OIIQ-RN

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March 2025 Exam

SEPTEMBER 2025 EXAM

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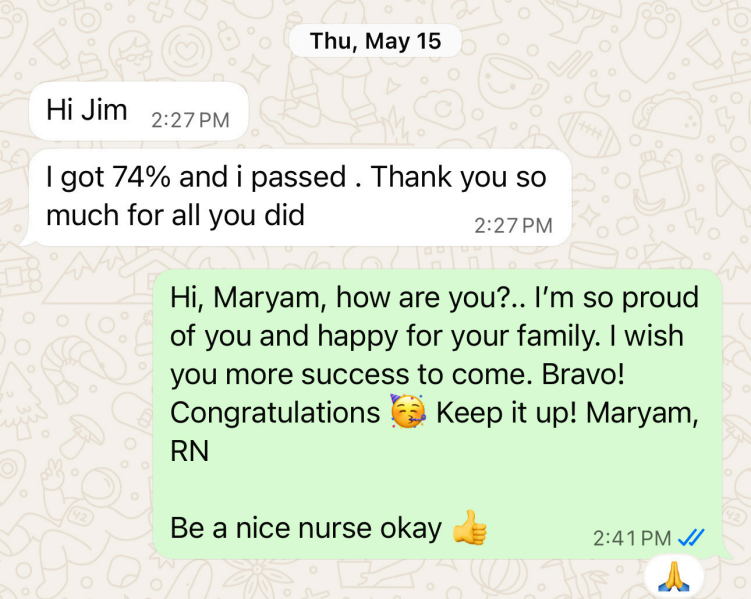

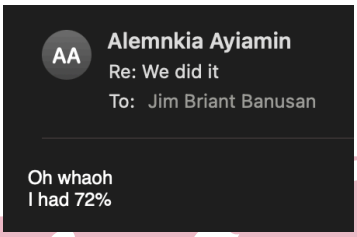

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⚠ Disclaimer

The questions and answers provided here are not the official questions from the upcoming September OIIQ exam. However, they have been carefully designed to closely reflect the style, format, and level of difficulty of the real exam.

Please note that any differences in scenarios, wording, or options are intentional and serve as opportunities to develop critical thinking. It is the student's responsibility to analyze the scenario, understand what the question is asking, and determine the best possible answer based on clinical judgment.

These are practice questions only, meant to simulate the OIIQ exam. While they are highly representative, they do not replace official materials. Students are encouraged to supplement with further study as needed.

⚠ Avertissement

Les questions et réponses fournies ici ne proviennent pas officiellement de l'examen de l'OIIQ de septembre. Toutefois, elles ont été soigneusement conçues pour refléter le plus fidèlement possible le style, le format et le niveau de difficulté de l'examen réel.

Veuillez noter que toute différence dans les scénarios, le libellé ou les choix de réponses est intentionnelle et vise à développer la pensée critique. Il revient à l'étudiant(e) d'analyser le scénario, de bien comprendre ce que la question demande et de choisir la meilleure réponse possible selon son jugement clinique.

Ces questions sont à des fins de pratique uniquement, conçues pour simuler l'examen de l'OIIQ. Bien qu'elles soient très représentatives, elles ne remplacent pas les documents officiels. Il est recommandé aux étudiant(e)s de compléter leur étude avec d'autres ressources au besoin.

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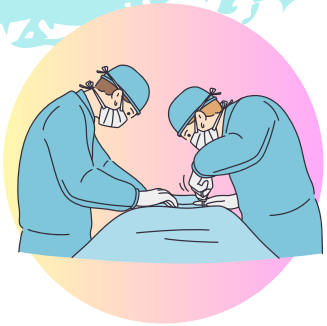

NOTES

"Today is your **OPPORTUNITY** to build the tomorrow that you **WANT.**"

How to Use This Book

This book was carefully designed to reflect the September 2025 OIIQ exam theme as closely as possible. Every question, rationale, and clinical scenario was selected and written with the goal of helping you think critically—not just memorize.

Don't just aim for the right answer.
While it may feel satisfying to get a multiple-choice question right, true learning happens in the rationales. Each rationale helps you understand why an answer is correct and, more importantly, why the others are not. This understanding is what will help you succeed in the real exam.

This is a preparation guide—not a replacement.
This book is not an official publication of the OIIQ and does not replace your school materials or the official resources provided by the OIIQ. It is meant to complement your study plan by offering realistic, high-yield practice questions and explanations.

Stay up to date.
At the time of writing, all the information in this book is based on the most current nursing guidelines, exam patterns, and clinical knowledge. However, nursing is a dynamic field, and changes can occur. We understand that this book cannot be updated once purchased. That's why any updates, additional questions, corrections, or new information will be made available on our website for subscribers:

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Tips for Studying with This Book
- Set a realistic study schedule
- Review the rationales even for questions you got right
- Reflect on questions you got wrong—was it a knowledge gap or a reading error?
- Discuss difficult concepts with your classmates or instructors
- Don't cram—consistency beats intensity

You're already on the path to becoming a Registered Nurse. Stay focused, stay curious, and remember — you've got this.

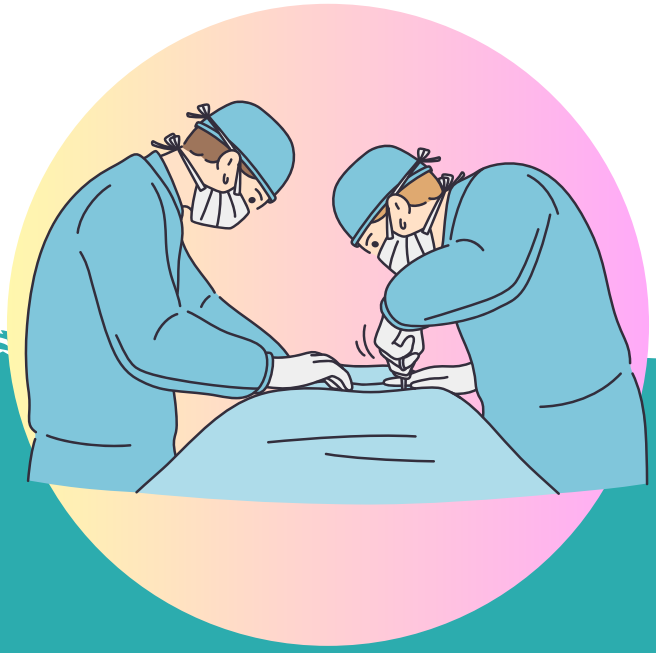
Before you start answering the questions, please take a few minutes to watch this YouTube video first.

- It contains important tips and strategies on how to approach and answer OIIQ exam questions effectively.

- Understanding the technique before diving in will help you avoid common mistakes and boost your confidence.

- Watch the video here or scan the QR CODE: https://www.youtube.com/watch?v=X4A4sFWAmIM&t=65s

- Once you've watched it, you can begin answering the questions. Good luck!



SURGERY

SITUATION 1

Scenario:
Ms. Machin, a 34-year-old patient, had a cesarean section five days ago. During a routine follow-up, you notice that her surgical dressing has been removed, and there is a small wound (separation of the surgical wound) at the incision site. She reports mild discomfort but no signs of infection (e.g., redness, heat, or purulent discharge). Ms. Machin is concerned because she needs to care for her two young children at home.

Question:
As the nurse, what should you do as a priority?
a. Apply Steri-Strips to approximate the wound edges and reinforce with a clean dressing.
b. Advise Ms. Machin to avoid lifting her children and provide instructions on activity modification.
c. Notify the doctor immediately for further instructions.
d. Clean the wound with an antiseptic solution and leave it open to air.

SITUATION 2

Scenario:
Mr. Delacruz, a 58-year-old patient, is recovering on the surgical floor following an open abdominal procedure performed five days ago. While assisting him during a coughing episode, he suddenly becomes alarmed and states, "Something just gave way in my belly." You quickly inspect the abdominal incision and observe a separation in the wound with visible tissue protruding through the opening. Mr. Delacruz appears anxious but remains hemodynamically stable.

Question:
What is your priority intervention?
a. Reassure the patient and check vital signs.
b. Cover the wound with sterile saline-moistened gauze and notify the surgeon.
c. Instruct the patient to lie flat and call for help.
d. Apply pressure to the wound to stop any bleeding.

SITUATION 3

Scenario:
Mr. Lewis, a 62-year-old client, is recovering from thoracic surgery performed three days ago. During your morning rounds, he reports experiencing pain at the incision site whenever he coughs or takes a deep breath. He appears apprehensive and states that the pain discourages him from performing breathing exercises. His vital signs are stable, and the surgical dressing appears dry and intact. He asks if the pain is normal and what he can do to relieve it.

Question:
Which action would the nurse take?
a. Instruct the client to splint the wound with a pillow when coughing
b. Place the client in the supine position and inspect the site of the incision
c. Assess the intensity of the pain and administer the prescribed analgesic
d. Notify the health care provider immediately

SITUATION 4

Scenario:
Ms. Rivera, a 47-year-old client, is in the postoperative unit after undergoing abdominal surgery two days ago. She is wearing an abdominal binder to provide support to her incision site, reduce pain during movement, and minimize the risk of wound complications. The physician has prescribed a dressing change to the surgical site. You are preparing to perform the procedure while ensuring her comfort and maintaining wound integrity.

