Fundamentals of Nursing

CREDIT HOURS: 8

LEVEL: LOWER

EXAM CODE: 403
CATALOG NUMBER: NURx210

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Before You Choose This UExcel Exam

Uses for the Examination

• Excelsior College, the test developer, recommends granting eight (8) semester hours of lower-level undergraduate credit to students who receive a letter grade of C or higher on this examination. This recommendation is endorsed by the American Council on Education. Please note that the exam is not applicable toward a nursing degree at Excelsior College.

• Other colleges and universities also recognize this exam as a basis for granting credit or advanced standing.

• Individual institutions set their own policies for the amount of credit awarded and the minimum acceptable grade.

Exam-takers who have applied to Excelsior College should ask their academic advisor where this exam fits within their degree program.

Exam-takers not enrolled in an Excelsior College degree program should check with the institution from which they wish to receive credit to determine whether credit will be granted and/or to find out the minimum grade required for credit. Those who intend to enroll at Excelsior College should ask an admissions counselor where this exam fits within their intended degree program.

Examination Length and Scoring

The examination consists of approximately 160 questions, most of which are multiple choice; for samples of all the item types on this exam, see the sample items in the back of this guide. Some items are unscored, pretest items. The pretest items are embedded throughout the exam and are indistinguishable from the scored items. You will have three (3) hours to complete the examination. Your score will be reported as a letter grade.

UExcel Exam Resources

Excelsior College Bookstore

The Excelsior College Bookstore offers recommended textbooks and other resources to help you prepare for UExcel exams.

The bookstore is available online at: www.excelsior.edu/bookstore

UExcel Practice Exams

The official UExcel practice exams are highly recommended as part of your study plan. Once you register for your UExcel exam, you are eligible to purchase the corresponding practice exam, which can be taken using any computer with a supported Web browser. Each practice exam includes two forms that you may take within a 180-day period.
Excelsior College Library

Enrolled Excelsior College students can access millions of authoritative resources online through the Excelsior College Library. Created through our partnership with the Sheridan Libraries of The Johns Hopkins University, the library provides access to journal articles, books, websites, databases, reference services, and many other resources. Special library pages relate to the nursing degree exams and other selected exams. To access it, visit www.excelsior.edu/library (login is required).

Our library provides:

- 24/7 availability
- The world’s most current authoritative resources
- Help and support from staff librarians

Online Tutoring

Excelsior College offers online tutoring through SMARTTHINKING™ to connect with tutors who have been trained in a variety of academic subjects. To access SMARTTHINKING, go to www.excelsior.edu/smartthinking. Once there, you may download a copy of the SMARTTHINKING Student Handbook as a PDF.

MyExcelsior Community

MyExcelsior Community enables Excelsior College students and alumni to interact with their peers online. As members, students can participate in real-time chat groups, join online study groups, buy and sell used textbooks, and share Internet resources. Enrolled students have automatic access from their MyExcelsior page. Visit www.excelsior.edu/myexcelsiorcommunity.

Preparing for UExcel Exams

How Long Will It Take Me to Study?

A UExcel exam enables you to show that you've learned material comparable to one or more 15-week college-level courses. As an independent learner, you should study and review as much as you would for a college course. For a 3-credit course in a subject they don't know, most students would be expected to study nine hours per week for 15 weeks, for a total of 135 hours.

Study Tips

Become an active user of the resource materials. Aim for understanding rather than memorization. The more active you are when you study, the more likely you will be to retain, understand, and apply the information.

The following techniques are generally considered to be active learning:

- **preview or survey** each chapter
- **highlight or underline text** you believe is important
- **write questions or comments** in the margins
- **practice re-stating content** in your own words
- **relate what you are reading** to the chapter title, section headings, and other organizing elements of the textbook
- **find ways to engage** your eyes, your ears, and your muscles, as well as your brain, in your studies
- **study with a partner or a small group** (if you are an enrolled student, search for partners on MyExcelsior Community)
- **prepare your review notes** as flashcards or create recordings that you can use while commuting or exercising

When you feel confident that you understand a content area, review what you have learned. Take a second look at the material to evaluate your understanding. If you have a study partner, the two of you can review by explaining the content to each other or writing test questions for each other to answer. Review questions from textbook chapters may be helpful for partner or individual study, as well.

UExcel Practice Exams

We recommend taking the first form of the practice exam when you begin studying, to see how much you already know. After taking the first practice exam, check your performance on each question and find out why your answer was right or wrong. This feedback will help you improve your knowledge of the subject and identify areas of weakness that you should address before taking the exam. Take the second form of the practice exam after you have finished studying. Analyze your results to identify the areas that you still need to review.
Although there is no guarantee, our research suggests that students who do well on the practice exams are more likely to pass the actual exam than those who do not do well (or do not take advantage of this opportunity).

About Test Preparation Services

Preparation for UExcel® exams and Excelsior College® Examinations, though based on independent study, is supported by Excelsior College with a comprehensive set of exam learning resources and services designed to help you succeed. These learning resources are prepared by Excelsior College so you can be assured that they are current and cover the content you are expected to master for the exams. These resources, and your desire to learn, are usually all that you will need to succeed.

There are test-preparation companies that will offer to help you study for our examinations. Some may imply a relationship with Excelsior College and/or make claims that their products and services are all that you need to prepare for our examinations.

Excelsior College is not affiliated with any test preparation firm and does not endorse the products or services of these companies. No test preparation vendor is authorized to provide admissions counseling or academic advising services, or to collect any payments, on behalf of Excelsior College. Excelsior College does not send authorized representatives to a student’s home nor does it review the materials provided by test preparation companies for content or compatibility with Excelsior College examinations.

To help you become a well-informed consumer, we suggest that before you make any purchase decision regarding study materials provided by organizations other than Excelsior College, you consider the points outlined on our website at www.excelsior.edu/testprep.

Preparing for This Exam

Prior Knowledge

A basic knowledge of anatomy and physiology, chemistry, and mathematics is assumed.

Using the Content Outline

Each content area in the outline includes (1) the minimum hours of study you should devote to that content area and (2) the most important sections of the recommended resources for that area. These annotations are not intended to be comprehensive. You may need to refer to other chapters in the recommended textbooks. Chapter numbers and titles may differ in later editions.

This content outline contains examples of the types of information you should study. Although these examples are numerous, do not assume that everything on the exam will come from these examples. Conversely, do not expect that every detail you study will appear on the exam. Any exam is only a broad sample of all the questions that could be asked about the subject matter.

Using the Sample Questions and Rationales

Each content guide provides sample questions to illustrate those typically found on the exam. These questions are intended to give you an idea of the level of knowledge expected and the way questions are typically phrased. The sample questions do not sample the entire content of the exam and are not intended to serve as an entire practice test.

Recommended Resources for the UExcel Exam in Fundamentals of Nursing

The study materials listed below are recommended by Excelsior College as the most appropriate resources to help you study for the examination. For information on ordering from the Excelsior College Bookstore, see page 1 of this guide. You may also find resource
materials in college libraries. Public libraries may have some of the textbooks or may be able to obtain them through an interlibrary loan program.

