

**Question 11**

**Type:** MCSA

The patient is receiving a sustained-release capsule for his cardiac condition. The patient tells the nurse there is no way he can swallow such a large pill. What is the best response by the nurse?

1. "Withhold the medication and contact the physician."
2. "Place the capsule on the back of the patient's tongue, and have him drink a full glass of water."
3. "Open the capsule and sprinkle the contents over applesauce."
4. "Encourage the patient to try and swallow the capsule because it is the best medication for his heart condition."

**Correct Answer:** 1

**Rationale 1:** The only option is to contact the physician. Several sustained-release medications cannot be opened and sprinkled on food. Placing the capsule on the back of the patient's tongue and having him drink a full glass of water may cause the patient to aspirate the capsule and/or the water. Encouraging the patient to try to swallow the capsule is coercive, and may result in the patient choking on the medication.

**Rationale 2:** The only option is to contact the physician. Several sustained-release medications cannot be opened and sprinkled on food. Placing the capsule on the back of the patient's tongue and having him drink a full glass of water may cause the patient to aspirate the capsule and/or the water. Encouraging the patient to try to swallow the capsule is coercive, and may result in the patient choking on the medication.

**Rationale 3:** The only option is to contact the physician. Several sustained-release medications cannot be opened and sprinkled on food. Placing the capsule on the back of the patient's tongue and having him drink a full glass of water may cause the patient to aspirate the capsule and/or the water. Encouraging the patient to try to swallow the capsule is coercive, and may result in the patient choking on the medication.

**Rationale 4:** The only option is to contact the physician. Several sustained-release medications cannot be opened and sprinkled on food. Placing the capsule on the back of the patient's tongue and having him drink a full glass of water may cause the patient to aspirate the capsule and/or the water. Encouraging the patient to try to swallow the capsule is coercive, and may result in the patient choking on the medication.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:** Physiological Integrity

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 3-7

**Question 12**

**Type:** MCSA

While in the hospital, the pediatric patient has been receiving amoxicillin 10 mL orally bid, pc. The child will be going home on this medication. What is the best instruction by the nurse for the parents?

1. Give 2 teaspoons by mouth, 3 times a day, on an empty stomach.
2. Give 2 teaspoons by mouth, twice a day, after meals.
3. Give 2 teaspoons by mouth, 3 times a day, after meals.
4. Give 2 teaspoons by mouth, twice a day, with meals.

**Correct Answer:** 2

**Rationale 1:** Giving 2 teaspoons by mouth, twice a day, after meals is correct. Giving 2 teaspoons by mouth, 3 times a day, after meals is incorrect. Giving 2 teaspoons by mouth, twice a day, with meals is incorrect. Giving 2 teaspoons by mouth, 3 times a day, on an empty stomach is incorrect.

**Rationale 2:** Giving 2 teaspoons by mouth, twice a day, after meals is correct. Giving 2 teaspoons by mouth, 3 times a day, after meals is incorrect. Giving 2 teaspoons by mouth, twice a day, with meals is incorrect. Giving 2 teaspoons by mouth, 3 times a day, on an empty stomach is incorrect.

**Rationale 3:** Giving 2 teaspoons by mouth, twice a day, after meals is correct. Giving 2 teaspoons by mouth, 3 times a day, after meals is incorrect. Giving 2 teaspoons by mouth, twice a day, with meals is incorrect. Giving 2 teaspoons by mouth, 3 times a day, on an empty stomach is incorrect.

**Rationale 4:** Giving 2 teaspoons by mouth, twice a day, after meals is correct. Giving 2 teaspoons by mouth, 3 times a day, after meals is incorrect. Giving 2 teaspoons by mouth, twice a day, with meals is incorrect. Giving 2 teaspoons by mouth, 3 times a day, on an empty stomach is incorrect.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:** Physiological Integrity

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 3-6

**Question 13**

**Type:** MCSA

The patient is 3 days postop, and the physician orders an oral pain medication. The patient asks the nurse if it wouldn't be better to get the medication in the intravenous (IV) line. What is the best response by the nurse?

1. "No, because you could not medicate yourself intravenously (IV) at home."
2. "No, because pills are more effective than intravenous (IV) medications."
3. "No, because pills are safer than intravenous (IV) medications."
4. "No, because we are going to take your intravenous (IV) line out."

**Correct Answer:** 3

**Rationale 1:** Oral medications are safer than intravenous (IV) medications. Telling the patient that she cannot have the medication intravenously because the intravenous line is to be removed does not answer the patient's question. There is no evidence that the patient will be going home with an intravenous line, so this answer is incorrect. Oral medications are not more effective than IV medications.