Question:
Which intervention should the nurse include in relation to the prescribed dressing change?
a. Remove the binder to change the abdominal dressing as prescribed and reapply it afterward
b. Slide the new dressing under the binder to avoid removing it and causing discomfort
c. Keep the binder in place and change only the outermost layer of the dressing
d. Loosen the binder slightly without removing it to access the incision site

SITUATION 5

Scenario:
Mr. Thompson, a 55-year-old patient, has just returned from surgery after undergoing an abdominal procedure. During the post-op assessment, the nurse receives a new order from the health care provider to apply an abdominal binder around the patient's midsection. The surgical dressing is dry and intact, and the patient is alert and reports mild discomfort at the incision site when moving or coughing.

Question:
What is the most likely indication for this intervention?
a. Promote blood flow to the incision site
b. Support the diaphragm and reduce pain when breathing
c. Reduce stress on the abdominal incision
d. Prevent the need for frequent dressing changes

SITUATION 6.1

Scenario:
Mr. Émile Bouchard, a 49-year-old patient, is recovering in the postoperative unit following bariatric surgery. He is alert but slightly drowsy from anesthesia. You are monitoring his airway, respiratory status, and surgical site. The physician has not yet prescribed ambulation, and Mr. Bouchard has not reported any pain or nausea.

Question:
How should you position the patient?
a. Keep the patient flat to reduce strain on the incision
b. Maintain the head of bed at 10–15 degrees to support circulation
c. Place the patient in the left lateral position with knees flexed

d. Maintain elevation of the head of bed at 30–45 degrees

SITUATION 6.2

Scenario:
A few days later, approximately 30 minutes after finishing his meal, he reports feeling lightheaded, flushed, and nauseated. He also complains of abdominal cramping and diarrhea. On assessment, his heart rate is 112 bpm, and he appears diaphoretic and anxious. He tells the nurse, "I feel like my heart is racing and I might faint."

Question:
What do you suspect is happening to the patient?
a. Hypoglycemia
b. Bowel obstruction
c. Dumping syndrome
d. Anastomotic leak

SITUATION 6.3

Mr. Émile Bouchard is preparing for discharge after an uncomplicated recovery from his surgery. As the nurse, you review postoperative education with him, including wound care, physical activity, and dietary guidelines. Mr. Bouchard expresses concerns about how his eating habits will need to change and asks, "What kind of diet should I follow so I don't get sick or gain the weight back?"

Question:
Which discharge teaching related to diet is most important?
a. "A high protein diet that is low in carbohydrates and fat will prevent diarrhea."
b. "Food should be high in fiber to prevent constipation from the pain medication."
c. "Three meals a day with no snacks between meals will provide optimal nutrition."
d. "Fluid intake should be at least 2000 mL per day with meals to avoid dehydration."

SITUATION 7.1

Scenario:
Mr. Laurent Gagnon, a 67-year-old client, is on his second postoperative day following cardiac surgery via sternotomy. During your morning assessment, you inspect his surgical incision. You note slight puffiness along the edges, but the area is non-reddened and without drainage. Mr. Gagnon is afebrile with a temperature of 99°F (37.2°C) orally, and his white blood cell count is 7500 cells/mm³. He is alert and reports mild tenderness at the incision site.

Question:
What is the most appropriate nursing action?
a. Document the findings as normal for a healing surgical incision
b. Notify the health care provider of a possible infection
c. Mark the puffy area with a pen and recheck it
d. Obtain a wound culture and start empiric antibiotics

SITUATION 7.2

Scenario:
On the third postoperative day, Mr. Laurent Gagnon, recovering from cardiac surgery, presses the call bell and states, "I'm feeling chest pain again, like yesterday, but I don't know if it's the same." The nurse immediately assesses him.
Mr. Gagnon describes the pain as sharp and localized near the sternum, worsened by movement and coughing, and rated 6 out of 10 on the pain scale. He reports that the pain eases slightly when resting in bed and does not radiate.
Vital signs:
- BP: 126/78 mmHg
- HR: 84 bpm
- RR: 18 breaths/min
- SpO2: 98% on room air
- Temperature: 37.1°C

Postoperative medical orders:
- Morphine 2 mg IV every 4 hours PRN for moderate to severe pain (pain scale ≥4)
- Nitroglycerin 0.4 mg SL every 5 minutes PRN for chest pain, max 3 doses
- ECG stat for unexplained chest pain
- Notify physician if chest pain is unrelieved after interventions

Question:
What is the most appropriate nursing action?
a. Administer morphine 2 mg IV as prescribed and reassess the pain response
b. Administer nitroglycerin 0.4 mg sublingually and prepare to repeat every 5 minutes
c. Notify the health care provider immediately to report possible cardiac ischemia
d. Instruct the patient to ambulate to determine if the pain improves with movement

SITUATION 8

Scenario:
Mme. Claudine Moreau, a 61-year-old client, is being discharged home after a successful heart transplant. As part of her lifelong immunosuppressive therapy, she has been prescribed cyclosporine and azathioprine to prevent organ rejection. Before discharge, you provide teaching regarding her medications, lifestyle modifications, and infection prevention. Mme. Moreau is alert and asks, "Are there any precautions I need to take while on these medications?"

Question:
Which two precautions should the nurse include in the discharge teaching? Choose TWO (2) answers
a. Advise to use contraceptive measures during treatment
b. Do not obtain live vaccinations
c. Drink at least 3 liters of fluids per day and watch the urine for sediment
d. Increase potassium-rich foods to prevent leg cramps

SITUATION 9.1

Scenario:
Mme. Isabelle Lefebvre, a 70-year-old client, is three days post-lobectomy and has a chest tube in place. The chest tube is functioning properly with minimal drainage and no signs of an air leak. The physician has ordered a CT scan of the chest. As the nurse prepares to transport Mme. Lefebvre to the radiology department, safety precautions must be taken in case the chest tube becomes dislodged or disconnected during transport.

Question:
Which supplies should the nurse bring when transporting this patient for a CT scan?
a. Manual resuscitation bag, extra suction tubing, and telemetry monitor
b. Blood pressure cuff, portable oxygen, and incentive spirometer
c. Two rubber-tipped clamps, petroleum gauze, sterile 4x4s, sterile water, and tape
d. Foley catheter kit, IV pump, and pulse oximeter probe

SITUATION 9.2

Scenario:
As the orderly arrives with the stretcher, the nurse double-checks the setup of the chest tube drainage system to ensure it remains safe and functional during transport.

Question:
What should the nurse ensure during the transport?
a. Place the chest tube drainage system above the level of the chest to prevent backflow.
b. Clamp the chest tube before transporting to avoid air entering the pleural space.
c. Place the drainage system below the level of the chest to allow proper drainage.
d. Disconnect the chest tube from the drainage system temporarily to make transport easier.

SITUATION 9.3

Scenario:
As Mme. Isabelle Lefebvre is preparing for transport to the CT scan, she attempts to get out of bed with assistance. In the process, the chest tube is accidentally pulled out of the pleural space. She immediately gasps and clutches her side. The nurse notes that the insertion site is open and exposed. Mme. Lefebvre appears mildly short of breath but is conscious and responsive. The nurse quickly moves to respond to the emergency.

Question:
Which action should the nurse implement first?
a. Notify the physician to have chest tubes reinserted STAT.
b. Instruct the client to take slow shallow breaths until the tube is reinserted.
c. Take no action and assess the client's respiratory status every 15 minutes.
d. Tape a petroleum jelly occlusive dressing on three sides to the insertion site.

SITUATION 10

Scenario:
You are overseeing a patient who has undergone a rectosigmoid resection, resulting in a stoma with an ostomy bag for fecal diversion. Recently, infection control has alerted your healthcare facility about a Vancomycin-resistant Enterococcus (VRE) outbreak. They recommend performing rectal swabs on all patients to identify carriers of VRE.

Question: Will you perform the rectal swab?
A. Yes, you will swab the patient's rectum.
B. Yes, but seek further guidance from infection control before deciding
C. No, you will swab the patient's stoma.
D. No, recommend alternative infection control measures without swabbing.

SITUATION 11

Scenario:
A patient who recently had a stoma placed in the upper right quadrant of his abdomen, is feeling concerned about his condition. During your rounds, he asks, "Why are my stools always liquid now? He appears anxious and worried about this change.

Question:
What is the most appropriate explanation to give the patient?
a. The stoma is located in the colon, which results in liquid stools.
b. The stoma is located in the small intestine, which results in liquid stools.
c. Liquid stools indicate a serious infection in your digestive system.
d. The stoma is not functioning properly, causing the stools to be liquid.

SITUATION 12

Scenario:
A patient diagnosed with new-onset Crohn's disease has recently undergone surgery and had an ileostomy placed. A few weeks after the surgery, the patient returns for a follow-up appointment. During the visit, he mentions that he has resumed his running routine and is looking for suitable snack options to incorporate into his day. The patient states, "I've started running again, and I need some snack recommendations to keep me energized throughout the day."

Question:
What advice do you give him?
a. Eat carrot sticks.
b. Eat unsalted peanuts.
c. Eat dried apricots.
d. Eat cheddar cheese.

SITUATION 13

Scenario:
You are a nurse on the surgical floor taking care of a patient named Jean-Claude, a 67-year- old man of French origin, who had a colostomy placed yesterday due to colorectal cancer. He is recovering well but has been a bit anxious about the changes to his body. While you are attending to another patient, Jean-Claude uses the call light to get your attention. When you arrive, he tells you that his surgical dressing has fallen off and he is unsure what to do.