You should allow sufficient time to obtain resources and to study before taking the exam.

Textbooks
This textbook was used by the examination development committee to verify all questions on the exam.


This textbook addresses a wide variety of contemporary fundamental nursing principles under major section headings such as The Nature of Nursing, Contemporary Health Care, Health Beliefs and Practices, and Integral Components of Client Care. Special features of the textbook include a focus on critical thinking, chapter highlights, and tables of practice guidelines. Pictures and graphs are used throughout to highlight information.


Supplemental Resources
These textbooks were identified by the examination development committee as additional resources to help you gain a deeper understanding of the subject.


These study materials may be purchased from the Excelsior College Bookstore. www.excelsior.edu/bookstore

Reducing Textbook Costs
Many students know it is less expensive to buy a used textbook, and buying a previous edition is also an option. The Excelsior College bookstore includes a buyback feature and a used book marketplace, as well as the ability to rent digital versions of textbooks for as long as students need them. Students are encouraged to explore these and the many other opportunities available online to help defray textbook costs.
Section Two

Content Outline

General Description of the Examination

The UExcel Fundamentals of Nursing examination is based on material typically taught in a two-semester sequence in fundamentals of nursing in an associate degree nursing program. The examination focuses on the health problems of adult patients that are commonly encountered by associate degree nurses in health care settings.

The examination measures knowledge and understanding of the concepts of nursing as a profession, communication, patient safety, patient comfort, nutrition, elimination, oxygenation, and fluid and electrolyte balance, as well as the ability to apply this knowledge through use of the nursing process.

Those beginning to study for this exam should have basic knowledge of anatomy, physiology, chemistry, and mathematics.

Learning Outcomes

After you have successfully worked your way through the recommended study materials, you should be able to demonstrate the following learning outcomes:

1. Discuss key legal and ethical issues for the profession of nursing.
2. Identify the roles and functions of the nurse and the nurse’s responsibilities related to recording and reporting.
3. Explain the health continuum, the health care delivery system, Maslow’s hierarchy, and concepts related to the stress response.
4. Describe the nursing process (assessment, analysis, planning, implementation, and evaluation) and define nursing diagnoses and patient goals.
5. Discuss theoretical framework and nursing process related to communication and interpersonal relations, asepsis and the body’s defenses, medication administration, physical and environmental safety, hygiene, rest and sleep, mobility and immobility, pain, nutrition, elimination, oxygenation, and fluid and electrolyte balance.
Content Outline

The content outline describes the various areas of the test, similar to the way a syllabus outlines a course. To fully prepare requires self-direction and discipline. Study involves careful reading, reflection, and systematic review.

The major content areas on the Fundamentals of Nursing examination, the percent of the examination, and the hours to devote to each content area are listed below.

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Percent of the Examination</th>
<th>Hours of Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The Profession of Nursing</td>
<td>8%</td>
<td>29</td>
</tr>
<tr>
<td>II. Communication and Interpersonal Relations</td>
<td>10%</td>
<td>36</td>
</tr>
<tr>
<td>III. Protection and Promotion of Safety</td>
<td>25%</td>
<td>90</td>
</tr>
<tr>
<td>IV. Comfort, Rest, and Activity</td>
<td>15%</td>
<td>54</td>
</tr>
<tr>
<td>V. Nutrition</td>
<td>10%</td>
<td>36</td>
</tr>
<tr>
<td>VI. Elimination</td>
<td>11%</td>
<td>40</td>
</tr>
<tr>
<td>VII. Oxygenation</td>
<td>10%</td>
<td>36</td>
</tr>
<tr>
<td>VIII. Fluid and Electrolyte Balance</td>
<td>11%</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Occasionally, examples will be listed for a content topic to help clarify that topic. However, the content of the examination is not limited to the specific examples given.

I. The Profession of Nursing

8 PERCENT OF EXAM | 29 HOURS OF STUDY

_Berman (2012)_

- Ch. 3, Nursing Theories and Conceptual Frameworks
- Ch. 4, Legal Aspects of Nursing
- Ch. 5, Values, Ethics, and Advocacy
- Ch. 6, Health Care Delivery Systems
- Ch. 10, Critical Thinking and Nursing Practice

Ch. 15, Documenting and Reporting
Ch. 16, Health Promotion
Ch. 17, Health, Wellness, and Illness
Ch. 42, Stress and Coping

A. Legal issues in nursing

1. General legal concepts: statutory, common, civil, and criminal laws
2. Nurse practice acts
   a. Definition and purposes of nurse practice acts
   b. Impact on the practice of nursing
   c. ANA Standards of Care
   d. Licensure: legal requirements, grounds for revocation, grounds for suspension, credentialing
3. Legal liability in nursing
a. Types of crimes: felonies, misdemeanors
b. Areas of liability: torts, negligence, invasion of privacy, defamation
   of character, assault and battery, false imprisonment, abandonment
c. Good Samaritan Laws
d. Informed consent
e. A Patient's Bill of Rights
f. Advance directives

B. Roles and functions of the nurse
   1. Caregiver
   2. Decision maker
   3. Communicator
   4. Manager of care
   5. Advocate
   6. Teacher

C. Ethics and values in nursing
   1. ANA Code of Ethics
   2. Resolution of ethical problems
   3. Nature and function of values

D. Basic nursing concepts
   1. The health continuum
      a. Wellness-illness continuum
      b. Factors influencing health
         1) Individual factors (for example: genetics, age)
         2) Environmental factors (for example: occupational hazards, stress)
         3) Socioeconomic and cultural factors (for example: lifestyle, single-parent households, fast foods, health practices)
      c. Effects of hospitalizations and/or illness (for example: loss of income, change in self-image, disruption of family)
   2. The health care delivery system
   3. Maslow's hierarchy of needs
      a. Structure of hierarchy

E. Nursing process methodology
   1. Purposes
   2. Steps
      a. Assessment: establishing a database concerning patient needs, including gathering subjective and objective data and assessing individual factors related to health
      b. Diagnosis: identification of the patient's actual or potential nursing diagnoses after analyzing and interpreting data
      c. Planning: setting priorities, identifying patient-centered outcomes and selecting nursing interventions to achieve those outcomes using clinical pathways
      d. Implementation: using nursing interventions to help the patient achieve goals
      e. Evaluation: determining the extent to which outcomes have been achieved
   3. Elements of a nursing diagnosis statement according to North American Nursing Diagnosis Association Taxonomy, 1997
4. Characteristics of a goal: measurable, patient-oriented, attainable with a specified time period

F. Recording and reporting

1. Concepts and principles
   a. Purposes of recording: charting, documentation (for example: providing a record of care given, charting patient’s response to care, evaluation and revision of the nursing care plan)
   b. Purposes of reporting: intermittent, change-of-shift (for example: promoting continuity of patient care, evaluation of effectiveness of nursing interventions)
   c. Principles of written communication (for example: accuracy, legibility, legality, abbreviations)
   d. Principles of oral communication (for example: objectivity, clarity, timeliness)