**Rationale 2:** Oral medications are safer than intravenous (IV) medications. Telling the patient that she cannot have the medication intravenously because the intravenous line is to be removed does not answer the patient's question. There is no evidence that the patient will be going home with an intravenous line, so this answer is incorrect. Oral medications are not more effective than IV medications.

**Rationale 3:** Oral medications are safer than intravenous (IV) medications. Telling the patient that she cannot have the medication intravenously because the intravenous line is to be removed does not answer the patient's question. There is no evidence that the patient will be going home with an intravenous line, so this answer is incorrect. Oral medications are not more effective than IV medications.

**Rationale 4:** Oral medications are safer than intravenous (IV) medications. Telling the patient that she cannot have the medication intravenously because the intravenous line is to be removed

does not answer the patient's question. There is no evidence that the patient will be going home with an intravenous line, so this answer is incorrect. Oral medications are not more effective than IV medications.

**Global Rationale:**

**Cognitive Level:** Applying

**Client Need:** Physiological Integrity

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 3-8

**Question 14**

**Type:** MCSA

The nurse plans to administer heparin by drawing the heparin up in an appropriate syringe, donning gloves, prepping the patient's abdominal area, injecting the needle, aspirating for blood, and injecting the medication. Which statement best describes the nurse's plan?

1. The nurse does not need to wear gloves.
2. The nurse should not aspirate for blood.
3. The nurse does not need to prep the skin.
4. The nurse performed the injection correctly.

**Correct Answer:** 2

**Rationale 1:** When performing heparin injections, the nurse should not aspirate for blood as this may cause bruising or bleeding. Gloves must always be worn for invasive techniques. The nurse did not perform the correct technique. The skin should be prepped with alcohol prior to administering an injection.

**Rationale 2:** When performing heparin injections, the nurse should not aspirate for blood as this may cause bruising or bleeding. Gloves must always be worn for invasive techniques. The nurse did not perform the correct technique. The skin should be prepped with alcohol prior to administering an injection.

**Rationale 3:** When performing heparin injections, the nurse should not aspirate for blood as this may cause bruising or bleeding. Gloves must always be worn for invasive techniques. The nurse did not perform the correct technique. The skin should be prepped with alcohol prior to administering an injection.

**Rationale 4:** When performing heparin injections, the nurse should not aspirate for blood as this may cause bruising or bleeding. Gloves must always be worn for invasive techniques. The nurse did not perform the correct technique. The skin should be prepped with alcohol prior to administering an injection.

**Global Rationale:**

**Cognitive Level:** Analyzing

**Client Need:** Physiological Integrity

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Evaluation

**Learning Outcome:** 3-7

**Question 15**

**Type:** MCSA

An order for a medication to be given prn means

1. as needed.
2. every day.
3. at bedtime.
4. with food.

**Correct Answer:** 1

**Rationale 1:** These are the letters used to designate as needed.

**Rationale 2:** PRN does not mean every day.

**Rationale 3:** PRN does not mean at bedtime.

**Rationale 4:** PRN does not mean with food.

**Global Rationale:**

**Cognitive Level:** Remembering

**Client Need:** Health Promotion and Maintenance

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Assessment

**Learning Outcome:** 3-5

**Question 16**

**Type:** MCSA

A patient has an increased reaction to a drug following a change in her dietary habits. Which of the following changes would most likely be the cause?

1. Increased intake of grapefruit juice
2. Reduced intake of alcohol
3. Increased fiber intake
4. Reduced intake of citrus fruit

**Correct Answer:** 1

**Rationale 1:** Grapefruit juice lowers the acidity of enzymes in the GI system that break down medications. This in turn results in higher medication absorption into the bloodstream. A reduction in citrus fruit intake would likely cause a lowered drug reaction. A reduced intake of alcohol or fiber would not likely produce an increased reaction to a drug. (p. 20)

**Rationale 2:** Grapefruit juice lowers the acidity of enzymes in the GI system that break down medications. This in turn results in higher medication absorption into the bloodstream. A reduction in citrus fruit intake would likely cause a lowered drug reaction. A reduced intake of alcohol or fiber would not likely produce an increased reaction to a drug. (p. 20)

**Rationale 3:** Grapefruit juice lowers the acidity of enzymes in the GI system that break down medications. This in turn results in higher medication absorption into the bloodstream. A reduction in citrus fruit intake would likely cause a lowered drug reaction. A reduced intake of alcohol or fiber would not likely produce an increased reaction to a drug. (p. 20)