You assess the stoma, noting that it appears healthy with no signs of excessive redness, swelling, or drainage. The skin surrounding the stoma looks intact.

Question:
You will re-apply what type of dressing over the stoma?
A. Wet to dry dressing
B. No dressing is needed. You will keep it open to air.
C. Petroleum gauze dressing
D. Telfa gauze

SITUATION 14.1

Scenario:
You are caring for Mr. Jean-Pierre Martel, a 68-year-old patient with a medical history of type 2 diabetes, peripheral vascular disease, and a permanent ileostomy following surgery for ulcerative colitis. The physician has written a new order:

- Aspirin EC 81 mg PO daily.

As you prepare to administer the medication, you review the patient's history and consider the implications of his ileostomy.

Question:
What is your next nursing action?
a. Administer the medication as ordered.
b. Crush the medication and mix it in applesauce.
c. Hold the medication and notify the doctor the patient has an ileostomy.
d. Crush the medication and mix it in pudding.

SITUATION 14.2

Scenario:
Mr. Martel expresses concern about applying the wafer correctly and avoiding skin irritation. He asks, "How do I know where to cut the hole in the skin barrier so it fits properly?"

Question:
Which teaching is most appropriate when applying the stoma barrier (wafer)?
a. Cut the wafer opening to be the exact same size as the stoma to avoid leaks.
b. Leave at least ½ inch of space between the stoma and the wafer opening to prevent pressure.
c. The barrier opening should be smaller than the stoma to allow a snug fit and reduce leaks.
d. The opening of the barrier should be 1/8 to 1/4 inch larger than the stoma to avoid skin damage.

SITUATION 14.3

Scenario:
Later in the shift, while checking Mr. Jean-Pierre Martel's ileostomy pouch and peristomal skin, you notice a concerning change. The stoma, which had previously appeared moist, pink, and healthy, now looks dark purple and slightly dry. Mr. Martel reports no pain at the site but appears concerned, asking, "Is it supposed to look like that?"

You quickly perform a full stoma assessment and check his vital signs. His BP and heart rate are within normal limits, and he is afebrile. Output from the stoma is present, though slightly decreased compared to the last measurement.

Question:
What do you suspect is happening, and what is your initial nursing intervention?
a. Apply warm saline compresses and reassess in 1 hour.
b. Document the finding and reassure the patient this is a normal healing phase.
c. Notify the physician immediately due to signs of stoma ischemia.
d. Irrigate the stoma with sterile water to stimulate blood flow.

SITUATION 15.1

Scenario:
Mr. Antoine Desrosiers, a 64-year-old patient, has undergone a total gastrectomy due to gastric cancer. The surgery was completed without complications, and he is now in the immediate postoperative recovery phase. A nasogastric (NG) tube is in place for gastric decompression and drainage.

Four hours postoperatively, the nurse notes that the NG tube is draining a moderate amount of bloody fluid. Mr. Desrosiers is stable, with no abdominal distension, and vital signs are within normal limits.

Question:
Which of the following is the appropriate nursing intervention?
a. Irrigate the nasogastric tube
b. Continue to monitor the drainage
c. Reposition the nasogastric tube
d. Measure the abdominal girth

SITUATION 15.2

Scenario:
During your routine assessment, you notice the NG tube has migrated outward by approximately 3 cm from the marked position documented in the operating room report. Mr. Desrosiers is resting but reports mild nausea.

Question:
What is your priority nursing action before notifying the surgeon?
a. Reposition the tube to the original marked length.
b. Push the tube back in to restore proper placement.

c. Secure the tube in its current position to prevent further displacement.
d. Aspirate the NG tube gently to check for gastric contents or resistance.

SITUATION 15.3

Scenario:
Mr. Desrosiers, now one week post–total gastrectomy, continues to receive enteral nutrition via a nasogastric (NG) feeding tube. During your morning assessment, you observe that his right nostril—the side where the tube is inserted—appears red and inflamed, and Mr. Desrosiers complains of soreness and irritation at the site. The left nostril is patent with intact skin and no signs of breakdown.

Question:
What is the best action to take at this time?
a. Call the physician; get an order to remove the feeding tube and insert a new feeding tube in the opposite naris.
b. Remove the feeding tube and reinsert it in the opposite naris.
c. Apply triple antibiotic ointment at the site of insertion and leave the tube in place.
d. Medicate the patient for pain and stop using the feeding tube.

SITUATION 15.4

Scenario:
Although his condition is stable, he now begins to complain of dry mouth and nasal irritation, especially around the new insertion site. He asks the nurse, "Is there anything you can do to help me feel less dry?"

Question:
Which of the following actions should the nurse take to help prevent dry mucous membranes?
a. Offer throat lozenges for the client to use
b. Apply petroleum jelly to the client's naris
c. Provide frequent mouth care
d. Allow the client to suck on ice chips

SITUATION 16.1

Scenario:
Mr. Badour, 46 years old, had a bowel resection with colostomy placement yesterday. When you enter his hospital room, you observe that his meal tray is upside down on the floor. He is sitting at the edge of the bed, with clenched fistsresting on the bedside table near a jug of water. He appears flushed, is breathing noisily, and coughs twice. His ostomy bag is on the floor, indicating possible self-removal or dislodgement. When he sees you, he says angrily:
"Get out of here right now. Leave me alone. Like my wife, who just left."

Question:
What is the most appropriate therapeutic response?
a. Mr. Badour, you must handle your ostomy with care in order to prevent complications in the immediate postoperative period.
b. Mr. Badour, you must take the time you need for you and your wife to adjust to your new condition.
c. Mr. Badour, you must feel very angry about your situation.

SITUATION 16.2

Scenario:
Three days have passed since Mr. Badour's emotional outburst. His physical condition is now stable, and there are no signs of postoperative complications. Today, during your routine care, Mr. Badour shares:
"I'm still nervous about it, but I hope I'll be able to take care of this ostomy on my own someday."
He seems calmer, makes eye contact, and engages in the conversation more willingly. You recognize this as a sign that Mr. Badour is becoming more open to discussing his care and future independence.

Question:
What aspect will you explore further with Mr. Badour now?
a. Past history of aggression.
b. Coping strategies used in the past.
c. Ability to perform his ostomy care.

SITUATION 16.3

Scenario:
It's now postoperative day 5, and Mr. Badour has made significant progress since his surgery and initial emotional distress. He has begun participating more actively in his care and expresses interest in managing his colostomy at home. He has also been practicing with the ostomy equipment under nursing supervision, and his vital signs, labs, and physical assessment findings are stable.

Today during your assessment, you are preparing for discharge planning and must determine whether Mr. Badour is ready to transition home safely and with confidence.

Question:
How will you know that Mr. Badour is generally ready for discharge with his new colostomy?
a. He verbalizes that he is tired of being in the hospital and wants to go home.
b. He states he will ask his wife to take care of his colostomy until he feels more confident.
c. He demonstrates how to clean and change his ostomy pouch with minimal assistance.
d. He can name two brands of colostomy supplies available at the pharmacy.

SITUATION 17.1

Scenario:
You are caring for Mrs. Clara Gendron, a 79-year-old patient who had a nasogastric (NG) tube inserted 24 hours agofollowing a stroke. A chest X-ray was previously completed to confirm correct placement. This morning, as you prepare to administer her enteral feeding, you notice that the tape securing the NG tube is missing and the tube appears to have shifted slightly.

There is no documentation of the insertion length, and the patient has been moving frequently in bed. You must now verify that the tube is still correctly placed before proceeding.

Question:
How should the nurse confirm NG tube placement at the bedside before administering the feeding?
a. Request a repeat chest X-ray to confirm correct placement before feeding.
b. Check the black marking at the nostril and compare it to the documented insertion length.
c. Aspirate gastric contents and check the pH to confirm gastric placement.
d. Inject air into the tube and listen over the stomach with a stethoscope for a "whooshing" sound.

SITUATION 17.2

After confirming the correct placement of Mrs. Gendron's nasogastric (NG) tube, you proceed to initiate her enteral feeding. Two hours later, you return to assess her tolerance. You note that the feeding appears to be pooling in the syringe, and the tube seems to have poor flow.

Question:
Which of the following findings most likely indicates that the NG tube has become occluded?
a. Increase in gastric secretions
b. Passing flatus
c. Increased abdominal distention
d. Active bowel sounds

SITUATION 18.1

Scenario:
Mme. Dubois, a 68-year-old woman, has been admitted to the hospital with severe dehydration and gastrointestinal obstruction. The doctor has ordered the insertion of a nasogastric (NG) tube to help decompress her stomach and relieve her symptoms. During the procedure, as the nurse is advancing the NG tube, Mme. Dubois suddenly begins to cough and exhibits difficulty breathing.

Question:
What is the most appropriate action for the nurse to take?
a. Notify the health care provider immediately.
b. Remove the tube and reinsert it when the respiratory distress subsides.
c. Insert the tube quickly.
d. Pull back on the tube and wait until the respiratory distress subsides.

SITUATION 18.2

Scenario:
You have just inserted a nasogastric tube (NGT) to Mme. Dubois. Before starting enteral feeding, you want to ensure that the NGT is correctly positioned.

Question
What should you do next?
a. Check for a return of gastric fluid.
b. Monitor the patient's oxygen saturation. If the nasogastric tube is in the lungs, the patient will desaturate.
c. Request a chest X-ray.
d. Inject air into the tube using a syringe and listen over the stomach.