2. Inclusion of appropriate information when recording and reporting (for example: when using narrative method, when using SOAP method; on a medication administration record, on a nursing care plan, in a team conference, at change-of-shift)

II. Communication and Interpersonal Relations

10 PERCENT OF EXAM | 36 HOURS OF STUDY

Berman

Ch. 11, Assessing
Ch. 12, Diagnosing
Ch. 13, Planning
Ch. 14, Implementing and Evaluating
Ch. 25, Caring
Ch. 26, Communicating
Ch. 27, Teaching
Ch. 30, Health Assessment

A. Theoretical framework

1. Therapeutic communication
   a. Definition and goals
   b. Types of communication: verbal, nonverbal
   c. Principles of therapeutic communication
      1) Techniques that facilitate communication
      2) Techniques that block communication

2. The nurse-patient relationship
   a. Definition and outcomes of the nurse-patient relationship
   b. Components of the nurse-patient relationship
   c. Phases of the nurse-patient relationship

3. Factors influencing the communication process (for example: cultural, sensory losses, language barriers, perception of the relationship, personal experiences and needs, attitudes)

4. Patient instruction: principles of teaching/learning

B. Nursing care

1. Assessment: establish a database concerning communication
a. Gather objective and subjective data (for example: primary language, use of sign language, unable to read, hearing ability)
b. Assess factors influencing communication and the nurse-patient relationship (see II A3)

2. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to communication
   a. Analyze and interpret data (for example: patterns of communication, readiness for learning)
   b. Identify nursing diagnoses (for example: impaired verbal communication related to oral surgery; knowledge deficit: low-calorie diet related to recently ordered therapy)

3. Planning: set priorities, identify patient-centered outcomes and select interventions related to communication
   a. Set priorities and establish outcomes (for example: patient will communicate needs using an alternate means of communication [whiteboard]; patient will make appropriate meal selections)
   b. Incorporate factors influencing communication in planning patient care (see IIA3)
   c. Select nursing interventions to facilitate communication (for example: provide the patient with a “magic slate”; select materials appropriate to the patient’s educational level)

4. Implementation: use nursing interventions to achieve outcomes related to communication and the nurse-patient relationship
   a. Use facilitative communication techniques (see IIA1c)
   b. Establish a therapeutic nurse-patient relationship (see IIA2)

5. Evaluation: determine the extent to which outcomes have been achieved
   a. Evaluate, record, and report the patient’s response to nursing actions (for example: due to sedation, patient is not able to use the magic slate; patient selects foods appropriate to a low-calorie diet)
   b. Modify the plan of care if necessary

III. Protection and Promotion of Safety

<table>
<thead>
<tr>
<th>25 PERCENT OF EXAM</th>
<th>90 HOURS OF STUDY</th>
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Berman

Ch. 31, Asepsis
Ch. 32, Safety
Ch. 35, Medications
Ch. 36, Skin Integrity and Wound Care
Ch. 38, Sensory Perception

A. Asepsis

1. Theoretical framework
   a. Chain of infection
   b. Principles of medical and surgical asepsis
   c. Methods of transmission (for example: direct contact, vehicles, airborne)
   d. Standard (universal) precautions
   e. Factors influencing an individual’s susceptibility to infection (for example: stress, nutritional status, physical status, medications, heredity, lifestyle, socioeconomic status, occupation)

2. Nursing care
   a. Assessment: establish a database concerning asepsis
      1) Gather objective and subjective data (for example: WBC count [normal values], history of exposure to pathogens, fever, thirst)
2) Assess factors influencing susceptibility to infection (see IIIA1e)

b. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to asepsis
1) Analyze and interpret data (for example: identify pathogen and possible method of transmission)
2) Identify nursing diagnoses (for example: high risk for infection related to poor nutritional status and exposure to pathogens)

c. Planning: set priorities, identify patient-centered outcomes and select appropriate interventions related to asepsis
1) Set priorities and establish outcomes (for example: patient will wash hands after using the toilet)
2) Incorporate factors influencing the individual’s susceptibility to infection (see IIIA1e)
3) Select nursing interventions to help the patient achieve the outcomes (for example: utilize appropriate aseptic measures, determine appropriate barriers)

d. Implementation: use nursing interventions to achieve the outcomes related to asepsis
1) Use nursing measures to contain organisms (for example: use medical asepsis)
2) Use nursing measures to exclude organisms (for example: use surgical asepsis when providing wound care)
3) Instruct the patient regarding prevention of infection (for example: handwashing)

e. Evaluation: determine the extent to which outcomes have been achieved
1) Evaluate, record, and report the patient’s response to nursing actions (for example: wound is approximated and free of drainage)
2) Continually reassess the physical environment (for example: dressings are disposed of in a closed container)
3) Modify the plan of care if necessary

B. The body’s defenses (includes the body systems, the immune system, and the inflammatory response)

1. Theoretical framework
   a. Physiological responses (for example: antigen-antibody response, leukocytosis, signs of inflammation, secretion of mucus, movement of cilia, removal of waste products, wound healing, fever)
   b. Factors influencing the body’s defenses
      1) Individual factors (for example: age, nutritional status, skin integrity, hygienic practices, physical activity, health status, cigarette smoking)
      2) Environmental factors (for example: climate, occupational hazards, exposure to communicable diseases, cigarette smoke, radiation)
   c. Techniques commonly used to promote the body’s defenses (for example: application of heat and cold, tetanus booster, flu vaccine)

2. Nursing care
   a. Assessment: establish a database concerning defenses
1) Gather objective and subjective data (for example: condition of the patient’s skin and mucous membrane, vital signs, redness, pain, swelling, WBC count, history of immunizations)

2) Assess factors influencing the body’s defenses (see IIIB1b)

b. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to defenses

1) Analyze and interpret data (for example: culture reports, identify impairment of the skin, WBC count [normal values], characteristics of drainage)

2) Identify nursing diagnoses (for example: high risk for infection related to altered skin integrity)

c. Planning: set priorities, identify patient-centered outcomes and select interventions related to defenses

1) Set priorities and establish outcomes (for example: patient will remain afebrile)

2) Incorporate factors influencing the body’s defenses (see IIIB1b)

3) Select nursing interventions to help the patient achieve the outcomes (for example: monitor vital signs q4h)

d. Implementation: use nursing interventions to achieve outcomes related to the body’s defenses

1) Use nursing measures to promote the body’s defenses (for example: provide adequate nutrition, apply heat and cold treatments, provide wound care, collect specimens for culture)

2) Instruct the patient to support and/or restore the body’s defenses (for example: emphasize the need to avoid exposure to infectious agents)

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient’s response to nursing actions (for example: patient’s temperature remains within normal limits)

2) Modify the plan of care if necessary

C. Medication administration

1. Theoretical framework

a. Pharmacokinetics: absorption, distribution, metabolism, excretion

b. Principles of administration: calculations (including equivalents), routes and sites, safety measures, controlled substances, use of nasogastric and gastrostomy tubes, transcribing medication orders

c. Factors influencing medication action and effectiveness (for example: age, sex, weight, psychological factors, time of administration, environment)