**Rationale 4:** Grapefruit juice lowers the acidity of enzymes in the GI system that break down medications. This in turn results in higher medication absorption into the bloodstream. A reduction in citrus fruit intake would likely cause a lowered drug reaction. A reduced intake of alcohol or fiber would not likely produce an increased reaction to a drug. (p. 20)

**Global Rationale:**

**Cognitive Level:** Understanding

**Client Need:** Physiological Integrity

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Evaluation

**Learning Outcome:** 3-1 and 3-2

**Question 17**

**Type:** MCSA

The nurse administers an oral preparation of liquid Tylenol 650 mg as ordered. Afterward, the patient indicates he had been receiving Tylenol 650 mg in pill form. Which of the following is accurate in regards to the five rights?

1. The nurse failed to deliver the correct dose.
2. The nurse failed to administer the right medication.
3. The nurse did not violate the five rights.
4. The nurse failed to give the medication via the correct route.

**Correct Answer: 3**

**Rationale 1:** Nothing in the question depicts a violation of the five rights.

**Rationale 2:** Nothing in the question depicts a violation of the five rights.

**Rationale 3:** Nothing in the question depicts a violation of the five rights.

**Rationale 4:** Nothing in the question depicts a violation of the five rights.

**Global Rationale:**

**Cognitive Level:** Understanding

**Client Need:** Safe Effective Care Environment

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 3-3

**Question 18**

**Type:** MCSA

Five milliliters is equivalent to

1. 2 tablespoons.
2. 1 fluid ounce.
3. 15 drops.
4. 1 teaspoon.

**Correct Answer: 4**

**Rationale 1:** Conversion from the metric system (p. 21)

**Rationale 2:** Conversion from the metric system (p. 21)

**Rationale 3:** Conversion from the metric system (p. 21)

**Rationale 4:** Conversion from the metric system (p. 21)

**Global Rationale:**

**Cognitive Level:** Remembering

**Client Need:** Health Promotion and Maintenance

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation

**Learning Outcome:** 3-6

**Question 19**

**Type:** MCSA

Placement of a tablet between the cheek and gum would be which route?

1. Buccal
2. Oral
3. Transdermal
4. Sublingual

**Correct Answer:** 1

**Rationale 1:** This is the term used to describe a medication placed between the cheek and gum.

**Rationale 2:** An oral medication is swallowed.

**Rationale 3:** A transdermal medication is applied to the skin.

**Rationale 4:** A sublingual medication is placed under the tongue.

**Global Rationale:**

**Cognitive Level:** Remembering

**Client Need:** Health Promotion and Maintenance

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Implementation



**Learning Outcome:** 3-7

**Question 20**

**Type:** MCSA

A patient who recently returned from surgery is experiencing nausea. Which statement best explains why this patient would benefit from IV medication administration?

1. The IV is already in place following the surgery.
2. IV medication administration should be avoided in patients with nausea.
3. Medications are more effective when given IV.
4. IV medications bypass the need for GI absorption.

**Correct Answer:** 4

**Rationale 1:** Nauseated patients might find medications that need to be absorbed through the GI system irritating, worsening their nausea. The presence of an existing IV line is not a reason to administer medications through it. Some medications are more effective when given IV, but bypassing the need for GI absorption is the better answer.

**Rationale 2:** Nauseated patients might find medications that need to be absorbed through the GI system irritating, worsening their nausea. The presence of an existing IV line is not a reason to administer medications through it. Some medications are more effective when given IV, but bypassing the need for GI absorption is the better answer.

**Rationale 3:** Nauseated patients might find medications that need to be absorbed through the GI system irritating, worsening their nausea. The presence of an existing IV line is not a reason to administer medications through it. Some medications are more effective when given IV, but bypassing the need for GI absorption is the better answer.

**Rationale 4:** Nauseated patients might find medications that need to be absorbed through the GI system irritating, worsening their nausea. The presence of an existing IV line is not a reason to administer medications through it. Some medications are more effective when given IV, but bypassing the need for GI absorption is the better answer.

**Global Rationale:**

**Cognitive Level:** Understanding

**Client Need:** Physiological Integrity

**Client Need Sub:**

**Nursing/Integrated Concepts:** Nursing Process: Evaluation

**Learning Outcome:** 3-8

**Question 21**

**Type:** MCSA

Which of the following is accurate regarding medication administration via the intradermal route?

1. Injections should be limited to 1–2 milliliters.
2. Hairy sites should be avoided.
3. Usual administration sites include the upper and lower abdomen.
4. Medications should be injected into the epidermis skin layer.