SITUATION 18.3

Scenario:
Mme. Dubois medical record indicates diagnoses of angina and hypertension controlled with a long-acting medication: dilTIAZem CD (Cardizem CDTM) 120 mg PO daily for the past five years.

The following is an excerpt from her medication administration record:

- Acetaminophen (TylenolTM) 500 mg/tab, 1 000 mg (2 tabs) PO qid via the nasogastric tube - 08:00 12:00 16:00 22:00
- DilTIAZem (CardizemTM) 30 mg/tab, 30 mg (1 tab) PO qid via the nasogastric tube - 08:00 12:00 16:00 22:00
- Dimenhydrinate (GravolTM) 50 mg/mL, 50 mg (1 mL) intravenously q 6 h PRN for nausea or vomiting

At 08:00, you administer Mme. Dubois's medications through the NG tube and she says: "This is not the same medication that I take for my blood pressure at home."

Question:
What is your most appropriate response to the patient?
a. "This medication is only temporary until your condition stabilizes, and then we'll resume your usual medication."
b. "The medication you're receiving is the same but in a different dosage to ensure it works effectively with your NG tube."
c. "Your blood pressure medication was altered to help manage your pain post-surgery."
d. "The long-acting medication was changed so that it could be administered via the NG tube."

SITUATION 19

Scenario:
Marie Dupont, a 45-year-old French national, is admitted to the hospital with severe nausea and vomiting. The registered nurse is preparing to insert a nasogastric (NG) tube to provide relief and facilitate treatment. To ensure the correct placement of the NG tube, the nurse needs to determine the accurate measurement of the length of the tube to be inserted.

Question:
What action should the nurse take?
a. Place the tube at the tip of the nose and measure by extending the tube to the earlobe and then down to the top of the sternum.
b. Mark the tube at 32 inches (81 cm).
c. Place the tube at the tip of the nose and measure by extending the tube to the earlobe and then down to the xiphoid process.
d. Mark the tube at 10 inches (25.5 cm).

SITUATION 20

Scenario:
You are caring for Mr. David Lamontagne, a 68-year-old patient diagnosed with anemia, scheduled to receive a transfusion of two units of packed red blood cells (PRBCs). You have just returned from the blood bank with the first unit.

Your assigned RN colleague is on a scheduled one-hour break and not available. A Licensed Practical Nurse (LPN) is present at the nurses' station and offers to assist with the required double verification before the transfusion.

Question:
Can the LPN verify the blood product with you (the RN) before administration?
a. Yes, the LPN can verify blood products in place of another RN at any time.
b. Yes, because the transfusion must begin within 30 minutes, and no second RN is available.
c. No, only two RNs or an RN and a physician can verify blood products.
d. No, LPNs are never permitted to participate in blood product verification.

SITUATION 21

Scenario:
Pierre Lefevre, a 74-year-old male with a history of congestive heart failure and chronic anemia, started receiving a blood transfusion 45 minutes ago. The nurse enters the room to assess him and notes that Pierre is flushed and dyspneic. Upon further assessment, the nurse auscultates the presence of crackles in the lung bases.

Question:
Mr. Lefevre is most likely experiencing which complication of blood transfusion therapy?
a. Bacteremia
b. Hypovolemia
c. Fluid overload
d. Transfusion

SITUATION 22.1

Scenario:
Marie-Claire Dubois, a 58-year-old patient, is scheduled to receive a blood transfusion following surgery for gastrointestinal bleeding. You are reviewing blood bank supplies and note that the only available unit is AB+.

Question:
Which of the following patients can safely receive AB+ blood?
a. A patient with AB+ blood
b. A patient with B- blood
c. A patient with A- blood
d. A patient with O- blood

SITUATION 22.2

Scenario:
She requires two units of packed red blood cells, and each unit contains 275 mL.

The LPN delivered the first unit at 12:45 PM, and you began the transfusion at 1:00 PM, following protocol to infuse the blood at 60 mL/h for the first 15 minutes to monitor for any transfusion reaction.

By 1:15 PM, there were no adverse reactions, and you are now ready to increase the rate to ensure the first unit is completed by 3:30 PM.

Question:
What should be the adjusted infusion rate (in mL/h) to ensure the transfusion is completed on time?
a. 208 mL/h
b. 160 mL/h
c. 312 mL/h
d. 116 mL/h

SITUATION 22.3

Scenario:
At 1:30 PM, she reports feeling hot and flushed. Shortly after, she begins to experience intense itching, generalized hives (urticaria) on her arms and chest, and mild shortness of breath. Her face appears flushed, and she becomes anxious.

Vital signs:
- Temperature: 38.1°C
- Heart rate: 106 bpm
- Blood pressure: 100/60 mmHg
- Respirations: 24/min
- Oxygen saturation: 94% on room air

Question:
What is the most appropriate action at this time?
a. Notify the doctor
b. Stop the transfusion
c. Continue the transfusion
d. Retake the vital signs in 15 minutes

SITUATION 22.4

Scenario:
The following medical orders are in the chart:
- Diphenhydramine 25 mg IV PRN for allergic symptoms
- Acetaminophen 650 mg PO PRN for fever
- Notify physician for any transfusion reaction
- Send blood product and tubing to the lab if a reaction is suspected
- Collect urinalysis and serum hemolysis panel if needed

Question:
What is your next priority intervention?
a. Administer diphenhydramine 25 mg IV PRN
b. Draw CBC and type & screen
c. Notify the physician
d. Do urinalysis and serum hemolysis panel

SITUATION 23

Scenario:
You are caring for Mr. Thomas Leclerc, a 62-year-old patient recovering from abdominal surgery complicated by long-standing type 2 diabetes mellitus and peripheral neuropathy. Despite receiving hydromorphone (Dilaudid) IV every 4 hours for the past 24 hours, he continues to complain of burning, tingling pain in his lower legs and feet, rated 8/10, especially at night.

Upon assessment, you note that the pain has a shooting, electric quality, consistent with neuropathic pain, which does not respond well to opioids alone.
You review the current post-op medication orders, which include:

- Hydromorphone (Dilaudid) 1 mg IV q4h PRN
- Acetaminophen (Tylenol) 650 mg PO q6h scheduled

Question:
Which additional medication (s) would you expect the doctor will prescribe to better manage his pain? Choose two answers.
a. NSAIDs
b. Fentanyl
c. Gabapentin
d. Amitriptyline

SITUATION 24.1

Scenario:
Mr. Robert Harris, a 72-year-old male, is admitted for an exploratory laparotomy under general anesthesia. His medical history includes:

- Hypertension (well-controlled with medication)
- Stable type 2 diabetes mellitus
- Chronic kidney failure
- Obstructive sleep apnea (OSA)

Following surgery, you are preparing his Therapeutic Nursing Plan (TNP).

Question:
What is the priority problem to address in Mr. Harris's Therapeutic Nursing Plan (TNP)?
a. Risk of pressure injury
b. Risk of hyperglycemia
c. Risk of hypoglycemia
d. Risk of respiratory depression

SITUATION 24.2

Scenario::
One hour post-op, the nurse finds Mr. Harris:

- Unresponsive to verbal stimuli, arousable only to painful stimulation
- Respiratory rate: 8 breaths/minute
- Shallow breathing
- Pulse oximeter: 88% on 2L nasal cannula
- Skin: Cool and slightly pale
- No airway obstruction visible
- Snoring has stopped, but breathing is minimal

You review the postoperative medical orders, which include:

- Hydromorphone (Dilaudid) 1 mg IV q4h PRN for pain
- Naloxone (Narcan) 0.1 mg IV PRN for signs of respiratory depression
- Oxygen 2–4 L/min via nasal cannula PRN
- Vital signs q15min for 2 hours post-op

Question:
What is your first nursing action?
a. Administer naloxone (Narcan) 0.1 mg IV as prescribed
b. Call the anesthesiologist STAT
c. Increase the oxygen flow rate to 4 L/min

SITUATION 25.1

Scenario:
M. Jean-François Lemoine, a 74-year-old patient, has just returned to the post-anesthesia care unit (PACU) following an abdominal laparotomy under general anesthesia. He is receiving intravenous fluids and has a patient-controlled analgesia (PCA) pump for postoperative pain management.
One hour post-op, your nursing assessment reveals:

- Pain severity: 2/10
- Level of consciousness: Drowsy
- SpO2: 94% on room air
- Respiratory rate: 10 breaths/minute, shallow and with occasional pauses
- Blood pressure: 128/72 mm Hg
- Heart rate: 78 bpm, regular

Question:
What is the priority nursing intervention before leaving M. Lemoine's room?
a. Take the PCA button away from the patient
b. Increase the oxygen flow rate
c. Encourage the patient to use the incentive spirometer
d. Administer naloxone as per protocol

SITUATION 25.2

Scenario:
Two days after the surgery, the PCA is replaced with a prescription for hydromorphone (Dilaudid) 1mg/tab, 1 tab PO q 3-4 h PRN and acetaminophen 325 mg/tab, 2 tabs PO q4-6h PRN. In the evening, Mr. Lemoine says that the last time he took the acetaminophen was in the morning and that it didn't give him much relief. He rates his pain at 5/10 right now and asks for an analgesic.