2. Nursing care

a. Assessment: establish a database concerning the patient’s medication regimen

1) Gather objective and subjective data (for example: history of allergies, vital signs, duration of pain)

2) Assess factors influencing medication action and effectiveness (see IIIC1c)

b. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to medications

1) Analyze and interpret data (for example: changes in vital signs, recognize side effects)
2) Identify nursing diagnoses
(for example: noncompliance related to fear of side effects)

c. Planning: set priorities, identify patient-centered outcomes and select interventions related to the patient’s medication regimen

1) Set priorities and establish outcomes (for example: patient will adhere to regimen as agreed)

2) Incorporate factors influencing medication action and effectiveness (see IIIIC1c)

3) Select nursing interventions to help the patient achieve outcomes (for example: instruct the patient to take the medication with food)

d. Implementation: use nursing interventions to achieve outcomes related to the medication regimen

1) Use nursing measures to safely administer medications (for example: calculation and measurement, patient identification, transcription, accurate recording, selection of correct site, administration of controlled substances)

2) Provide information and instruction regarding the medication regimen (for example: self-administration, storage, reporting side effects)

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient’s response to nursing actions (for example: patient adheres to the medication regimen)

2) Modify the plan of care if necessary

D. Safety

1. Theoretical framework

a. Factors influencing an individual’s safety

1) Individual factors (for example: age, medications, level of awareness, sensory perception, emotional state)

2) Environmental factors (for example: occupation, presence of lead paint)

3) Socioeconomic and cultural factors (for example: ability to communicate, unemployment)

4) Psychological factors (for example: stress, anxiety)

b. Identification of environmental hazards (for example: physical and mechanical, thermal, chemical, radiation, ecological)

c. Devices commonly used to promote safety (for example: restraints, walkers, siderails)

2. Nursing care

a. Assessment: establish a database concerning the patient’s safety needs

1) Gather objective and subjective data (for example: confusion, visual acuity)

2) Determine presence of environmental hazards (see IIID1b)

3) Assess factors influencing the patient’s safety (for example: age, hearing impairment) (see IIIID1a)

b. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to safety

1) Analyze and interpret data (for example: recognize loss of equilibrium, calculate fall risk)

2) Identify nursing diagnoses (for example: high risk for injury related to sensory deficit)
Planning: set priorities, identify patient-centered outcomes and select interventions related to safety

1) Set priorities and establish outcomes (for example: patient will request assistance with ambulation)

2) Incorporate factors influencing safety in planning for individualized patient care (for example: consider age, lifestyle, level of consciousness, mobility)

3) Select nursing interventions for alleviating or minimizing safety hazards (for example: modify the environment)

4) Select the appropriate safety device based on the individual's needs (for example: walkers, restraints)

d. Implementation: use nursing interventions to achieve outcomes related to safety

1) Use nursing measures to provide a safe environment (for example: elevate siderails, use restraining jacket)

2) Use equipment and devices safely (for example: walkers, ice packs, heat applications)

3) Instruct the patient regarding safety (for example: orient to environment, explain use of wheelchair)

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient's response to nursing actions (for example: patient ambulates with the nurse's assistance)

2) Modify the plan of care if necessary

IV. Comfort, Rest, and Activity

15 PERCENT OF EXAM | 54 HOURS OF STUDY

Berman

Ch. 33, Hygiene
Ch. 44, Activity and Exercise
Ch. 45, Sleep
Ch. 46, Pain Management

A. Hygiene

1. Theoretical framework
   a. Components of hygiene
   b. Factors influencing hygiene (for example: cultural factors, age, physical status, body image, self-esteem)
   c. Agents commonly used on the skin and mucous membrane (for example: soaps, lotions, emollients, mouthwashes)

2. Nursing care
   a. Assessment: establish a database concerning hygiene
      1) Gather objective and subjective data (for example: cleanliness of the skin, condition of the nails, complaints of dryness)
      2) Assess factors influencing the patient's hygiene (see IVA1b)
   b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to hygiene
      1) Analyze and interpret data
      2) Identify nursing diagnoses (for example: altered oral mucous membrane related to mouth breathing)
c. Planning: set priorities, identify patient-centered outcomes and select interventions related to hygiene

1) Set priorities and establish outcomes (for example: patient’s oral mucous membrane will be pink and moist)

2) Incorporate factors influencing hygiene in planning patient care (see IVA1b)

3) Select nursing interventions to achieve outcomes (for example: provide mouth care q2h)

d. Implementation: use nursing interventions to achieve outcomes related to hygiene

1) Use nursing measures to provide comprehensive hygienic care (for example: bathing, hair care, nail care, skin care, perineal care)

2) Use nursing measures to promote psychological comfort (for example: provide privacy during bathing)

3) Provide information and instruction (for example: instruct the patient on the use of dental floss, discuss indications for use of skin lotions rather than alcohol-base skin products)

e. Evaluation: determine the extent to which outcomes have been achieved

1) Evaluate, record, and report the patient’s response to nursing actions (for example: the patient’s lips remain dry and cracked)

2) Modify the plan of care if necessary

B. Rest and sleep

1. Theoretical framework

a. Principles related to rest and sleep (for example: sleep stages, circadian rhythm)

b. Factors influencing rest and sleep (for example: age, noise level, fatigue, use of caffeine, use of alcohol, hospitalization, sensory deprivation)

c. Agents commonly used to promote rest and sleep (sedatives, hypnotic)

2. Nursing care

a. Assessment: establish a database concerning rest and sleep

1) Gather objective and subjective data (for example: usual sleep habits, use of over-the-counter medications, bedtime routines)

2) Assess factors influencing the patient’s rest and sleep (see IVB1b)

b. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to rest and sleep

1) Analyze and interpret data (see IVB2a)

2) Identify nursing diagnoses (for example: sleep pattern disturbance related to unfamiliar surroundings)

c. Planning: set priorities, identify patient-centered outcomes and select interventions

1) Set priorities and establish outcomes (for example: patient will get six hours of uninterrupted sleep per night

2) Incorporate factors influencing rest and sleep (see IVB1b)
C. Mobility and immobility

1. Theoretical framework
   a. Principles of body mechanics, transfer, ambulation, range-of-motion, exercise
   b. Responses of body systems to mobility (for example: improved circulation, peristalsis)

2. Nursing care
   a. Assessment: establish a database concerning mobility and immobility
      1) Gather objective and subjective data (for example: range-of-motion, skin integrity, elimination patterns, activity level, joint mobility, muscle strength)
   b. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to mobility or immobility
      1) Analyze and interpret data
      2) Identify nursing diagnoses (for example: high risk for impaired physical mobility related to bed rest, activity intolerance)
   c. Planning: set priorities, identify patient-centered outcomes, and select appropriate interventions related to mobility or immobility
      1) Set priorities and establish outcomes (for example: patient will maintain usual range of motion in all joints)
      2) Consider the responses of the body to mobility and immobility (see IVC1b–c)
      3) Select nursing interventions to help the patient achieve outcomes (for example: supervise the patient in active range-of-motion exercises t.i.d.)
   d. Implementation: use nursing interventions to achieve outcomes related to mobility or immobility
1) Use appropriate devices to maintain normal body alignment (for example: footboard, pillows, trochanter roll)
2) Use nursing measures to promote mobility and maintain muscle tone (for example: range of motion, ambulation, positioning)
3) Use nursing measures to prevent tissue breakdown (for example: massage, pressure-relieving devices, turning)
4) Use nursing measures to prevent complications related to immobility (for example: leg exercises, antithrombosis stockings, deep breathing and coughing)
5) Instruct the patient regarding activity needs

