

**NR217 Fall 2025 Exam #3**

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1. A nurse is teaching a class about routes of medication administration. The nurse should include that which of the following routes has the fastest rate of absorption?
  - A. Enteral  
Rationale: The nurse should include that medications administered via the enteral route are absorbed through the gastrointestinal tract. However, there is another route that has the fastest rate of absorption.
  - B. Intramuscular  
Rationale: The nurse should include that medications administered via the intramuscular route are absorbed through blood vessels in the muscles. However, there is another route that has the fastest rate of absorption.
  - C. **Intravenous**  
Rationale: Evidence-based practice indicates that medications administered via the intravenous route have the fastest rate of absorption because these medications are injected directly into the circulatory system.
  - D. Topical  
Rationale: The nurse should include that medications administered via the topical route are absorbed through the skin and produce local and systemic effects. However, there is another route that has the fastest rate of absorption.
  
2. A nurse opens a unit-dose of a prescribed medication prior to administering it to a client. The client refuses to take the medication. Which of the following actions should the nurse take?
  - A. **Report the incident to the provider**  
Rationale: The client has the right to refuse a medication. The nurse should investigate the reason for the refusal, educate the client about the potential adverse effects of the refusal, and notify the provider.
  - B. Notify the facility's ethics committee.  
Rationale: The nurse should not notify the ethics committee because this is not an ethical issue.
  - C. Fill out an incident report.  
Rationale: The nurse should fill out an incident report to document an unusual occurrence, such as a medication error, or an accident such as a fall.
  - D. Return the opened medication to the medication cart.  
Rationale: The nurse should not return the opened medication to the medication cart because once the package is opened, the nurse can no longer verify the identification of the medication.
  
3. A nurse is administering a powdered medication to a client. Which of the following actions should the nurse take first?

- A. Determine the client's response to the medication.  
Rationale: The nurse should check the client's response to the medication to monitor the client for a therapeutic response and/or adverse effects. However, there is another action that should come first.
- B. Document that the medication was administered.  
Rationale: The nurse should document that the medication was administered immediately after it is administered to decrease the risk of an error. However, there is another action that should come first.
- C. Mix the medication at the client's bedside.  
Rationale: The nurse should mix the medication at the client's bedside to keep the medication from thickening before administration. However, there is another action that should come first.
- D. **Check the client for allergies.**
4. A nurse is teaching a newly licensed nurse about incident reports. Which of the following information should the nurse include?
- A. Include personal opinions regarding an event in an incident report.  
Rationale: The incident report should contain facts, not personal opinions so that the incident report is accurate.
- B. Identify other people involved with the event in the incident report**  
The nurse should include the facts about what happened, who was involved, and what actions were taken in an incident report to ensure accuracy.
- C. Identify the person responsible for the error in the incident report.  
Rationale: The nurse should include the facts and not blame another person in an incident report to ensure accuracy.
- D. Include a note in the medical record that an incident report was completed.  
Rationale: The nurse should not indicate that an incident report was completed in the client's medical record to legally protect the nurse.
5. A nurse is teaching a newly licensed nurse about incident reports. The nurse should include that which of the following events requires an incident report?
- A. A client vomits their morning medications.  
Rationale: The nurse should check for evidence of the medication in the vomitus and report the event to the provider,
- B. A lipid-lowering medication is administered to a client 1 hr after the scheduled time.  
Rationale: This is a non-time-critical medication that can be administered 1 to 2 hours later or early without adverse effects.
- C. A client has an allergic reaction to an antibiotic.  
Rationale: The nurse should discontinue the antibiotic, check the

client's vital signs, and report the findings to the provider.

**D. An IV medication is administered via an oral route.**

Rationale: The nurse should check vital signs and report this event to the provider. Since the client is at risk for an adverse reaction, once the client is stable, the nurse should fill out an incident report.