Question:
What other information must you collect to assess the effectiveness of the medication Mr. Lemoine has taken in the last 8 hours?
a. The frequency and duration of his pain episodes
b. How often he has taken the acetaminophen
c. The presence of any side effects such as nausea or dizziness
d. The exact time he took his last dose of hydromorphone

SITUATION 25.3

Scenario:
Mr. Lemoine has expressed a preference to avoid taking the prescribed opioid (hydromorphone). He reports that acetaminophen taken in the morning did not provide sufficient relief, and his current pain level is 5/10. You need to recommend a strategy for managing his pain without using the opioid medication.

Question:
Given that Mr. Lemoine refuses to take the prescribed opioid, what recommendation will you give him to help manage his pain better?
A. Use cold packs on the surgical site every hour.
B. Take the acetaminophen q 4-6 h regularly to maintain optimal serum levels.
C. Increase physical activity to distract from the pain.
D. Wait until the pain becomes severe before taking acetaminophen.

SITUATION 25.4

Question:
What do you reply when Mr. Lemoine's ex-wife calls to ask when he will be discharged?
a. "I'm sorry, but I can't share that information due to patient confidentiality."
b. "He is doing well, and we expect him to be discharged soon."
c. "He should be discharged in the next few days, but I can't give an exact date."
d. "I'll transfer you to Mr. Lemoine's room so you can speak with him directly."

SITUATION 26

Scenario:
Mrs. McDonald is diagnosed with a femoral head fracture. The surgery is scheduled for tomorrow morning.

At 13:15, during your assessment, you observe that Mrs. McDonald is in unbearable pain and that she says she is worried about the surgery tomorrow.

You consult the excerpt from her medication record:

- Hydromorphone (Dilaudid®) 1 mg/tab., 1 mg (1 tab.) PO q 3 h
  - Given at 9:00 and 12:00
- Acetaminophen (Tylenol®) 500 mg/tab. 500 mg (1 tab.) PO q 4 h PRN for pain or fever
  - Given at 9:00
- Hydromorphone (Dilaudid®) 2 mg/mL, 0.25 mg (0.125 mL) SC q 4 h PRN for pain
- Lorazepam (Ativan®) 0.5 mg/tab., 0.5 mg (1 tab.) SL q 6 h PRN for anxiety or insomnia

Question:
Which medication(s) will you administer?
a. Acetaminophen PO.
b. Hydromorphone PO.
c. Hydromorphone SC.
d. Lorazepam SL.

SITUATION 27

Scenario:
Mr. Julien Martel, a 63-year-old patient, underwent endoscopic carpal tunnel release surgery today to relieve symptoms of carpal tunnel syndrome. The procedure was completed under local anesthesia without any complications.

He is awake, alert, and stable. His surgical dressing is clean and dry, and he has tolerated fluids postoperatively. As discharge preparations are underway, his wife approaches you and asks:
"He still hasn't peed since the surgery. Are we really allowed to go home like this?"

Question:
What is the best response?
a. "No, he cannot leave until he urinates. Urinary retention is always a concern after any surgery."
b. "Yes, it's generally safe to go home after local anesthesia, even if he hasn't urinated yet, unless he feels discomfort."
c. "Let me call the doctor. If he hasn't voided yet, we may need to delay discharge."
d. "We should insert a urinary catheter before discharge to prevent complications at home."

SITUATION 28.1

Scenario:
Ms. Cloutier, 68 years old, was admitted to the surgical unit following left hip arthroplasty. She was diagnosed with severe osteoarthritis in the shoulders and hips five years ago.

At 12:00, when she returns from the post-anesthesia care unit (recovery room), Ms. Cloutier grimaces and moans. She says that she does not have any pain in her left hip. Her neurovascular signs are appropriate, her dressing on the left hip is clean and the urinary catheter is draining straw-coloured fluid. Her intravenous solution is infusing at 80 mL/h.

Her vital signs are:

- BP: 135/80 mmHg;
- P: 99 beats/min., rhythm regular;
- R: 22 breaths/min., rhythm regular, depth normal;
  SpO2: 95%;
- T: 36.2°C.

Her medical record contains the following prescription:

- Epidural analgesia at a flow rate of 10 mL/h. If the pain is greater than 4/10, increase the flow rate by 2 mL/h q 1 h. The maximum flow rate is at 14 mL/h.

You continue your assessment.

Question:
What are you evaluating?
a. Sedation level
b. Body alignment
c. Shoulder pain
d. Breath sounds

SITUATION 28.2

Scenario:
At 15:00, Ms. Cloutier says that she has had a non-radiating burning pain rated at 6/10 in her left hip for the past twenty minutes.

You complete the follow-up sheet for the epidural analgesia.

- 14:00 - BP: 135/80 mmHg - P: 99/min. - R: 22/min. - SpO2: 95% - O2: None - Pain: 0/10 - Motor block (Bromage Scale): 0
- 15:00 - BP: 130/80 mmHg - P: 88/min. - R: 18/min. - SpO2: 96% - O2: None - Pain: 6/10 - Motor block (Bromage Scale): 0

Bromage Scale Legend:
0 = Full flexion of knee and foot, 1 = Just able to move knee, 2 = Able to move foot only, 3 = Unable to move knee and foot.

Question:
What are you checking?
a. The presence of sensory block in the lower limbs
b. The insertion site of the epidural catheter
c. The patency of the peripheral intravenous catheter
d. The analgesia received in the recovery room

SITUATION 28.3

Scenario:
The next day, during the change-of-shift report, your colleague says that the epidural analgesia flow rate was increased to 14 mL/h during the night and that Ms. Cloutier is well relieved.

At 08:30, Ms. Cloutier has a score of 3 on the Bromage Scale.

Her vital signs are:

- BP: 106/70 mmHg;
- P: 72 beats/min., rhythm regular;
- R: 14 breaths/min., rhythm regular, depth normal; SpO2: 95%;
- T: 37.8°C.

Bromage:

- **0** = Observe hourly for first 4 hours, then every 4 hours
- **1** = Contact pain service/physician/anesthesiologist for patient assessment and order review
- **2** = Stop infusion and contact pain service/physician/anesthesiologist
- **3** = Stop infusion and contact pain service/physician/anesthesiologist

Question:
What will you do?
a. Assess neurovascular sign
b. Notify the anesthesiologist
c. Stop the epidural analgesia
d. Perform a sensory block assessment

SITUATION 28.4

Scenario:
The epidural analgesia was discontinued yesterday afternoon, as prescribed. Today, at 07:45, Ms. Cloutier says that she has a burning pain rated at 4/10 in her left hip and a shooting pain rated at 2/10 in her shoulders. You consult the excerpt from Ms. Cloutier's medication administration record as well as her therapeutic nursing plan (TNP).

YESTERDAY

- Acetaminophen (TylenolTM) 325 mg/tab, 650 mg (2 tabs) PO qid - GIVEN AT = 8:00, 12:00, 18:00, 22:00
- ENOXAparin (LovenoxTM) 100 mg/mL, 40 mg (0.4 mL) subcutaneously daily - GIVEN AT = 10:00
- Pregabalin (LyricaTM) 150 mg/caps, 150 mg (1 caps) PO at bedtime - GIVEN AT = 22:00
- Morphine sulfate (MS ContinTM) 15 mg/tab, 15 mg (1 tab) PO bid - GIVEN AT = 08:00, 20:00
- Morphine sulfate (StatexTM) 5 mg/tab, 5 mg (1 tab) PO q 4 h PRN for pain - GIVEN AT = 16:00, 20:00, 23:50
-

TODAY

- Acetaminophen (TylenolTM) 325 mg/tab, 650 mg (2 tabs) PO qid - TIME OF ADMINISTRATION = 8:00, 12:00, 18:00, 22:00
- ENOXAparin (LovenoxTM) 100 mg/mL, 40 mg (0.4 mL) subcutaneously daily - TIME OF ADMINISTRATION = 10:00
- Pregabalin (LyricaTM) 150 mg/caps, 150 mg (1 caps) PO at bedtime - TIME OF ADMINISTRATION = 22:00
- Morphine sulfate (MS ContinTM) 15 mg/tab, 15 mg (1 tab) PO bid - TIME OF ADMINISTRATION = 08:00, 20:00
- Morphine sulfate (StatexTM) 5 mg/tab, 5 mg (1 tab) PO q 4 h PRN for pain

THERAPEUTIC NURSING PLAN

Priority problem or need:

1. Left hip arthroplasty
2. Unrelieved pain in left hip

Nursing directive

1. Routine follow-up for left hip arthroplasty
2. Administer StatexTM 5 mg PO q 4 h regularly for 12 h

Question:
Which medication (s) will you administer?
a. MS Contin
b. Tylenol
c. Statex
d. Pregabalin
e. ENOXAparin
f. Advil

SITUATION 29.1

Scenario:
Mr. Desjardin, a 68-year-old male patient, has just returned to the nursing unit after undergoing an above-knee amputation (AKA) of his right leg due to complications from peripheral artery disease. The surgery was completed without complications, and he is now in the recovery phase. As he arrives on the unit,

he was transfered from the stretcher to his hospital bed.

Question:
You should place the patient in which position?
a. Prone
b. Supine, with the residual limb supported with pillows
c. Reverse trendelenburg's
d. Supine, with the residual limb flat on the bed

SITUATION 29.2

Scenario:
He has been healing well and receiving daily care, including physical therapy and emotional support. During your morning assessment, he tells you:
"My leg feels a bit swollen. I'd like to elevate my limb to help reduce the swelling. Is that okay?"