D. The pain experience
   1. Theoretical framework
      a. Concepts related to pain (for example: gate control theory, acute vs. chronic pain, pain threshold, endorphins)
      b. Factors influencing pain (for example: etiology of pain, duration of pain, sensory overload, cultural factors)
      c. Agents and techniques commonly used to control pain (for example: guided imagery, relaxation, administration of nonnarcotic analgesics, narcotic analgesics, patient-controlled analgesia, placebos, cutaneous stimulation)

2. Nursing care
   a. Assessment: establish a database concerning pain
      1) Gather objective and subjective data (for example: changes in vital signs, facial expression, body language, verbalization by the patient)
      2) Assess factors influencing the patient’s pain (see IVD1b)
   b. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to pain
      1) Analyze and interpret data
      2) Identify nursing diagnoses (for example: pain related to recent abdominal surgery)
   c. Planning: set priorities, identify patient-centered outcomes and select interventions related to pain
      1) Set priorities and establish outcomes (for example: patient will report decrease in pain)
      2) Incorporate factors influencing pain (see IVD1b)
      3) Select nursing interventions to help the patient achieve outcomes (for example: position the patient to minimize stress on the incision; administer pain medication on a regular schedule)
   d. Implementation: use nursing interventions to achieve outcomes related to pain
1) Use nursing measures to reduce the patient’s pain (for example: positioning, cutaneous stimulation, assess the operative site, promote relaxation)

2) Use nursing measures specific to drug classifications for prescribed medications (for example: monitor vital signs for a patient receiving a narcotic analgesic, schedule administration of medications to maximize effectiveness)

3) Instruct the patient regarding pain (for example: use of relaxation techniques, use of guided imagery)

   e. Evaluation: determine the extent to which outcomes have been achieved

   1) Evaluate, record, and report the patient’s response to nursing interventions (for example: patient states that pain has been relieved)

   2) Modify the plan of care if necessary

V. Nutrition

10 PERCENT OF EXAM | 36 HOURS OF STUDY

Berman

Ch. 47, Nutrition

A. Theoretical framework

1. Processes of ingestion, digestion, and absorption of nutrients

2. Normal nutritional requirements

   a. Food Guide Pyramid

   b. Basic functions and common food sources of carbohydrates, proteins, fats, vitamins, minerals

   c. Caloric values

3. Common nutritional disturbances (for example: vomiting, heartburn, obesity, anorexia, malnutrition)

4. Factors influencing nutrition

   a. Individual factors (for example: age, sedentary lifestyle, vegetarian diet, dental status, physical condition, need for assistance with feeding)

   b. Socioeconomic and cultural factors (for example: income, religion)

   c. Psychological factors (for example: fad diets, anorexia)

5. Adaptations of normal diet: definitions, foods allowed, and indications for use

   a. Clear liquid

   b. Full liquid

   c. Soft

6. Alternative feeding methods (for example: gavage, gastrostomy)

7. Agents commonly used to promote nutrition (for example: vitamins and minerals)

B. Nursing care

1. Assessment: establish a database concerning nutritional status

   a. Gather objective and subjective data (for example: weight, height, anorexia)

   b. Assess factors influencing nutrition (see VA4)

2. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to nutrition

   a. Analyze and interpret data (for example: serum albumin, body weight)

   b. Identify nursing diagnoses (for example: imbalanced nutrition: less than body requirements related to anorexia)

3. Planning: set priorities, identify patient-centered outcomes and select interventions related to nutrition

   a. Set priorities and establish outcomes (for example: patient will gain one pound per week until ideal body weight is achieved)
b. Incorporate factors influencing nutrition in planning for patient's dietary needs (for example: plan nutritionally adequate diet based on patient's cultural preferences) (see VA4)
c. Select nursing interventions to help the patient achieve outcomes related to nutrition

4. Implementation: use nursing interventions to achieve outcomes related to nutrition
   a. Use nursing measures to increase nutritional intake (for example: assist in food selection, assist in feeding, modify the environment, place the patient in the most appropriate position)
   b. Use nursing measures appropriate to particular feeding methods (for example: nasogastric tube feedings, gastrostomy tube feedings)
   c. Use nursing measures specific to drug classifications for prescribed medications (for example: administer liquid iron through a straw)
   d. Instruct the patient regarding nutrition

5. Evaluation: determine the extent to which outcomes have been achieved
   a. Evaluate, record, and report the patient's response to nursing interventions (for example: the patient has gained two pounds this week)
   b. Modify the plan of care if necessary

VI. Elimination

Berman

Ch. 48, Urinary Elimination

Ch. 49, Fecal Elimination

A. Theoretical framework
   1. Urinary elimination
      a. Anatomy and physiology of urinary tract
      b. Common disturbances (for example: incontinence, frequency, retention, urgency)
   2. Intestinal elimination
      a. Anatomy and physiology of intestinal tract
      b. Common disturbances (for example: constipation, diarrhea, impaction, flatulence, incontinence)
   3. Factors influencing elimination
      a. Individual factors (for example: age, activity level, dietary habits)
      b. Environmental factors (for example: privacy)
      c. Psychological factors (for example: stress)
   4. Agents commonly used to promote elimination (for example: laxatives, stool softeners, antidiarrheal agents)

B. Nursing care
   1. Assessment: establish a database concerning elimination
      a. Gather objective and subjective data (for example: changes in normal elimination patterns; color, odor, and consistency of urine and feces)
      b. Assess factors influencing elimination (see VIA3)
   2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to elimination
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to elimination
   a. Set priorities and establish outcomes (for example: patient will have one soft brown stool daily)
   b. Incorporate factors influencing elimination in planning patient care (for example: the patient is on bed rest) (see VIIA3)
   c. Select nursing interventions to help the patient achieve outcomes (for example: consult with the dietician about increasing fiber in the patient’s diet)

4. Implementation: use nursing interventions to achieve outcomes related to elimination
   a. Use nursing measures to facilitate elimination (for example: perform catheterization, administer enema, administer laxatives and stool softeners, provide appropriate intake, collect specimens, ensure appropriate activity, decrease stress, provide proper positioning, ensure privacy)
   b. Use nursing measures specific to drug classifications for prescribed medications (for example: administer a laxative at the time that evacuation is desired, encourage the patient to retain the suppository for 15 minutes)
   c. Instruct the patient regarding elimination (for example: assist patient to plan an exercise program and to increase intake of fluids)

5. Evaluation: determine the extent to which outcomes have been achieved
   a. Evaluate, record, and report the patient’s response to nursing actions (for example: patient reports passing a hard, dry stool)
   b. Modify the plan of care if necessary

