidney stones, chronic headaches, and visual disturbances can be associated with hypertension, they are typically less direct or less serious than heart failure. Each of these conditions may arise as secondary effects or complications, but heart failure represents a more critical risk resulting from prolonged and untreated high blood pressure.

10. How should a nurse react to a patient experiencing a seizure?

A. Place something in the patient's mouth to prevent biting

B. Restrict the patient's movement to prevent injury

C. Protect the patient from injury and ensure a clear airway

D. Leave the patient alone until the seizure ends

When a patient is experiencing a seizure, the primary focus of the nurse's response should be to protect the patient from injury and ensure that their airway remains clear. During a seizure, individuals may lose muscle control and fall, so it is crucial to gently guide them to the ground if they are not already there, and to place cushioning around their head to prevent head injury. It is important not to restrain their movements, as this can lead to additional injury or distress. Maintaining a clear airway is essential because during a seizure, a patient may have altered levels of consciousness and be at risk of aspiration or obstructed breathing. Therefore, positioning the patient in a way that facilitates breathing and allows for any secretions to drain (like rolling them onto their side as soon as it's safe to do so) is vital. The other choices are less appropriate responses for a nurse during a seizure. Inserting objects into the patient's mouth poses a significant risk of dental injury or can cause choking. Attempting to restrict the patient's movements can lead to injuries and does not prevent the seizure itself. Leaving the patient alone during a seizure is not in the best interest of their safety, as they need assistance to navigate the potential risks associated with the seizure event.

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