6. A nurse administers the wrong medication to a client. Which of the following actions should the nurse take first?

**A. Check the client's vital signs.**

Rationale: The nurse should first check the client's vital signs and monitor the client for changes in condition since the client is at risk for an adverse reaction due to the medication error.

- B. Notify the provider.

Rationale: The provider should be notified, but there is another action that should come first.

- C. Fill out an incident report.

Rationale: The nurse should fill out an incident report to document the error, but there is another action that should come first.

- D. Document the client's condition in the electronic health record.

Rationale: The nurse should document the factual information about the client's condition in the electronic health record, but there is another action that should come first.

7. A nurse is assessing a client who is receiving continuous IV therapy through a peripheral IV. The catheter site is cool and taut, and there is IV fluid leaking. The nurse should identify that the client has manifestations of which of the following complications?

- A. Phlebitis

Rationale: Localized pain, heat, and swelling are manifestations of phlebitis.

**B. Infiltration**

Rationale: Pain, swelling, cool temperature, taut skin, and leaking of IV fluid are manifestations of IV infiltration.

- C. Infection

Rationale: Purulent drainage, fever, and chills are manifestations of infection.

- D. Circulatory overload

Rationale: Crackles, shortness of breath, and dependent edema are manifestations of circulatory overload.

8. A nurse is preparing to administer a metered dose inhaler (MDI) medication to a client. Which of the following actions should the nurse take?

- A. Ask the client to hold their breath for 2 seconds after inhalation.

- Rationale: Clients should hold their breath for 5 to 10 seconds after inhalation to promote absorption of the medication.
- B. Shake the MDI prior to administration.**  
 Rationale: The nurse should shake the MDI briskly for 2 to 5 seconds to aerosolize the medications particles.
- C. Wash the MDI canister in warm water after each use.  
 Rationale: The nurse should not wash the MDI canister as this can cause damage to the valve mechanism. The mouthpiece should be removed and rinsed with warm water once each day.
- D. Ask the client to inhale the medication quickly for 1 second.  
 Rationale: The medication should be inhaled slowly for 3 to 5 seconds to promote absorption.
9. A nurse is preparing to administer an ophthalmic medication to a client. Which of the following actions should the nurse plan to take?
- A. Instill the ophthalmic medication directly on the client's cornea.  
 Rationale: This is not correct since this can cause pain, irritation, and increase systemic effects. The nurse should instill the medication on the conjunctival sac.
- B. Ask the client to tightly squeeze their eyes shut after the instillation.  
 Rationale: The client should gently close their eyes to allow for absorption of the medication.
- C. Clean the client's eye from the outer canthus to the inner canthus before instillation.  
 Rationale: The nurse should clean from the inner canthus to the outer canthus to reduce the risk of infection.
- D. Apply pressure to the client's nasolacrimal duct after instillation.**  
 Rationale: Gentle pressure to the client's nasolacrimal duct prevents the medication from entering systemic circulation
10. A nurse is providing teaching for a client who has a new prescription for an antibiotic. Which of the following statements should the nurse make?
- A. Check with your provider before taking over-the-counter medications.**  
 Rationale: Over the counter medications may interact with with certain antibiotics.
- B. Antibiotics are administered to treat viral infections.  
 Rationale: Antibiotics are ineffective for viral infections.
- C. Blood stools are expected while taking antibiotics.  
 Rationale: Bloody stools can indicate a Clostridium difficile infection
- D. Discontinue the medication when you feel better.  
 Rationale: Client should complete the course of the antibiotic to eradicate the infection.