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VII. Oxygenation

**10 PERCENT OF EXAM | 36 HOURS OF STUDY**

Berman

**Ch. 50, Oxygenation**

A. Theoretical framework

1. Normal respiratory functions
   a. Anatomy and physiology
   b. Ventilation, diffusion, and transport

2. Common respiratory disturbances (for example: dyspnea, tachypnea, orthopnea, hypoxia)

3. Factors influencing oxygenation
   a. Individual factors (for example: fever, activity level, excess secretions)
   b. Environmental factors (for example: smoking, room ventilation)
   c. Psychological factors (for example: stress, anxiety)

4. Techniques commonly used to promote oxygenation (for example: administration of oxygen via nasal cannula and face mask, incentive spirometry, chest physiotherapy)

B. Nursing care

1. Assessment: establish a database concerning oxygenation status
   a. Gather objective and subjective data (for example: skin color, tolerance for activity, vital signs, respiratory status, shortness of breath, confusion, restlessness)

b. Assess factors influencing oxygenation (see VIIA3)
2. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to oxygenation
   a. Analyze and interpret data (for example: vital signs, hemoglobin, hematocrit [normal values], oxygen saturation)
   b. Identify nursing diagnoses (for example: ineffective breathing pattern related to abdominal pain)
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to oxygenation
   a. Set priorities and establish outcomes (for example: patient will demonstrate increased depth of respiration)
   b. Incorporate factors influencing oxygenation in planning patient care (for example: pain assessment, anxiety, positioning)
   c. Select nursing interventions to help the patient achieve outcomes (for example: provide comfort measures, reposition the patient, administer the prescribed analgesic)
4. Implementation: use nursing interventions to achieve outcomes related to oxygenation
   a. Use nursing measures to promote oxygenation (for example: turning, deep breathing, and coughing; administering oxygen; nasopharyngeal suctioning; monitoring vital signs; reducing anxiety)
   b. Use nursing measures appropriate to the method of oxygen administration (humidifiers, oxygen masks, cannula)
   c. Instruct the patient regarding oxygenation (for example: demonstrate coughing and deep-breathing exercises)
5. Evaluation: determine the extent to which outcomes have been achieved
   a. Evaluate, record, and report the patient’s response to nursing actions (for example: patient’s respirations are 12–14/minute, deep and rhythmical)
   b. Modify the plan of care if necessary

VIII. Fluid and Electrolyte Balance

<table>
<thead>
<tr>
<th>11 PERCENT OF EXAM</th>
<th>40 HOURS OF STUDY</th>
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Berman

Ch. 52, Fluid, Electrolyte, and Acid-Base Balance

A. Concepts and principles

1. Principles related to fluid and electrolyte balance (for example: composition, regulation, and movement of fluid and electrolytes)
   a. Hypercalcemia, hypocalcemia
   b. Hyperkalemia, hypokalemia
   c. Hypernatremia, hyponatremia
   d. Hypermagnesemia, hypomagnesemia
   e. Hypervolemia, hypovolemia
2. Common disturbances of fluid and electrolyte balance
   a. Hypercalcemia, hypocalcemia
   b. Hyperkalemia, hypokalemia
   c. Hypernatremia, hyponatremia
   d. Hypermagnesemia, hypomagnesemia
   e. Hypervolemia, hypovolemia
3. Common intravenous fluids
   a. Lactated Ringer's
   b. 5% dextrose and water
   c. Normal saline
   d. Half saline
4. Factors influencing fluid and electrolyte balance
   a. Physical status (for example: vomiting, fever, diarrhea, use of diuretics, exercise)
b. Environmental factors (for example: temperature, humidity)

5. Agents commonly used to promote fluid and electrolyte balance (for example: administration of IV fluids, electrolyte supplements)

B. Nursing care

1. Assessment: establish a database concerning fluid and electrolyte status.
   a. Gather objective and subjective data (for example: skin turgor, pulse quality, condition of oral mucous membranes, output, weight, edema, muscle weakness, thirst)
   b. Assess factors influencing fluid and electrolyte status (see VIII A4)

2. Diagnosis: identify the patient’s actual or potential nursing diagnoses related to fluids and electrolytes
   a. Analyze and interpret data (for example: serum electrolyte level, hematocrit [normal values] specific gravity of urine [normal values])
   b. Identify nursing diagnoses (for example: fluid volume deficit related to insufficient intake)

3. Planning: set priorities, identify patient-centered outcomes and select interventions related to fluids and electrolytes
   a. Set priorities and establish outcomes (for example: patient’s total fluid intake will be 2,500 cc/day)
   b. Incorporate factors influencing fluid and electrolyte status (for example: establish a pattern of fluid intake based on individual patient preferences) (see VIII A4)
   c. Select nursing interventions to help the patient achieve outcomes (for example: monitor IV therapy, provide oral fluids)

4. Implementation: use nursing interventions to achieve outcomes related to fluid and electrolyte balance
   a. Promote fluid and electrolyte balance (for example: assist with food and fluid selection, measure and record intake and output)
   b. Use nursing measures appropriate to oral and parenteral replacement (for example: establish daily fluid regimen with patient, assist with parenteral administration of fluids [gravity flow and IV infusion pumps], identify signs and symptoms of untoward reactions)
   c. Instruct the patient regarding fluid and electrolyte requirements (for example: discuss dietary sources of potassium)

5. Evaluation: determine the extent to which outcomes have been achieved
   a. Evaluate, record, and report the patient’s response to nursing actions (for example: patient’s 24-hour fluid intake is 2,500 cc)
   b. Modify the plan of care if necessary
The sample questions give you an idea of the level of knowledge expected in the exam and how questions are typically phrased. They are not representative of the entire content of the exam and are not intended to serve as a practice test.

Rationales for the questions can be found on pages 25–28 of this guide. In that section, the correct answer is identified and each answer is explained. The number in parentheses at the beginning of each rationale refers to the corresponding section of the content outline. For any questions you answer incorrectly, return to that section of the content outline for further study.

You will be provided with an erasable white board to use during your exam. During your exam, a basic 8-function calculator will also be available on your computer. A typical calculator is printed at the back of this content guide.

1. A mentally competent patient refuses an injection. The nurse administers the injection despite the patient’s refusal. In this situation, the nurse can be held liable for which offense?
   1) assault
   2) battery
   3) invasion of privacy
   4) a misdemeanor

2. Which term describes the rules or principles that govern professional conduct?
   1) beliefs
   2) ethics
   3) morals
   4) values

3. A patient is being admitted to the hospital. The nurse notes that the patient’s pulse and blood pressure are higher than they were on previous routine office visits. How should the nurse interpret these findings initially?
   The findings are indicative of
   1) the resistance stage of stress.
   2) an autonomic nervous system response.
   3) an inflammatory response.
   4) the local adaptation syndrome.

