

Detailed Answer Key medsurge Resp

1. A nurse is admitting a client who has **active tuberculosis** to a room on a medical-surgical unit. Which of the following room assignments should the nurse make for the client?

- A. A room with air exhaust directly to the outdoor environment

Rationale: A room with air exhaust directly to the outside environment eliminates contamination of other client-care areas. This type of ventilation system is referred to as an airborne infection isolation room.

- B. A room with another nonsurgical client

Rationale: A two-bed room with another nonsurgical client exposes the other client to tuberculosis. A client who has tuberculosis should have a private room.

- C. A room in the ICU

Rationale: A client who has active tuberculosis and no other comorbidities is not critically ill.

- D. A room that is within view of the nurses' station

Rationale: The client's room should be well ventilated and private, but it is not necessary for it to be close to the nurses' station.

2. A nurse is conducting a primary survey of a client who has sustained life-threatening injuries due to a motor-vehicle crash. Identify the sequence of actions the nurse should take. (Move the actions into the box on the right, placing them in the selected order of performance. Use all the steps.)

- C. Open the airway using a jaw-thrust maneuver.
D. Determine effectiveness of ventilator efforts.
B. Establish IV access.
A. Perform a Glasgow Coma Scale assessment.
E. Remove clothing for a thorough assessment.
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3. A nurse is caring for a client who has emphysema. Which of the following findings should the nurse expect to assess in this client? (Select all that apply.)

- A. Dyspnea
 B. Bradycardia
 C. Barrel chest
 D. Clubbing of the fingers
 E. Deep respirations

Rationale:

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Dyspnea is correct. Emphysema is a lung disease involving damage to the alveoli in which they become weakened and collapse. Dyspnea is seen in clients with emphysema as the lungs try to increase the amount of oxygen available to the tissues.

Bradycardia is incorrect. With emphysema, the heart rate will increase as the heart tries to compensate for less oxygen to the tissues.

Barrel chest is correct. Clients with emphysema lose lung elasticity; the diaphragm becomes permanently flattened by hyperinflation of the lungs; the muscles of the rib cage become rigid; and the ribs flare outward. This produces the barrel chest typical of emphysema clients.

Clubbing of the fingers is correct. Clubbing results from chronic low arterial-oxygen levels. The tips of the fingers enlarge and the nails become extremely curved from front to back.

Deep respirations is incorrect. Clients with emphysema lose lung elasticity and have muscle fatigue; consequently, respirations become increasingly shallow.

~~4. A nurse is caring for a client who has returned from the surgical suite following surgery for a fractured mandible. The client had intermaxillary fixation to repair and stabilize the fracture. Which of the following actions is the priority for the nurse to take?~~

- A. Prevent aspiration.

Rationale: When using the airway, breathing, circulation approach to client care, the nurse should determine that the priority goal is to prevent the client from aspirating. Because the client's jaws are wired together, aspiration of emesis is a possibility. Therefore, the client should be given medication for nausea, and wire cutters should be kept at the bedside in case of vomiting.

- B. Ensure adequate nutrition.

Rationale: The client should be NPO initially after surgery until the gag reflex has returned. Once the client is able to eat, the client may advance to a calorie-appropriate, high-protein liquid diet. However, this is not the priority at this time.

- C. Promote oral hygiene

Rationale: The client will have an incision inside the mouth. While it is important that the client receive frequent mouth cleaning, this is not the priority at this time.

- D. Relieve the client's pain.

Rationale: While the client may be in pain and will need to be medicated, this is not the priority at this time.

5. A nurse is caring for a client who has a new diagnosis of myasthenia gravis. For which of the following manifestations should the nurse monitor?

- A. Confusion

Rationale: Myasthenia gravis does not affect cognition, level of consciousness, or orientation.

- B. Weakness

Rationale: Generalized weakness of the diaphragmatic and intercostal muscles may produce respiratory distress or predispose the client to respiratory infections.

- C. Increased intracranial pressure

Rationale:

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Myasthenia gravis does not affect pressure within the brain.

D. Increased urinary output

Rationale: Myasthenia gravis does not cause increased urine output.

6. A nurse is assessing a client who has a long history of smoking and is suspected of having laryngeal cancer. The nurse should anticipate that the client will report that her earliest manifestation was

A. dysphagia.

Rationale: Dysphagia, difficulty swallowing, is a later manifestation of cancer of the larynx. It occurs as the tumor grows in size and impedes the esophagus.

B. hoarseness.

Rationale: Laryngeal cancer, a malignant tumor of the larynx, is most often caused by long exposure to tobacco and alcohol. Hoarseness that does not resolve for several weeks is the earliest manifestation of cancer of the larynx because the tumor impedes the action of the vocal cords during speech. The voice may sound harsh and lower in pitch than normal.

C. dyspnea.

Rationale: Dyspnea, shortness of breath, is a later manifestation of laryngeal cancer. It occurs as the tumor grows in size and impedes the airway opening.

D. weight loss.

Rationale: Weight loss is a later manifestation of laryngeal cancer, usually indicative of metastasis.

7. A nurse in the emergency department is caring for a client who has extensive **partial and full-thickness burns** of the head, neck, and chest. While planning the client's care, the nurse should identify which of the following risks as the priority for assessment and intervention?

A. Airway obstruction

Rationale: When using the airway, breathing, circulation approach to client care, the nurse determines that the priority risk is airway obstruction. Burns of the head, neck, and chest often involve damage to the pulmonary tree due to heat as well as smoke and soot inhalation. This can result in severe respiratory difficulty. Nursing measures to maintain a patent airway should take priority in this client's care.