11. A nurse is preparing to teach a client about a new medication. Which of the following actions should the nurse take?
- A. Turn on the television in the client's room.  
Rationale: The nurse should provide a quiet environment to promote client learning.
  - B. Use technical language in the educational session.  
Rationale: The nurse should use simple, easy to comprehend language to ensure client understanding.
  - C. Provide education material written at a 6<sup>th</sup> grade reading level.**  
Rationale: Educational material at the 5<sup>th</sup> to 6<sup>th</sup> grade reading level promotes learning.
  - D. Begin with the least important information.  
Rationale: The nurse should begin with the most important information because the client is likely to remember the education given at the beginning of the session.
12. A nurse is teaching a client about how to administer a topical medication. After showing the client the procedure, the nurse asks the client to perform the skill. Which of the following types of teaching strategies is the nurse using?
- A. Discussion  
Rationale: Discussion is an active teaching method using the expression of feelings and application of the material based on the cognitive or affective domain of learning.
  - B. Return demonstration**  
Rationale: Return demonstration is an active teaching method of the psychomotor domain of learning based on a demonstration of the skill.
  - C. Role play  
Rationale: Role play is an active teaching method in which the client acts in a role to practice a desired behavior.
  - D. Question and answer  
Rationale: question and answer is an active teaching method in the cognitive domain of learning. The client actively participates in learning and gets their concerns addressed.
13. A nurse is teaching how to instill eye drops. The nurse asks the client to explain the procedure in their own words. Which of the following types of teaching methods is the nurse using?
- A. Teach-back**  
Rationale: During teach-back the nurse can evaluate the client's understanding of the education and determine whether further instruction is indicated.
  - B. Lecture  
Rationale: Lecture allows the client to passively gain knowledge and understanding.
  - C. Role play

Rationale: In role playing, the client acts in a role to practice a desired behavior.

D. Question and answer

Rationale: During question and answer, the client actively participates in learning and any concerns can be addressed.

14. A nurse is teaching a class about pharmacodynamics. The nurse should include that which of the following medication levels occurs when a medication is at the lowest serum concentration?

A. Toxic

Rationale: Medication toxicity occurs when a medication accumulates in the blood due to the inability to be effectively metabolized or excreted by the body.

B. Trough

Rationale: Trough blood level is the lowest concentration of a medication in the circulatory system.

C. Half-life

Rationale: Half-life is the amount of time required for 50% of the medication to be excreted from the body.

D. Peak

Rationale: Peak blood level is the highest concentration of a medication in the circulatory system without being at a toxic level.

15. What are the manifestations of anaphylaxis that should be reported immediately to the provider and require follow-up? Choose all that apply.

A. Urticaria

B. Euphoria

C. Low blood pressure

D. Panic disorder

E. Difficulty swallowing

Rationale: The nurse should identify the findings of urticaria, hypotension, and difficulty swallowing as manifestations of anaphylaxis and should report them immediately to the provider.

16. A nurse is caring for a client who is receiving an IV infusion of dextrose 10% in water. The nurse should monitor the client for which of the following adverse effects?

A. Hypokalemia

Rationale: A client who has diarrhea should be monitored for hypokalemia.

B. Hypercalcemia

Rationale: A client who has hyperparathyroidism should be monitored for hypercalcemia.

C. Hypovolemia

Rationale: The nurse should monitor the client for circulatory overload.

**D. Hyperglycemia**

Rationale: The nurse should infuse the IV slowly and monitor the client for hyperglycemia.

17. A nurse is caring for a client who is receiving a continuous IV infusion through a short-peripheral device. Which of the following actions should the nurse take?

**A. Change the client's IV tubing every 96 hours**

Rationale: Continuous IV infusions need the tubing changed every 96 hours to reduce the risk of infection

B. Replace the client's transparent IV dressing every 24 hours

Rationale: Transparent IV dressings should be changed only when clinically indicated to reduce the risk of infection.

C. Check the client's IV site every 8 hours

Rationale: IV sites should be assessed at least every 4 hours to monitor for signs of infection, phlebitis, infiltration, and to monitor the client's fluid status.

D. Ensure the client's IV solution is changed every 48 hours.

Rationale: The client's IV solution should be changed every 24 hours to reduce the risk of infection.