4. Which observation is most indicative of a localized infection?
   1) diaphoresis
   2) fatigue
   3) fever
   4) swelling

5. Which information in a patient’s health history indicates that the patient is at risk for infection?
   1) The patient had mumps three years ago.
   2) The patient had rubella one year ago.
   3) The patient had a tetanus booster 12 years ago.
   4) The patient was a year late receiving the polio vaccine.
6. A patient is being discharged with an indwelling urinary catheter. Which instruction should the nurse give to the patient to help prevent a urinary tract infection?
   1) Allow the collection bag to fill completely before emptying it.
   2) Separate the catheter from the tubing when emptying the collection bag.
   3) Clamp the tubing before exercising or ambulating.
   4) Position the tubing so the urine flows into the collection bag.

7. Which assessment finding indicates that a hospitalized patient is at risk for physical injury?
   1) diminished lung sounds
   2) hyperactive bowel sounds
   3) weak right hand grasp
   4) bilateral +1 ankle edema

8. When administering a medication via the Z-track method, the nurse should include which action?
   1) Massage the site following the injection.
   2) Give the injection into subcutaneous tissue.
   3) Change the needle prior to the injection.
   4) Administer the medication rapidly.

9. When administering a medication to a patient with decreased liver function, the nurse should be most concerned with which mechanism of the drug’s action?
   1) absorption
   2) distribution
   3) excretion
   4) metabolism

10. Which instruction should the nurse give to a patient who uses a bath oil?
    1) Be certain to remove all oil residue from the skin.
    2) Take precautions to prevent falls in the bathtub.
    3) Alternate the use of bath oil with a skin lotion.
    4) Use a washcloth to apply the bath oil.

11. To which stage of sleep will a patient return after being awakened for a treatment?
    1) the stage from which she was awakened
    2) the first stage of sleep
    3) the rapid eye movement stage
    4) the second stage of sleep

12. A patient is on bed rest. To avoid a complication of immobility, the nurse should give priority to which assessment?
    1) activity tolerance
    2) bowel sounds
    3) lung sounds
    4) urinary output

13. Which analgesic is most commonly associated with an increased incidence of gastric bleeding in older adults?
    1) acetaminophen (Tylenol)
    2) codeine
    3) indomethacin (Indocin)
    4) meperidine hydrochloride (Demerol)

14. Which measure should the nurse include in the plan of care for a patient who is experiencing pain?
    1) Implement pain relief measures before the pain becomes severe.
    2) Use the same pain relief measure for each pain experience.
    3) Administer pain medications on a predetermined schedule.
    4) Encourage the patient to increase the intervals between pain medication requests.

15. Which food is highest in saturated fat?
    1) butter
    2) margarine
    3) olive oil
    4) peanut oil

16. Which observation indicates that a patient is responding positively to oxygen therapy?
    1) dyspnea
    2) eupnea
    3) hyperpnea
    4) orthopnea
17. Which assessment data should alert the nurse to the likelihood that a patient may be experiencing fluid volume deficit?
   1) increased hematocrit
   2) leukocytosis
   3) distended neck veins
   4) peripheral edema

18. When a patient's serum sodium level is 129 mEq/L, the nurse should anticipate an order for which IV fluid?
   1) 5% dextrose in water
   2) 5% dextrose in 0.45% NaCl
   3) 5% dextrose in 0.9% NaCl
   4) lactated Ringer's solution

19. The physician orders an IV infusion of 1,000 cc 0.9% NaCl to run over 10 hours. The IV administration set delivers 10 drops per cc. The nurse should regulate the flow rate at how many drops per minute?
   1) 6 to 7
   2) 16 to 17
   3) 25 to 26
   4) 31 to 32

20. Which instructional technique should maximize independence for a patient who needs to limit sodium in the diet?
   1) Calculate the actual volume of salt in the patient's usual diet.
   2) Provide the patient with a list of foods that must be avoided.
   3) Give the patient a set of written, preplanned, low-sodium menus.
   4) Explain to the patient how to read and interpret food labels.
1.(IA3b)
1) Assault is a threat or an attempt to make bodily contact with another person without that person’s consent. This nurse actually touched the patient.

*2) Battery is assault carried out and includes the willful, angry, and violent touching of another person’s body or clothes. Administering an injection after a patient has refused it is a classic example of battery.

3) The nurse’s action is not an invasion of privacy. An example of invasion of privacy is breach of confidentiality.

4) A misdemeanor is a classification of a crime; it is not in itself a type of offense.

2.(IC)
1) Beliefs are individually held attitudes and are not the rules of a profession.

*2) Ethics are the rules or principles that govern professional conduct; ethics are the expected, publicly stated standards of a particular group.

3) Morals are personal standards of right and wrong, not the standards of a group.

4) Values are the beliefs of an individual, not the rules of a profession.

3.(IIB)
1) The stage of resistance occurs later in an illness, as the body adapts.

*2) Stress activates the sympathetic nervous system, causing the findings.

3) The inflammatory response is a localized response to tissue injury or infection.

4) The local adaptation syndrome occurs when one part of the body responds to an injury.

4.(IIIB2a)
1) Diaphoresis is a systemic response to fever and infection.

2) Fatigue is a systemic response to infection.

3) Fever is a systemic response to infection.

*4) Swelling occurs when blood vessels dilate to increase blood flow to localized infectious agents.

5.(IIIB1b)
1) This would have no effect on a patient’s risk for infection.

2) See 1).

*3) A tetanus booster should be repeated every 10 years in adults, so this patient is susceptible to tetanus, that is, at risk for infection.

4) The patient did receive the polio vaccine, even though it was late, so the patient is immune to polio and not at risk for infection.

*correct answer
6.(III B2c)
1) A full bag of standing urine is a medium for bacterial growth.
2) The drainage system should remain intact. Breaking the connection allows a portal for bacteria to enter the system.
3) Clamping the tubing promotes stasis of urine in the bladder.
*4) Positioning the tubing correctly promotes drainage and limits urinary stasis, thereby limiting bacterial growth.

7.(III B2a)
1) Diminished breath sounds place a patient at risk for impaired gas exchange, not physical injury.
2) Hyperactive bowel sounds do not place a patient at risk for physical injury.
*3) A weak right hand grasp indicates the patient has altered mobility, placing the patient at risk for physical injury.
4) Bilateral ankle edema is an indicator of fluid volume excess which does not place a patient at risk for physical injury.

8.(III C1b)
1) Massaging the site following the injection is not recommended because it may force the medication back into the needle track and cause irritation.
2) The Z-track method is used for intramuscular injections, not subcutaneous injections.
*3) Changing the needle prior to the injection ensures that no medication clings to the needle as it is inserted through the subcutaneous tissue into the muscle where it is injected.
4) The medication should not be administered rapidly. It is injected slowly and the needle is allowed to remain in place for 10 seconds after injecting the medication.

9.(III C2a)
1) Absorption is the process by which a drug is transferred from its site of entry to the bloodstream.
2) Distribution is the movement of a drug throughout the body. The rate of distribution depends on perfusion and capillary permeability of the drug. Distribution usually does not involve the liver.
3) Excretion is the removal of a drug from the body. The kidneys excrete most drugs.
*4) Metabolism is the breakdown of a drug into inactive form. Liver disease may interfere with this process.

