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A nurse is reinforcing teaching about sleep promotion with a client who reports difficulty sleeping. Which of the following client statements indicates an understanding of the teaching?

- "I should drink a cup of hot chocolate before I go to bed."
- "I should stop vigorous exercise 1 hour before bedtime."
- "I should play music that relaxes me before I go to bed."
- "I will nap for 1 hour each afternoon."

Answer: "I should play music that relaxes me before I go to bed."

Rationale: The client should establish a relaxing routine such as taking a warm bath, reading, or listening to soothing sounds, such as soft music. The client should avoid playing music while sleeping because this can be a distraction and interrupt sleep.

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A charge nurse is reviewing written documentation in case of an EHR system failure with a group of newly licensed nurses. Which of the following information should the nurse include?

- Leave space to document late entries.
- Have the provider cosign each entry.
- Entries should be signed with name and title.
- Written errors should be completely scratched through.

Answer: Entries should be signed with name and title.

Rationale: Each written entry in the medicalrecord should be signed and dated with full name and title.

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A nurse is reinforcing teaching with a male client about clean intermittent self-catheterization. Which of the following instructions should the nurse include?

- Use water-soluble jelly to lubricate the tip of the catheter up to 2.5 cm (1 in.).
- Hold the penis downward at a 30° angle when inserting the catheter.
- Remove the catheter quickly after urine stops flowing.
- Wash the catheter with soap and water after use.

Answer: Wash the catheter with soap and water after use.

Rationale: Medical aseptic technique is used for clean intermittent self-catheterization. Therefore, the client should wash the catheter with soap and water and store it in a clean place. The client should replace the catheter before it becomes dry and brittle.

A nurse is explaining the purpose of informed consent to a client. Which of the following statements should the nurse make?

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- "Informed consent documents your concerns about the procedure."
- "Informed consent indicates your understanding of the procedure."
- "Informed consent protects the facility and provider from liability."
- "Informed consent ensures you don't change your mind about the procedure."

Answer: "Informed consent indicates your understanding of the procedure."

Rationale: An informed consent is permission given by the client to be treated or have a procedure after they have been completely informed of the procedure, risks, benefits, and any alternative treatments that my have been available. It is providing the client the right to choose or refuse treatment.

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A nurse is assisting with the plan of care for a client who has had diarrhea for 3 days. Which of the following foods should the nurse include in the plan?

- White rice
- Black coffee
- Fresh fruits
- Raw vegetables

Answer: White rice.

Rationale: White rice is low in fiber, contains electrolytes, and promotes rehydration. This is a good food selection for a client who has diarrhea.

A nurse is preparing to collect blood samples from an older adult client. Which of the following actions should the nurse take when performing venipuncture?

- Use a 12-gauge needle to obtain the sample.
- Use a needle insertion angle of 35°.
- Apply the tourniquet over the client's sleeve.
- Apply traction above the projected insertion site.

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Answer: Apply the tourniquet over the client's sleeve.

Rationale: The nurse should apply the tourniquet over the client's sleeve to reduce the risk for trauma to the fragile skin of older adult clients.

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A nurse is caring for a client who is upset about receiving a terminal diagnosis. The client states, "I want some time alone to pray." Which of the following is an appropriate response by the nurse?

- "Why do you feel prayer will bring you comfort?"
- "Let's think of some other ways you can deal with your feelings."
- "I will sit quietly and hold your hand while you pray."
- "How much time alone do you think you will need?"

Answer: "How much time alone do you think you will need?"

Rationale: It is important for the nurse to respect and accommodate the client's choice to pray. This statement by the nurse is open-ended and provides a lead for the client to offer more information. It also helps the nurse minimize interruptions for the client during prayer.

A nurse is caring for a client who is post-operative following an above-the-knee amputation. The client tells the nurse they do not want to go to physical therapy and are "ready to give up." Which of the following responses should the nurse make?

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- "The physical therapist said you made progress yesterday."
- "You sound like you are feeling pretty discouraged."
- "I am sure you will fell better once you get your prosthesis."
- "Why don't you give physical therapy one more try?"

Answer: "You sound like you are feeling pretty discouraged."

Rationale: This response by the nurse validates the client's feelings, which encourages the client to express feelings of grief and loss.

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