18. A nurse is caring for a client who is receiving a unit of PRBCs. The nurse suspects the client is experiencing a transfusion reaction. Which of the following actions should the nurse take first?

**A. Stop the transfusion.**

Rationale: The priority action is to stop the infusion to reduce the risk of further injury to the client.

B. Infuse 0.9% sodium chloride.

Rationale: The nurse should change the tubing and keep the IV open with 0.9% sodium chloride, but there is another action the nurse should take first.

C. Return the unit of blood to the blood bank.

Rationale: The nurse should return the blood to the blood bank, but there is another action the nurse should take first.

D. Obtain a blood sample from the client.

Rationale: The nurse should obtain a blood sample from the client, but there is another action the nurse should take first.

19. A nurses is caring for a client who is receiving a continuous IV through a peripheral intravenous device. The nurse notes the catheter site is warm and painful to touch. Which of the following actions should the nurse take?

A. Slow the IV infusion

- Rationale: The nurse should not continue the IV infusion but should notify the provider and discontinue the infusions to reduce the risk of further injury.
- B. Place the affected extremity below the level of the client's heart.  
Rationale: The affected extremity should be elevated above the level of the client's heart to decrease inflammation and promote comfort.
- C. Apply a warm compress to the IV site.  
Rationale: Applying heat would increase the risk of inflammation.
- D. Remove the peripheral IV and replace it in another location if the infusion is still necessary.**  
Rationale: Once an IV site becomes painful and warm to the touch, the risk of failure and infiltration is increased.
20. A nurse is caring for an older adult client. The client has an increased risk for dehydration due to which of the following physiological change that can occur with aging?
- A. Increase in percentage of body water.  
Rationale: Older adult clients can experience a decrease in percentage of body water.
- B. Increase in saliva production.  
Rationale: Older adults can experience a decrease in saliva production and diminished thirst response which can increase the risk of dehydration.
- C. Decrease in kidney function.**  
Rationale: Older adults can experience a decrease in kidney function which can result in an extracellular fluid volume deficit and dehydration.
- D. Decrease in systolic blood pressure.  
Rationale: Older adult clients can experience an increase in systolic blood pressure.
21. A nurse is caring for a client who is nauseous and is vomiting. The nurse should identify the client is at risk for which of the following acid-base imbalances?
- A. Respiratory acidosis  
Rationale: Hypoventilation, atelectasis, pneumonia, and central nervous system depression are causes of increased risk of respiratory acidosis.
- B. Respiratory alkalosis  
Rationale: hyperventilation, acute pain, and anxiety are processes that increase the risk of respiratory alkalosis
- C. Metabolic acidosis  
Rationale: Diarrhea increased the risk of metabolic acidosis due to loss of bicarbonate.
- D. Metabolic alkalosis**  
Rationale: Nausea and vomiting increase the risk of metabolic alkalosis due to the loss of metabolic acid

22. A nurse has completed the planning step of the nursing process for a client who has an acid-base imbalance. Which of the following steps should the nurse take next?
- A. Analysis  
Rationale: Analysis is the second step in the nursing process. It has already taken place during the planning process.
  - B. Evaluation  
Rationale: Evaluation is the final step in the nursing process during which outcomes are evaluated.
  - C. Assessment  
Rationale: This is the first step in the nursing process.
  - D. Implementation**  
Rationale: The next action should be implementation once the planning process is completed.
23. A nurse is supervising a newly licensed nurse replace a short-peripheral IV device for a client. Which of the following actions by the new nurse indicates an understanding of the procedure?
- A. Shaves the hair on the client's skin before inserting the new IV.  
Rationale: The nurse should clip the client's hair near the access site iff needed. Shaving the hair can cause abrasions which place the client at risk for infection.
  - B. Wears clean gloves during the new IV insertion.**  
Rationale: The nurse should wear clean gloves to protect the nurse from exposure to blood or body fluids, while maintaining aseptic technique.
  - C. Leaves small air bubbles in the new infusion tubing  
Rationale: The nurse should remove all air bubbles from the infusion tubing to reduce the risk for an air embolism.
  - D. Inserts the new device distal to the old IV site.  
Rationale: The new device should be placed proximally to the old IV site to reduce the risk of infiltration into the tissue surrounding the old site.
24. A nurse is planning to administer a unit of PRBCs for a client. Which of the following actions should the nurse plan to take?
- A. Administer the blood transfusion over 1 hr.  
Rationale: Blood should be administered over 2 to 4 hours to reduce the risk of circulatory overload.
  - B. Stay with the client for the first 10 minutes after starting the transfusion.  
Rationale: The nurse should stay with the client for at least 15 minutes after starting the transfusion to monitor for a transfusion reaction.
  - C. Flush the transfusion tubing with 5% dextrose in water.