B. Infection

Rationale: Prevention of infection is essential throughout hospitalization and treatment; however, another risk is the priority.

C. Fluid imbalance

Rationale: Adequate fluid replacement is essential throughout the acute phase of burn treatment; however, another risk is the priority.

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D. Paralytic ileus

Rationale: Paralytic ileus can develop during the acute phase of burn care and might require nasogastric decompression; however, another risk is the priority.

~~8. A nurse is caring for a client who has chronic obstructive pulmonary disease (COPD). The client tells the nurse, "I can feel the congestion in my lungs, and I certainly cough a lot, but I can't seem to bring anything up." Which of the following actions should the nurse take to help this client with tenacious bronchial secretions?~~

A. Maintaining a semi-Fowler's position as often as possible

Rationale: Although a semi-Fowler's position can help the client breathe more easily, it will not alter the consistency of secretions.

B. Administering oxygen via nasal cannula at 2 L/min

Rationale: Administration of oxygen helps correct hypoxemia, but it will not alter the consistency of secretions.

C. Helping the client select a low-salt diet

Rationale: Although a low-salt diet can help limit peripheral edema, it will not alter the consistency of secretions.

D. Encouraging the client to drink 2 to 3 L of water daily

Rationale: COPD is a term for two diseases of the respiratory system: chronic bronchitis and emphysema. Maintaining hydration through the consumption of adequate fluids will help liquefy thick secretions and facilitate their expectoration.

~~9. A nurse is observing the closed chest drainage system of a client who is 24 hr post thoracotomy. The nurse notes slow, steady bubbling in the suction control chamber. Which of the following actions should the nurse take?~~

A. Check the tubing connections for leaks.

Rationale: This action is used to determine why a water seal chamber has continuous bubbling, not slow, steady bubbling.

B. Check the suction control outlet on the wall.

Rationale: This action is used to determine why a suction control chamber that is hooked to wall suction has little or no bubbling.

C. Clamp the chest tube.

Rationale: The nurse should briefly clamp the chest tube to check for air leaks or to change the drainage system. This is not an appropriate action for the nurse to take at this time.

D. Continue to monitor the client's respiratory status.

Rationale: Slow, steady bubbling in the suction control chamber is an expected finding. Therefore, the

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nurse should continue to monitor the client's respiratory status.

10. A nurse is caring for a client who is in the immediate postoperative period following a partial laryngectomy. Which of the following parameters should the nurse assess first?

A. Pain severity

Rationale: The nurse should assess the client's pain level to help provide adequate pain management; however, another assessment is the priority.

B. Wound drainage

Rationale: The nurse should assess the quantity and character of drainage from the surgical wound to monitor for hemorrhage; however, another assessment is the priority.

C. Tissue integrity

Rationale: Head and neck surgeries often require tissue flaps to close the surgical wound. The nurse should monitor color and capillary refill in the area of the flap(s) to help determine viability; however, another assessment is the priority.

D. Airway patency

Rationale: When using the airway, breathing, circulation approach to client care, the nurse determines that the priority assessment is airway patency. After head and neck surgery, a major, life-threatening complication is airway obstruction. The priority actions involve airway maintenance and gas exchange.

11. A nurse is caring for a client with a tracheostomy. The client's partner has been taught to perform suctioning. Which of the following actions by the partner should indicate to the nurse a readiness for the client's discharge?

A. Attending a class given about tracheostomy care

Rationale: This option does not require the spouse to demonstrate competence in the procedure.

B. Verbalizing all steps in the procedure

Rationale: This demonstrates that the spouse is motivated to learn, which is the first step in teaching and learning, but does not require the spouse to demonstrate competence in the procedure.

C. Performing the procedure independently

Rationale: The nurse should recognize that the client is ready for discharge when the spouse demonstrates an ability to perform the procedure that will need to be performed independently at home.

D. Asking appropriate questions about suctioning

Rationale: This demonstrates that the spouse is motivated to learn, which is the first step in teaching and learning, but does not require the spouse to demonstrate competence in the procedure.

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12. ~~A nurse is reviewing the laboratory findings for a client who developed fat embolism syndrome (FES) following a fracture. Which of the following laboratory findings should the nurse expect?~~

- A. Decreased serum calcium level

Rationale: A decreased serum calcium level is an expected finding for FES, although the reason for this finding is unknown.

- B. Decreased level of serum lipids

Rationale: An increase serum lipid level is an expected finding for FES, although the reason for this finding is unknown.

- C. Decreased erythrocyte sedimentation rate (ESR)

Rationale: An increased ESR is an expected finding for FES, although the reason for this finding is unknown.

- D. Increased platelet count

Rationale: A decreased platelet count is an expected finding for FES, although the reason for this finding is unknown.

13. A nurse is caring for a client who is unconscious and has a breathing pattern characterized by alternating periods of hyperventilation and apnea. The nurse should document that the client has which of the following respiratory alterations?

- A. Kussmaul respirations

Rationale: Kussmaul respirations are deep, rapid, regular respirations and are commonly seen in clients who are experiencing metabolic acidosis.

- B. Apneustic respirations

Rationale: Apneustic respirations are characterized by a prolonged inspiratory phase alternating with expiratory pauses.

- C. Cheyne-Stokes respirations

Rationale: Cheyne-Stokes respirations (CSR) are characterized by a rhythmic increase (to the point of hyperventilation) and decrease (to the point of apnea) in the rate and depth of respiration. CSR are common respiratory alterations seen in clients who are unconscious, comatose, or moribund (approaching death).

- D. Stridor

Rationale: Stridor is a continuous, high-pitched sound heard on inspiration in clients who have partial airway obstruction of the larynx or trachea.
