PLAINWORK

NCLEX-RN Med-Surg Health Alterations Practice App: Questions with Rationales

Free sample: 10 of 304 questions

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Sample

1. The amount of suction pressure utilized for oropharyngeal suctioning is aligned to the patient's:

A. A. Age
B. B. Height
C. C. Weight
D. D. Gender

A. Age — Suction pressure limits are determined by the patient's age to prevent mucosal damage and hypoxemia. Standard pressures range from 60-80 mmHg for neonates up to 100-150 mmHg for adults, making age the deciding factor.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, https://wtcs.pressbooks.pub/nursingskills/chapter/22-8-learning-activities/); rationale written by Plainwork.

2. The Glascow Coma scale measures patients according to what three categories of response:

A. A. Motor, Sensory, and Verbal
B. B. Motor, Cognition, and Verbal
C. C. Motor, Eye Opening, and Verbal
D. D. Eye Opening, Verbal, and Auditory

C. Motor, Eye Opening, and Verbal — The Glasgow Coma Scale (GCS) is a standardized tool used to assess a patient's level of consciousness by evaluating three specific categories of response: eye opening, verbal response, and motor response.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, https://wtcs.pressbooks.pub/nursingskills/chapter/6-13-learning-activities/); rationale written by Plainwork.

3. A nurse is performing an abdominal assessment and places his/her hand on the patient's abdomen over an area with moderate pressure. The nurse then abruptly withdraws his/her hand. This assessment technique is indicated when assessing for:

A. A. abdominal rigidity
B. B. borborygmus
C. C. guarding
D. D. rebound tenderness

D. rebound tenderness — Rebound tenderness is elicited by applying gentle pressure then quickly releasing; pain on release indicates peritoneal irritation, such as appendicitis. The described abrupt hand withdrawal after moderate pressure is classic for this sign.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, https://wtcs.pressbooks.pub/nursingskills/chapter/12-7-learning-activities/); rationale written by Plainwork.

4. "Are you having any issues with seeing, hearing, smelling, tasting, or feeling things?" would fall into what category of functional health assessment?

A. A. Health Perception - Health Management
B. B. Self-Perception and Self-Concept
C. C. Cognitive and Perceptual
D. D. Roles and Relationships

C. Cognitive and Perceptual — Gordon's Functional Health Patterns classify sensory functions—such as vision, hearing, taste, touch, and smell—along with cognitive abilities and pain perception, under the Cognitive and Perceptual pattern. This question directly assesses these sensory capabilities.

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5. Which of the following is the best patient positioning option for blood pressure measurement accuracy?

A. A. Patient lying supine with arms elevated to the level of the heart
B. B. Patient lying supine with arms extended
C. C. Patient sitting upright both feet on the floor with arm elevated to the level of the heart
D. D. Patient sitting upright with ankles crossed, arms resting on lap

C. Patient sitting upright both feet on the floor with arm elevated to the level of the heart — Accurate BP measurement requires the patient seated, back supported, feet flat, arm supported at heart level; this position eliminates hydrostatic error and stabilizes vascular tone.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, https://wtcs.pressbooks.pub/nursingskills/chapter/1-8-learning-activities/); rationale written by Plainwork.

6. Visual inspection of the patient's abdomen should occur with the patient placed in which of the following positions for optimal assessment:

A. A. Prone
B. B. Supine
C. C. Semi-fowlers
D. D. Fowlers

B. Supine — The supine position places the abdomen flat on the table, allowing unobstructed visual inspection of all quadrants and preventing gravity from distorting organ contours, which is essential for an accurate assessment.

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7. Cold viruses, influenza, and strep throat are common causes of:

A. A. Epistaxis
B. B. Pharyngitis
C. C. Sinusitis
D. D. Candidiasis

B. Pharyngitis — Pharyngitis, commonly known as a sore throat, is an inflammation of the pharynx. It is most frequently caused by viral infections like colds and influenza, or bacterial infections such as Streptococcus pyogenes.

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8. The _____nerve is a vital spinal nerve because of its control of the diaphragm to assist in breathing.

A. A. Lumbar
B. B. Sacral
C. C. Motor
D. D. Phrenic

D. Phrenic — The phrenic nerve arises from the cervical spinal levels C3 through C5 and provides the essential motor innervation to the diaphragm, which is the primary muscle used for respiration.

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9. According to the Glascow Coma Scale (GCS) patients scoring less than 8 would be classified as:

A. A. Alert and Oriented X 2
B. B. Lethargic
C. C. Obtunded
D. D. Comatose

D. Comatose — The Glasgow Coma Scale (GCS) measures level of consciousness based on eye, verbal, and motor responses. A GCS score of 8 or less indicates severe brain injury, which clinically classifies the patient as comatose and typically requires intubation.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, https://wtcs.pressbooks.pub/nursingskills/chapter/6-13-learning-activities/); rationale written by Plainwork.

10. "Do you take any naps during the day?" would fall into what category of functional health assessment?

A. A. Sleep and Rest
B. B. Mobility, Activity, and Exercise
C. C. Coping-Stress
D. D. Nutrition

> **A.** Sleep and Rest — Asking about daytime napping directly assesses a patient's daily sleep-wake cycle, rest patterns, and sleep quality. This information is categorized under Gordon's functional health pattern of sleep and rest.
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> Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, https://wtcs.pressbooks.pub/nursingskills/chapter/2-12-learning-activities/); rationale written by Plainwork.

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