- Rationale: The nurse should flush the transfusion tubing with 0.9% sodium chloride to reduce the risk of hemolysis.
- D. **Ensure 2 nurses check the label on the unit of blood.**  
 Rationale: The nurses should check and compare the label on the unit of blood with the client's identification. The two nurses should ensure compatibility of the unit with the client's blood type to reduce the risk of a transfusion reaction.
25. A nurse is caring for a client who has COPD. The nurse should identify the client is at risk for which of the following acid-base imbalances?
- A. **Respiratory acidosis**  
 Rationale: Clients who have COPD, atelectasis, pneumonia, or central nervous system depression, are at risk for respiratory acidosis due to an increased PCO<sub>2</sub> from hypoventilation.
- B. Respiratory alkalosis  
 Rationale: Clients who hyperventilate, such as those who have acute pain or anxiety are at risk for respiratory alkalosis due to loss of PCO<sub>2</sub>.
- C. Metabolic acidosis  
 Rationale: Clients who have diarrhea are at risk of metabolic acidosis due to loss of bicarbonate.
- D. Metabolic alkalosis  
 Rationale: Clients who have nausea and vomiting are at risk for metabolic alkalosis due to loss of metabolic acid.
26. What are the assessments and interventions expected from a nurse who suspects a hemolytic transfusion reaction? Choose all that apply.
- A. **Report an elevation of the client's temperature, flank back pain, red or dark brown urine color, and decreased blood pressure to the provider.**  
 Rationale: Each of these manifestations are indications of an acute hemolytic transfusion reaction.
- B. The patient falls asleep during the blood transfusion.  
 Rationale: The nurse should not report this finding to the provider in the absence of any signs of an acute hemolytic transfusion reaction.
- C. The nurse should continue the transfusion and wait to confirm the findings of an elevated temperature and decreased blood pressure during the next scheduled vital signs.  
 Rationale: These signs are indicative of an acute hemolytic transfusion reaction. The transfusion should be stopped immediately, and the provider should be notified immediately.
- D. **The nurse should stop the transfusion immediately and notify the provider if the client complains of flank back pain.**

Rationale: This finding is concerning for an acute hemolytic transfusion reaction. The nurse should stop the transfusion immediately and notify the provider if the client complains of flank back pain to reduce the risk of further injury.

27. A nurse is preparing a client for outpatient surgery. After the nurse inserts the IV catheter, the client reports pain in the insertion area. Which of the following actions should the nurse take?

**A. Remove the catheter and insert another into a different site.**

Rationale: It is possible that the catheter is up against a valve or near a nerve and is causing more pain than an IV catheter should. The nurse should remove the source of the pain and establish peripheral IV access elsewhere.

B. Administer an analgesic PO.

Rationale: Before administering any medication for the client's discomfort, the nurse should assess the pain and try to identify and eliminate its cause.

C. Request an order for placement of a central venous access device.

Rationale: A central venous access device is for long-term administration of various medications and IV preparations. Outpatient surgery is not an indication for this type of IV access.

D. Administer a local anesthetic.

Rationale: Before administering any medication for the client's discomfort, the nurse should assess the pain and try to identify and eliminate its cause.