Question:
As the nurse, what is the most appropriate response?
a. Yes, elevating the residual limb is always encouraged after amputation.
b. No, elevating the limb is contraindicated due to the risk of impaired circulation.
c. Yes, elevating the limb at any time is safe to reduce edema and promote healing.
d. No, because elevation may cause flexion contractures and should be avoided during the recovery period.

SITUATION 29.3

Scenario:
Later in the day, as part of the care plan, you encourage Mr. Desjardins to lie in a prone position (on his stomach) for short periods several times a day. He looks puzzled and asks:

"Why do I need to lie on my stomach? It's not comfortable for me."

You explain, "Lying on your stomach can be very beneficial for your recovery."

Question:
Which statement is your most appropriate response?
a. "Lying on your stomach will help prevent contractures."
b. "Many times this will help decrease pain in the limb."
c. "This position will help your lungs expand better."
d. "The position will take pressure off your backside."

SITUATION 29.4

Scenario:
His postoperative pain has been moderately well controlled, but today he reports a burning, stabbing pain in the missing limb, especially when trying to rest.

You review his medication record, which includes:
- Gabapentin (Neurontin) 300 mg PO tid
- Acetaminophen + Codeine (Atasol 30) 1–2 tabs PO q4h PRN

However, Mr. Desjardin tells you:
"I've been skipping the gabapentin. I don't have epilepsy, so I don't think I need it."

Question:
What is the most appropriate response to help Mr. Desjardin understand the role of gabapentin in his care?
a. "It's best to take all medications prescribed after surgery, even if you don't know what they're for."
b. "Gabapentin prevents seizures that can sometimes occur after surgery."
c. "Gabapentin helps relieve nerve pain like the one you're describing in your missing limb."
d. "That medication is used for sleep. It might help you rest better after surgery."

SITUATION 29.5

Scenario:
During your shift, the physiotherapist suggests introducing mirror box therapy as part of his rehabilitation program.

Mr. Desjardin looks confused and asks:
"How is looking in a mirror supposed to help the pain in a leg I don't even have?"

Question:
What is the most appropriate explanation to give Mr. Desjardin about the purpose of the therapy?
a. "It helps strengthen the opposite leg by increasing brain coordination."
b. "It helps train your brain to forget that the missing limb is still in pain."
c. "It distracts you from the discomfort using visual stimulation."
d. "It teaches you how to transfer without the help of assistive devices."

SITUATION 30

Scenario:
Mrs. Gagnon, 54, had a vaginal hysterectomy earlier today. At 18:30, she appears pale and anxious, reports severe lower abdominal pain (8/10), dizziness, and weakness. Her lower abdomen is firm and distended. The surgical dressing shows minimal bleeding.

Vital signs:
- BP: 88/54 mmHg
- P: 124 bpm, weak
- R: 24/min
- SpO2: 94% on room air
- T: 37.2°C

Question:
What do you suspect is happening, and what is your immediate nursing intervention?
a. Reaction to anesthesia; administer naloxone
b. Urinary tract infection; encourage fluids
c. Internal hemorrhage; notify the physician immediately
d. Anxiety due to pain; offer lorazepam

SITUATION 1

A. Apply Steri-Strips to approximate the wound edges and reinforce with a clean dressing.

Applying Steri-Strips helps approximate the wound edges, promoting healing. Covering the area with a clean dressing provides a barrier against contamination and supports a sterile environment. This action addresses the immediate concern of wound separation. While notifying the physician is necessary, immediate intervention to secure the wound is the priority.

While advising activity modification is essential for wound healing, it is not the immediate priority. Once the wound is managed, you should educate the patient about avoiding strenuous activities such as lifting heavy objects (e.g., children).

Leaving the wound open to air increases the risk of contamination and infection. Proper wound care with sterile techniques is necessary to protect the wound and facilitate healing.

SITUATION 2

B. Cover the wound with sterile saline-moistened gauze and notify the surgeon.

The patient is likely experiencing wound dehiscence or evisceration, a serious surgical complication. The priority is to protect the exposed tissue or organs by immediately covering the wound with sterile saline-moistened gauze, which keeps the tissues moist and reduces the risk of infection or further trauma. Prompt notification of the surgical team is essential to arrange for emergency management.

Although lying the patient flat, reassuring them, and checking vital signs are appropriate supportive interventions, they should follow the immediate protective action.

Applying direct pressure is contraindicated, as it can cause damage to the exposed organs or worsen the wound opening.

SITUATION 3

A. Instruct the client to splint the wound with a pillow when coughing

Postoperative pain during coughing and deep breathing is common after thoracic surgery due to the location and sensitivity of the incision. Teaching the client to splint the incision with a pillow provides support to the surgical site, reducing discomfort and encouraging effective coughing and deep breathing—both critical for preventing complications such as atelectasis and pneumonia.

Although pain assessment and medication may also be appropriate, splinting is a non-pharmacologic, immediate intervention that empowers the patient and enhances respiratory function.

Placing the client supine and inspecting the wound is not the priority unless there are signs of wound complications.

There is no indication of wound dehiscence, so notifying the provider immediately would be premature.

SITUATION 4

A. Remove the binder to change the abdominal dressing as prescribed and reapply it afterward

The correct approach is to remove the abdominal binder temporarily to perform a sterile dressing change as prescribed, ensuring full access to the incision site. Once the dressing change is complete, the binder should be reapplied properly to maintain abdominal support and promote healing.

Slipping the dressing under the binder or loosening it without full removal compromises wound assessment, sterility, and proper dressing placement.

Changing only the outer layer is inappropriate unless specifically directed, as it can lead to retained moisture, bacterial growth, or undetected complications.

SITUATION 5

C. Reduce stress on the abdominal incision

An abdominal binder is commonly used postoperatively to support the abdominal muscles and incision, especially during movements like coughing, deep breathing, turning, or getting out of bed. It helps reduce mechanical stress on the surgical site, promoting wound healing and reducing the risk of dehiscence.

While a binder may offer secondary benefits such as increased comfort or support during breathing, its primary purpose is mechanical support of the incision site. It does not directly promote blood flow, nor does it eliminate the need for appropriate wound care and dressing changes.

SITUATION 6.1

D. Maintain elevation of the head of bed at 30–45 degrees

Following bariatric surgery, patients are at increased risk for postoperative nausea, vomiting, and aspiration. Elevating the head of the bed to 30–45 degrees helps facilitate gastric emptying and protects the airway by reducing the risk of aspiration in the event of vomiting. This position also promotes respiratory function by allowing better chest expansion. Keeping the patient flat or at a low angle increases aspiration risk. The lateral position is not contraindicated but is not the standard initial positioning unless specifically

indicated.

Elevation to 30–45 degrees is the priority intervention for airway protection and complication prevention in the immediate postoperative period.

SITUATION 6.2

C. Dumping syndrome

Dumping syndrome is a common complication following bariatric or gastric surgery, caused by rapid emptying of food into the small intestine, especially if the meal is high in sugar or consumed too quickly. It typically occurs within 15 to 30 minutes after eating and presents with:

- Tachycardia
- Diaphoresis
- Abdominal cramping
- Nausea and diarrhea
- Feeling faint or lightheaded

These symptoms match Mr. Bouchard's presentation.

- Hypoglycemia (a) may cause similar symptoms but typically occurs 1–3 hours post-meal, not immediately.
- Bowel obstruction (b) would present with abdominal distension, vomiting, and absence of bowel movements, not flushing and tachycardia.
- Anastomotic leak (d) would likely involve fever, severe abdominal pain, and signs of sepsis, which are not evident here.

SITUATION 6.3

A. "A high protein diet that is low in carbohydrates and fat will prevent diarrhea."

After bariatric surgery, it is essential for patients to follow a high-protein, low-carbohydrate, low-fat diet to promote healing, maintain muscle mass, and prevent dumping syndrome or gastrointestinal complications such as diarrhea and nausea. Protein is vital for tissue repair, and reducing sugar and fat helps minimize intolerance and malabsorption symptoms.
High-fiber foods are not immediately recommended post-op, as they can be difficult to digest in the early recovery phase and may cause gas or bloating.
Eating three meals a day without snacks can lead to inadequate nutrient intake—small, frequent meals are typically recommended instead.
Finally, fluids should be sipped between meals, not during, to avoid overfilling the stomach and to reduce the risk of vomiting or dumping syndrome. Drinking large volumes with meals is contraindicated.

SITUATION 7.1

A. Document the findings as normal for a healing surgical incision

Slight puffiness around a surgical incision is expected in the early postoperative period as part of the normal inflammatory healing response. The absence of redness, drainage, increased pain, or fever, along with a normal WBC count, supports the interpretation that there are no signs of infection.
Notifying the provider or obtaining a culture is unnecessary and premature without evidence of infection (e.g., redness, warmth, purulent discharge, elevated WBC, or fever).
Marking the area may be appropriate if swelling is excessive or worsening—but in this case, it is mild and expected.
Empiric antibiotics should never be started without indication or provider order, especially in the absence of clinical infection.