10.(III D2d)
1) A small amount of oil on the skin will help to moisturize.
*2) Oil is a slippery substance and can cause falls in the bathtub.
3) Alternating the use of bath oil with a skin lotion is personal preference and not a priority instruction for the patient.
4) The oil can be applied any way the patient likes. This is not a priority instruction.

11.(IV B1a)
1) The patient will not return to the stage from which she was awakened.
*2) After being awakened, a patient begins the sleep cycle at stage one and progresses through all of the stages.
3) See 2).
4) See 2).

12.(IV C1c)
1) The inability to endure or complete daily activities is not life threatening.
2) Poor gastrointestinal elimination is not life threatening.
*3) Loss of respiratory functioning may become a serious threat to health.
4) Urinary problems have a lower priority than do pulmonary problems.
13. (IVD1c)
1) Tylenol is not associated with gastric bleeding.
2) Codeine is a narcotic analgesic and is not associated with gastric bleeding.
*3) Indocin is a nonsteroidal anti-inflammatory agent (NSAID). NSAIDs have been associated with gastric irritation and bleeding. Indocin is especially difficult to tolerate and should be used cautiously, if at all, in older adults.
4) Demerol is a narcotic analgesic and is not associated with gastric bleeding.

14. (IVD2c)
*1) Providing an analgesic before the onset of pain is preferable. If the nurse waits for the patient to report pain, a larger dose may be required.
2) Pain may vary in intensity from moment to moment and different pain relief measures may be required to control pain.
3) The choice of pain relievers is based on the patient’s report of pain. Report of mild pain may require a different analgesic than more severe pain.
4) Pain therapy should not increase discomfort or harm the patient. In a trusting relationship, the nurse should manage the patient’s pain regardless of the time intervals.

15. (VA2b)
*1) Butter, being of animal origin, contains saturated fat.
2) Margarine contains monounsaturated fat.
3) Olive oil contains monounsaturated fat.
4) Peanut oil contains monounsaturated fat.

16. (VIIB1b)
1) Dyspnea, feeling short of breath, is not a positive response to oxygen therapy.
*2) Eupnea, normal effortless breathing, is a positive response to oxygen therapy.
3) Hyperpnea, an increased depth of respiration, is not a positive response to oxygen therapy.
4) Orthopnea, the inability to breathe except in an upright position, is not a positive response to oxygen therapy.

17. (VIIIA1)
*1) Loss of fluid makes the blood more concentrated and results in an increased hematocrit.
2) Leukocytosis is an elevated WBC and is evidence of infection, not fluid volume deficit.
3) Distended neck veins are an indicator of fluid volume excess.
4) Peripheral edema is an indicator of fluid volume excess.

18. (VIIIIB1b)
1) A 5% dextrose in water solution is sodium-free and would not be used for a patient with hyponatremia.
2) A 5% dextrose in 0.45% NaCl solution only contains half as much sodium as does normal blood and would not be used for a patient with hyponatremia.
*3) A 5% dextrose in 0.9% NaCl solution is normal saline and would provide additional intake of sodium for a patient with hyponatremia.
4) Lactated Ringer’s solution is an isotonic solution used primarily for maintaining or replacing volume.

19. (VIIIIB3b)
1) See 2).
*2) The standard formula for calculating IV flow rate is:
\[
\text{flow rate (gtt/min)} = \frac{\text{volume (mL)} \times \text{drop factor (gtt/mL)}}{1,000 \times \text{time in minutes}}
\]
\[
= \frac{1,000 \times 10}{600} = 16.66
\]
3) See 2).
4) See 2).
20.(VIII.B3c)

1) Calculating the volume of salt in the patient’s diet does not teach the patient how to limit sodium in the diet.

2) Giving the patient a list of foods to avoid may provide information regarding foods high in sodium, but it does not teach the patient how to read and interpret food labels.

3) Giving the patient a set of preplanned menus does not allow for flexibility in the diet and patients often have difficulty complying with strict plans.

*4) Sodium is found in many foods and the patient must know how to read and interpret food labels in order to calculate a daily intake. The patient can then include personal preferences in the dietary plan, which should improve compliance with limiting sodium.

*correct answer
SECTION FIVE
Taking the Exam

Registering for Your Exam

Register Online
www.excelsior.edu/examregistration
Follow the instructions and pay by Visa, MasterCard, American Express, or Discover Card.

Examination Administration
Pearson Testing Centers serve as the administrator for all Excelsior College computer-delivered exams. The Disability Services office at Excelsior College is responsible for considering requests for reasonable accommodations (exceptions for individual students with documented disabilities). If you are requesting an accommodation due to a disability, download and complete a Request for Accommodation form that can be accessed by visiting the Excelsior College website at www.excelsior.edu/disability-services.

Computer-Delivered Testing
You will take the exam by computer, entering your answers using either the keyboard or the mouse. The system is designed to be as user-friendly as possible, even for those with little or no computer experience. On-screen instructions are similar to those you would see in a paper examination booklet.

We strongly encourage you to use the online tutorial before taking your exam at a Pearson Testing Center. To access the tutorial, go to www.pearsonvue.com/uexcel and click on the Pearson VUE Tutorial link on the right hand side of the page.

On the Day of Your Exam

Important Reminders
On the day of your exam, remember to:

• dress comfortably: the computer will not mind that you’re wearing your favorite relaxation outfit
• arrive at the test site rested and prepared to concentrate for an extended period
• allow sufficient time to travel, park, and locate the test center
• be prepared for possible variations in temperature at the test center due to weather changes or energy conservation measures
• bring your ID, but otherwise, don’t weigh yourself down with belongings that will have to be kept in a locker during the test.

Academic Honesty
Nondisclosure Statement
• All test takers must agree to the terms of the Excelsior College Academic Honesty Policy before taking an examination. The agreement will be presented on screen at the Pearson VUE Testing Center before the start of your exam.

• Once the test taker agrees to the terms of the Academic Honesty Nondisclosure Statement, the exam will begin.

If you choose not to accept the terms of the agreement
• your exam will be terminated
• you will be required to leave the testing center
you will not be eligible for a refund. For more information, review the Student Policy Handbook at
www.excelsior.edu/studentpolicyhandbook.

Student behavior is monitored during and after the exam. Electronic measures are used to monitor the security of test items and scan for illegal use of intellectual property. This monitoring includes surveillance of Internet chat rooms, websites, and other public forums.

Information About UExcel Exams for Colleges and Universities

A committee of teaching faculty and practicing professionals determines the learning outcomes to be tested on each exam. Excelsior College Center for Educational Measurement staff oversee the technical aspects of test construction in accordance with current professional standards. To promote fairness in testing, we take special care to ensure that the language used in the exams and related materials is consistent, professional, and user friendly. Editorial staff perform systematic quantitative and qualitative reviews to ensure accuracy, clarity, and compliance with conventions of bias-free language usage.

Excelsior College, the test developer, recommends granting three (3) semester hours of upper-level undergraduate credit to students who receive a letter grade of C or higher on the UExcel Exam in Abnormal Psychology. Other colleges and universities also recognize this exam as a basis for granting credit or advanced standing. Individual institutions set their own policies for the amount of credit awarded and the minimum acceptable grade.

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