28. A nurse is preparing to administer phenytoin IV to a client who has a seizure disorder. Which of the following actions should the nurse plan to take?

A. Administer the medication at 100mg/min.

Rationale: The nurse should administer phenytoin IV slowly, not faster than 50mg/min, to reduce the risk of hypotension.

**B. Administer a saline solution after injection.**

Rationale: The nurse should flush the injection site with a saline solution after the injection of phenytoin to reduce and prevent venous irritation.

C. Hold the injection if seizure activity is present.

Rationale: The nurse should administer phenytoin to prevent and to abort seizure activity.

D. Dilute the medication with dextrose 5% in water.

Rationale: The nurse should dilute phenytoin in 0.9% sodium chloride solution to prevent precipitation of the medication.

29. A nurse is preparing medication for a client when another client has an emergency. Which of the following actions should the nurse take?

A. Have another nurse guard the medication preparations until the nurse returns.

Rationale: This is impractical on a busy nursing unit, plus the nurse cannot confirm the security of the medications. The nurse guarding them might also have to respond to a client's urgent need.

- B. Have another nurse finish preparing the medications.

Rationale: The nurse may only administer medication he has prepared himself for the client.

- C. Lock the medication in a room and finish preparing it after returning from the emergency.

Rationale: No one else should have access to or administer medications the nurse has prepared. Securing them and returning later to finish preparing them and administering them decreases the risk of medication errors.

- D. Discard the prepared medications and begin again after returning.

Rationale: The nurse should not discard medication unless he has drawn an incorrect amount of medication into a syringe or is wasting excess medication.

30. A nurse arrives for her shift and is preparing to count the controlled substances in the secure cabinet. Which of the following actions should the nurse take?

- A. Set aside any controlled substances the nurse plans to give during her shift.

Rationale: The nurse should include all medications in the secure cabinet in her count. She should not remove any medications from the cabinet until she is ready to administer them.

- B. Verify that the amounts of each medication she counts match the amounts on the inventory record.

Rationale: If the amounts available do not match the amounts on the inventory record after subtracting what the nurses administered during the previous shift and adding any medication the nurses added to the cabinet, the nurse must address and reconcile the count.

- C. Co-sign any notations of wasting controlled substances on the previous shift.

Rationale: It is the responsibility of the nurse who administered the partial dose to have a second nurse witness the discards at the time the nurse discarded it.

- D. Discard in the sharps container any partial doses she finds in the cabinet.

Rationale: It is the responsibility of the nurse who administered the partial dose to have a second nurse witness the discard at the same time the nurse discarded it.

Policies vary with the facility, but the nurse must discard the remaining portion of a controlled substance in a place where other staff cannot access it, such as by retrieving it from the sharps container.

31. Before administering a medication to a client, the nurse must identify the client. Which of the following methods of identification should the nurse use?

- A. Ask the client's full name and date of birth.