SITUATION 7.2

A. Administer morphine 2 mg IV as prescribed and reassess the pain response

Mr. Gagnon is experiencing sternotomy-related incisional pain, which is sharp, localized, rated 6/10, and aggravated by movement or coughing—classic signs of post-surgical musculoskeletal pain. Since the pain is moderate, the nurse should follow the medical order to give morphine, then reassess his response.
Opioids are effective for incisional pain because they target nociceptive pain resulting from surgical trauma.
In contrast, angina pain is often described as pressure-like, squeezing, or burning, sometimes radiating to the arm or jaw, relieved by rest or nitroglycerin, and unrelated to movement. These features are absent in Mr. Gagnon's report.
Option b (nitroglycerin) would be appropriate if the pain resembled ischemia, but this is not the case.
Option c (notify HCP immediately) is unnecessary at this stage since the pain appears musculoskeletal and a medication order already exists.
Option d (ambulate the patient) may increase pain and does not help differentiate the cause, and could compromise patient comfort and safety.

SITUATION 8

A. Advise to use contraceptive measures during treatment
B. Do not obtain live vaccinations

Azathioprine is teratogenic, so patients of childbearing potential must be advised to use effective contraception during treatment.
Additionally, both cyclosporine and azathioprine suppress the immune system, making live vaccines contraindicateddue to the risk of vaccine-induced illness. Also, Avoidance of crowds will decrease the clients chance of contact with infections, especially those spread by droplets.
While staying hydrated is generally a good practice, monitoring urine for sediment is not specific or prioritized for this medication.
Option d is incorrect because cyclosporine may cause hyperkalemia, and increasing potassium-rich foods could exacerbate this risk, not prevent cramps.
Cyclosporine may cause growth of extra tissue in your gums so visit a dentist regularly and use a soft-bristled brush.

SITUATION 9.1

C. Two rubber-tipped clamps, petroleum gauze, sterile 4x4s, sterile water, and tape

When transporting a patient with a chest tube, the nurse must be prepared for accidental dislodgement or disconnectionof the chest drainage system. The essential emergency supplies include:

- Two rubber-tipped clamps: to temporarily clamp the chest tube if needed
- Petroleum gauze and sterile 4x4s: to seal the insertion site immediately if the tube is accidentally pulled out
- Sterile water or saline: to submerge the open chest tube if it disconnects, maintaining a temporary water seal
- Tape: to secure any emergency dressings

These items help prevent tension pneumothorax and support quick response to an emergency.
The other options (a, b, and d) include general medical equipment, but they do not directly address chest tube safety during transport.

SITUATION 9. 2

C. Place the drainage system below the level of the chest to allow proper drainage.

To maintain effective drainage and prevent backflow of fluid or air into the pleural space, the chest tube drainage system must always be kept below the level of the chest during transport. This position relies on gravity to facilitate the removal of air and fluid from the pleural cavity and prevents complications such as pneumothorax or infection.

- Option a is incorrect because elevating the drainage system above chest level increases the risk of fluid backflowinto the pleural space.
- Option b is incorrect—clamping a chest tube is contraindicated unless specifically ordered or in certain emergencies (e.g., tube disconnection), as it may cause a tension pneumothorax.
- Option d is unsafe—disconnecting the system exposes the pleural space to atmospheric air, which can lead to lung collapse or infection.

SITUATION 9.3

D. Tape a petroleum jelly occlusive dressing on three sides to the insertion site.

The immediate priority when a chest tube is accidentally removed is to prevent air from being sucked into the pleural space, which could lead to a tension pneumothorax. The nurse should apply a petroleum jelly dressing (occlusive) and tape it on three sides only—this acts as a flutter valve, allowing air to escape but not re-enter the pleural space. This temporarily restores a seal until the chest tube can be reinserted.

- Option a (notify the physician) is important but comes after the emergency dressing is applied to stabilize the patient.
- Option b (shallow breathing) may help limit air movement but does not address the open chest wall, and is insufficient alone.
- Option c (taking no action) is unsafe—delayed intervention can result in respiratory distress or collapse.

SITUATION 10

C. No, you will swab the patient's stoma.

After rectosigmoid resection, the stoma is the correct site for sampling to detect VRE colonization, as it represents the current flow of gastrointestinal contents.

SITUATION 11

B. The stoma is located in the small intestine, which results in liquid stools.

The reason your stools are liquid is that your stoma is located in the small intestine. In the small intestine, the waste has not yet had the chance to travel through the colon where water is absorbed, which would normally make the stool more solid. This is a typical result of an ileostomy, and it's completely normal for your situation.

SITUATION 12

D. Eat cheddar cheese.

Cheddar cheese is a low-fiber food that is generally well-tolerated by individuals with an ileostomy. It provides a good source of protein and calcium, making it a suitable snack option for someone needing to maintain energy levels while running.

SITUATION 13

C. Petroleum gauze dressing.

A petroleum gauze dressing is appropriate in this situation as it provides a moist environment that can promote healing and protect the stoma from drying out. This type of dressing allows for drainage while ensuring that the area remains covered and helps to prevent irritation.

SITUATION 14.1

C. Hold the medication and notify the doctor the patient has an ileostomy.

Enteric-coated (EC) medications are designed to dissolve in the small intestine, not the stomach, to prevent gastric irritation.

SITUATION 14.2

D. The opening of the barrier should be 1/8 to 1/4 inch larger than the stoma to avoid skin damage.

When cutting the wafer or skin barrier for an ileostomy, it is critical to leave a margin of 1/8 to 1/4 inch around the stoma. This ensures the stoma has room to expand slightly and prevents the barrier from rubbing or putting pressure on the delicate stoma tissue, which

could cause injury or necrosis. At the same time, a properly sized barrier helps protect the surrounding peristomal skin from exposure to drainage, which is especially important for ileostomies because the output is more liquid and enzyme-rich.

- Option a (exact size) can cause the wafer to rub against the stoma and lead to tissue damage.
- Option b (½ inch space) leaves too much exposed skin, increasing the risk of irritation and leakage.
- Option c (smaller than the stoma) risks cutting off circulation and injuring the stoma.

SITUATION 14.3

c. Notify the physician immediately due to signs of stoma ischemia.

A purple, bluish, or black-tinged stoma is an alarming sign of impaired blood flow, indicating stomal ischemia or necrosis. This is a surgical emergency and requires immediate notification of the healthcare provider. Time is critical to prevent full tissue death or systemic complications.

- Option a (warm compresses) is not appropriate—this is not a superficial circulation issue and delays urgent care.
- Option b is incorrect—a healthy stoma should be moist and pink to red, never purple or dusky.
- Option d (irrigation) is contraindicated—no fluid should be introduced into the stoma unless specifically ordered, and it will not improve vascular supply.

SITUATION 15.1

B. Continue to monitor the drainage

It is expected to see a moderate amount of bloody drainage from the NG tube during the first 6–12 hours post–total gastrectomy. This results from surgical trauma and the healing process. The appropriate nursing action is to closely monitor the amount, color, and consistency of the drainage, along with the patient's vital signs and overall condition.

- Option a (irrigating the NG tube) is contraindicated in recent gastric surgery unless specifically ordered, as it can disrupt surgical sites.
- Option c (repositioning) may risk injury to the anastomosis or stomach bed and should not be done without physician guidance.
- Option d (measuring abdominal girth) is more appropriate for monitoring suspected gas retention, distension, or obstruction, not routine postoperative assessment in the absence of abdominal changes.

SITUATION 15.2

D. Aspirate the NG tube gently to check for gastric contents or resistance.

Before notifying the provider, the nurse should perform a focused assessment to evaluate the current function of the NG tube. Aspirating the tube is a safe, non-invasive action to determine whether the tube is still functioning, if there is return of gastric drainage, or if there's resistance indicating the tube may be kinked or misplaced. This information will help the physician make decisions about further management.

- Option a (repositioning) is unsafe in a post-gastrectomy patient—manipulating the tube could damage the surgical site.
- Option b (pushing it back in) is dangerous and strictly contraindicated, especially after GI surgery, due to risk of perforation or anastomotic disruption.
- Option c (securing it as-is) may prevent further movement but fails to assess tube function, which is the immediate priority.

SITUATION 15.3

A. Call the physician; get an order to remove the feeding tube and insert a new feeding tube in the opposite naris.

In a patient with nasal irritation or skin breakdown from an NG tube, the best course of action is to relieve pressure from the affected site by inserting the tube in the opposite naris, provided it is patent. However, NG tube insertion—especially for feeding—requires a physician's order, so the nurse must notify the provider first before taking action.

- Option b is inappropriate because it assumes autonomous reinsertion, which is outside the nurse's scope without a provider order, especially for feeding tubes.
- Option c (antibiotic ointment) does not address the pressure injury caused by the tube and may worsen skin maceration.
- Option d (pain meds and stopping feeds) is inappropriate as it interrupts nutrition without a clinical justification or medical directive.

SITUATION 15.4

C. Provide frequent mouth care

Patients with NG tubes are prone to oral dryness and mucosal irritation because they are often NPO and cannot maintain moisture naturally through eating or drinking. The best intervention is to perform frequent mouth care using swabs or gentle rinses to maintain moisture, remove debris, and improve comfort.

- Option a (throat lozenges) is not appropriate for patients who are NPO or at risk of aspiration.
- Option b (petroleum jelly) should be used with caution; if used near the tube site, it may soften adhesive or cause skin irritation—water-soluble lubricants are preferred.
- Option d (sucking on ice chips) may be contraindicated post-gastrectomy or if the patient is NPO.