- Rationale: The nurse must use two identifiers before administering medications. Acceptable identifiers include the client's , date of birth, identification number within the facility of system, telephone number, and photo identification card or badge.
- B. Verify the client's room number.  
Rationale: This is not an acceptable identifier because clients can have a room change, and ambulatory clients can visit other rooms.
- C. Check the client's name on the medication administration record (MAR).  
Rationale: This is not an acceptable identifier because the nurse could have inadvertently accessed another client's MAR.
- D. Ask a family member to verify the client's identity.  
Rationale: Checking the client's name with family members could cause error. The nurse should not rely on a client's family for information when the primary source (the client) is available.
32. A nurse is preparing to administer penicillin IM to an adult client. Which of the following angles should the nurse use for injection into the client's ventrogluteal muscle?
- A. 45 degrees  
Rationale: This angle would deposit the medication into subcutaneous tissue..
- B. 60 degrees  
Rationale: Beside being a somewhat difficult angle to estimate, this angle might not deposit the medication deeply enough into the muscle tissue.
- C. 75 degrees  
Rationale: Beside being a somewhat difficult angle to estimate, this angle might not deposit the medication deeply enough in the the muscle tissue.
- D. 90 degrees**  
Rationale: With this angle, the nurse will deposit the medication deeply into the muscle to ensure rapid absorption of the medication due to the vascularity of muscle tissue.
33. A nurse is preparing to administer the hepatitis B vaccine to a client. Which of the following techniques should the nurse use to locate the deltoid muscle?
- A. Locating the center of the arm between the elbow and the shoulder.  
Rationale: Locating the center of the arm does not give the nurse specific location for injecting the vaccine.
- B. Find the center of the anterior aspect of the thigh.  
Rationale: This identifies the rectus femoris site, not the deltoid site.
- C. Locate the middle third of the anterior thigh between the greater trochanter of the femur and the lateral femoral condyle.  
Rationale: This identifies the vastus lateralis site, not the deltoid site.

D. Place one finger across the acromion process and measure 3 fingerbreadths below to the midpoint and center of the lateral aspect of the upper arm.

Rationale: This identifies the deltoid muscle, into which the nurse should inject the vaccine.

34. A nurse is caring for a client who requires a medication that is packaged in a single dose glass ampule. Which of the following techniques should the nurse use when opening the glass ampule?

A. Wear sterile gloves and break off the neck of the glass ampule with a single snap to the right side.

Rationale: The nurse does not need to wear sterile gloves and the ampule is not snapped off to the right side.

B. Wear sterile gloves and break off the glass ampule with a single snnpa in a downward motion.

Rationale: The nurse does not need to wear sterile gloves and the ampule is not snapped off in a downward motion.

C. Tap the bottom of the ampule, place a gauze pad around the ampule neck, and break off the bottom with a forward motion away from the body.

Rationale: The nurse should not tap the bottom of the ampule, place the gauze pad or alcohol swab around the neck and break at the bottom with a forward motion away from the hands.

D. Tap the top of the ampule, place a sterile gauze around the ampule neck, and break off the top by bending it toward the body.

Rationale: The nurse should tap the top of the ampule, place a sterile gauze pad around the ampule neck, and break off the top by bending it toward the body. The sterile gauze prevents broken glass coming in contact with the fingers, and bending the ampule top toward the body allows glass fragments to spray away from the nurse.

35. A nurse is caring for a client who has a prescription for potassium chloride (KCL) 20 mEq PO daily. The nurse reviews the client's most recent laboratory results and finds the client's potassium level is 5.2 mEq/L. Which of the following actions should the nurse take?

A. Give the ordered KCL as prescribed.

Rationale: As a potassium level of 5.2 mEq/L is above the expected reference range, this is not the action the nurse should take.

B. Omit the KCL dose and document it was not given.

Rationale: It is not an appropriate action for the nurse to omit the administration of an ordered medication.

C. Call the prescribing physician and inform her of the client's serum potassium level results.

Rationale: As a potassium level of 5.2 mEq/L is above the expected reference range, the nurse should hold the medication and notify the provider of the client's serum potassium level.

D. Call the lab to verify the client's results.

Rationale: The nurse has already received the lab values from the lab, so notifying the laboratory is not indicated.

36. A nurse is preparing to administer medications to a client who states, "I don't want to take those drugs." Which of the following actions should the nurse take?

A. Tell the client the physician wants him to take the medications.

Rationale: This is not the appropriate action for the nurse to take.

B. Ask the client why he is refusing to take the medications.

Rationale: This is not the appropriate action for the nurse to take.

C. Explain the purpose for the medications.

Rationale: This is not the appropriate action for the nurse to take.

**D. Document that the client refuses the medications.**

Rationale: The client has the right to refuse the medication. It is appropriate for the nurse to document the client's refusal of the medications. The nurse should then inform the provider of the client's refusal.

37. A nurse is preparing to administer heparin subcutaneously to a client who has a deep vein thrombosis. Which of the following techniques should the nurse use?

A. Cleanse the skin with an alcohol swab, insert the needle aspirate, and inject the heparin.

Rationale: This is the incorrect technique for the nurse to use to inject heparin.

B. Cleanse the skin with an alcohol swab, insert the needle, aspirate, inject the heparin, and massage the site.

Rationale: This is the incorrect technique for the nurse to use to inject heparin.

**C. Cleanse the skin with an alcohol swab, insert the needle, inject the heparin, and observe for bleeding.**

Rationale: This is the correct technique for the nurse to use to inject heparin.

D. Cleanse the skin with an alcohol swab, insert the needle, inject the heparin, aspirate, and observe for bleeding.

Rationale: This is the incorrect technique for the nurse to use to inject heparin.

38. A nurse is administering an oral medication to an older adult client. The client states, "The pill I always take is green. I don't take an orange pill." Which of the responses should the nurse make?

A. Sometimes the same pill comes in a different color.

Rationale: The appropriate nursing response is to check the provider's original medication to avoid a medication error, not to justify the color of the medication.

- B. "Let me explain the purpose of the medication."

Rationale: The appropriate nursing response is to check the provider's original medication to avoid a medication error, not to explain the purpose of the medication.

- C. "I will check your medication order again."

Rationale: The appropriate nursing response is to check the provider's original medication to avoid a medication error.

- D. "This is the medication that your doctor wants you to take."

Rationale: The appropriate nursing response is to check the provider's original medication to avoid a medication error, not to try to justify the reason for taking the medication.

39. A nurse is caring for a client who is using a patient-controlled analgesia (PCA) pump for postoperative pain management. The nurse enters the room to find the client asleep and his partner pressing the button to dispense another dose. Which of the following responses should the nurse make?

- A. "Next time you think he needs more medication, call me and I'll push the button."

Rationale: The nurse should administer a PRN or around-the-clock dosing if the client is having breakthrough pain, but should not push the client's

- B. "It's a good idea to help make sure your husband can sleep comfortably."

Rationale: The nurse should determine with the client's awareness if there is breakthrough pain that may require more pain medication.

- C. "Why do you think your husband needs more medication when he is asleep?"

Rationale: The nurse's goal is to educate the client's partner. Asking "why" questions can make the partner defensive.

- D. "Your husband should decide when more medication is needed."

Rationale: The nurse should explain to the client's partner that the client is the only one who should operate the PCA pump. In situations where the client is not able to do so, the provider may authorize a nurse or a family member to operate the pump.

40. A charge nurse is observing a newly licensed nurse administer medications to a client. Which of the following actions by the newly licensed nurse should prompt the charge nurse to intervene?

- A. Verifies the medication against the prescription and medication label.

Rationale: The nurse should check the medication 3 times prior to administering. The nurse should verify the medication against the provider's prescription, the medication administration record, and the medication label.

- B. Scans the bar code on the medication administration record and the client's arm band.

- Rationale: Most institutions now have client identifying bar codes that are located on charts, computer charting systems, electronic medical records, medication dispensing systems, and medication administration records. This bar code is scanned prior to administering the medication to ensure that the correct client is receiving the medication.
- C. Check the provider's orders and confirms dosage in a medication reference guide.  
Rationale: It is the nurse's responsibility to verify that the dose prescribed is correct for the client's body size, weight, and renal and liver function. This is verified by checking the initial prescription and then double checking in a medication reference book as necessary.
- D. Documents medication administration prior to administering it.**  
Rationale: The nurse should document administering medications after they are given to reduce the risk of error.

### **Addendum**

These test questions were referenced in, and based on, the classroom lecture content in addition to the assigned ATI modules content for which the students were responsible. The questions were developed according to the NCSBN guidelines as seen in the test blueprint.