SITUATION 16.1

C. Mr. Badour, you must feel very angry about your situation.

This is a moment of emotional crisis. Mr. Badour is showing signs of frustration, grief, and possible

depression related to his new colostomy and his wife's absence. The priority nursing response is to acknowledge and validate the patient's feelings using therapeutic communication.

- Option a (about handling the ostomy carefully) is factual but dismisses his emotional distress, which must be addressed first before education.
- Option b attempts to support him long term, but still misses the opportunity to reflect his present emotional state, which is essential for trust-building and crisis de-escalation.
- Option c is the only option that shows empathy and emotional presence, helping the patient feel heard and supported.

SITUATION 16.2

B. Coping strategies used in the past

At this stage, Mr. Badour is expressing a desire for autonomy, but he also shows anxiety and uncertainty about managing his new condition. Before jumping into technical teaching, it's important to understand how he typically copes with challenges and major life changes. This helps you tailor your support and teaching plan to his psychological readiness and emotional strengths.

- Option a (past aggression) is not relevant here; he has shown no ongoing behavioral issues—his initial anger was a normal emotional reaction to surgery and loss.
- Option c (ability to perform ostomy care) is important, but must come after assessing coping—you need to know how he deals with stress and adapts before focusing on skill performance.

SITUATION 16.3

C. He demonstrates how to clean and change his ostomy pouch with minimal assistance.

The best indicator of discharge readiness for a patient with a new colostomy is the ability to safely perform essential self-care tasks, especially ostomy care. Mr. Badour must be able to demonstrate, not just discuss, how to manage his stoma, clean the area, apply a new pouch, and recognize signs of complications. This shows both practical and emotional readiness.

- Option a is emotionally understandable, but doesn't prove discharge readiness.
- Option b shows dependence and may be a red flag for inadequate self-care preparation.
- Option d demonstrates product knowledge, but not actual care competency.

SITUATION 17.1

C. Aspirate gastric contents and check the pH to confirm gastric placement.

When the NG tube's external position appears compromised (e.g., tape is off, no insertion length documented), the safest and most reliable bedside method to verify placement before feeding is to aspirate gastric contents and check the pH. A gastric pH of ≤5.5 typically confirms that the tube is still in the stomach.

- Option a (repeat chest X-ray) may be necessary if bedside confirmation is not possible, but it is not the first-line nursing intervention unless signs of displacement or aspiration are present.
- Option b (checking the black marking) is helpful only if the original insertion length is known and documented—it does not confirm internal placement alone.
- Option d (the "whoosh" test) is outdated and no longer recommended due to its inaccuracy and potential to misidentify placement in the lungs.

SITUATION 17.2

C. Increased abdominal distention

Increased abdominal distention is a classic sign of NG tube occlusion, as it suggests that gastric contents or feeding are not draining or passing properly. This may lead to discomfort, bloating, and even risk of aspiration if not resolved. An occluded tube may prevent both decompression and feeding delivery.

- Option a (increase in gastric secretions) may occur in many GI conditions, but it's not specific to occlusion.
- Option b (passing flatus) indicates return of bowel function, which is a positive sign.
- Option d (active bowel sounds) also suggests intestinal activity, not obstruction or occlusion.

SITUATION 18.1

D. Pull back on the tube and wait until the respiratory distress subsides.

During the insertion of a nasogastric tube, if the client experiences difficulty breathing or any respiratory distress, withdraw the tube slightly, stop the tube advancement, and wait until the distress subsides. It is not necessary to notify the health care provider immediately or remove the tube completely. Quickly inserting the tube is not an appropriate action because, in this situation, it is likely that the tube has entered the bronchus.

SITUATION 18.2

A. Request a chest X-ray.

This is the correct and most reliable method for confirming the placement of a nasogastric tube. A chest X-ray provides a clear image showing whether the tube is correctly positioned in the stomach and not in the lungs or another incorrect location.

Ensuring the correct placement of a nasogastric tube is crucial before initiating enteral feeding to prevent complications such as aspiration pneumonia or feeding into the lungs.

Monitor the patient's oxygen saturation. If the nasogastric tube is in the lungs, the patient will desaturate. This option is incorrect because while desaturation can occur if the tube is misplaced, it is not

a reliable method to confirm the placement of an NGT. Inject air into the tube using a syringe and listen over the stomach. This option is not recommended as the primary method of verification because it is less reliable and can be misleading. The auscultation method can sometimes incorrectly suggest the tube is in the stomach even if it is in the respiratory tract.

SITUATION 18.3

D. "The long-acting medication was changed so that it could be administered via the NG tube."

The long-acting dilTIAZem CD (Cardizem CDTM) 120 mg, which Ms. Sansoucy was taking before admission, is not suitable for administration via an NG tube because it cannot be crushed or altered without risking the loss of its extended-release properties. To ensure safe administration through the NG tube, the healthcare team switched to a short-acting form of dilTIAZem (30 mg PO qid). This change allows the medication to be given via the NG tube while still managing Ms. Sansoucy's hypertension. Explaining this adjustment helps address her concerns and ensures she understands the reasons for the modification in her treatment.

SITUATION 19

C. Place the tube at the tip of the nose and measure by extending the tube to the earlobe and then down to the xiphoid process.

The correct method for measuring the length of an NG tube to be inserted involves placing the tube at the tip of the nose, extending it to the earlobe, and then down to the xiphoid process. This measurement ensures that the tube reaches the stomach, where it needs to be for effective decompression or feeding. Marking the tube at 10 inches (25.5 cm) or 32 inches (81 cm) would not provide an accurate measurement for proper placement in an adult. Measuring to the top of the sternum would also be incorrect, as it would not ensure the tube reaches the stomach. By using the nose-earlobe-xiphoid process method, the nurse can accurately measure the length needed for proper NG tube placement.

SITUATION 20

B. Yes, because the transfusion must begin within 30 minutes, and no second RN is available.

Although blood product verification is typically performed by two RNs, the OIIAQ allows an LPN to assist in this process when no second RN is available, particularly in time-sensitive situations. In this case, the 30-minute windowto begin the transfusion justifies involving the LPN to prevent delay and preserve the integrity of the blood product.
This practice should always be documented, and the LPN must be competent and authorized within their scope to assist in the verification. The RN remains responsible for overall transfusion management and monitoring.

- Option a is incorrect—routine substitution is not allowed.
- Option c ignores the flexibility provided in urgent/time-sensitive cases.
- Option d is false under current OIIAQ guidance.

SITUATION 21

C. Fluid overload

Fluid overload, also known as transfusion-associated circulatory overload (TACO), occurs when the circulatory system becomes overwhelmed by the volume of fluid being transfused. This condition is more likely in patients with pre-existing heart conditions, such as congestive heart failure. Symptoms of fluid overload include dyspnea, orthopnea, elevated blood pressure, tachycardia, and the presence of crackles in the lungs due to pulmonary edema. In this scenario, Pierre's flushed appearance, difficulty breathing (dyspnea), and crackles in the lung bases suggest fluid overload. The nurse should immediately slow or stop the transfusion, elevate the head of the bed, and notify the physician.
Administering diuretics may be necessary to manage the fluid overload.
Bacteremia would present with signs of infection, such as fever and chills. Hypovolemia involves decreased blood volume and would typically present with hypotension and tachycardia, not fluid accumulation.
A transfusion reaction encompasses a range of potential adverse responses, but the specific symptoms described here align more closely with fluid overload.

SITUATION 22.1

A. A patient with AB+ blood

A person with AB+ blood is the universal recipient for red blood cells. This means they can receive any ABO and Rh blood type (A, B, AB, or O; Rh-positive or Rh-negative) without experiencing a hemolytic reaction. However, the reverse is not true—only a patient who is AB+ can safely receive AB+ blood.

- B-, A-, and O- recipients all lack one or more antigens (A, B, or Rh), and receiving AB+ blood would result in a dangerous immune response due to incompatible antigens.

SITUATION 22.2

E. 116 mL/h

- Total unit volume = 275 mL
- Volume already infused in the first 15 minutes at 60 mL/h:
- 60mL/60min×15min= 15mL
- Volume remaining = 275 − 15 = 260 mL
- Time remaining from 1:15 PM to 3:30 PM = 2 hours and 15 minutes = 2.25 hours

260mL/2.25hr=115.56mL/h

≈116mL/h

SITUATION 22.3

B. Stop the transfusion

Mme. Dubois is displaying clear signs of an allergic transfusion reaction:

- Flushing, hives, pruritus (itching), and respiratory involvement (mild SOB)

According to transfusion protocols (e.g., Canadian Blood Services, WHO, hospital guidelines), any suspected transfusion reaction — especially with systemic allergic symptoms — requires the nurse to:

1. Immediately stop the transfusion
2. Maintain IV access with normal saline
3. Assess and monitor vitals
4. Notify the physician
5. Administer medications (e.g., antihistamines, epinephrine, corticosteroids) as prescribed

- a. Notify the doctor. While notifying the provider is essential, it should occur after stopping the transfusion to prevent worsening of the reaction.
- c. Continue the transfusion. Unsafe. Never continue a transfusion when any signs of reaction are present — this can lead to anaphylaxis or worsening respiratory distress.
- d. Retake the vital signs in 15 minutes. Delays emergency intervention. Waiting is inappropriate in the presence of active allergic symptoms.

SITUATION 22.4

A. Administer diphenhydramine 25 mg IV PRN

This is a classic allergic transfusion reaction — with itching, rash, hives, and mild respiratory involvement. Diphenhydramine is clearly indicated as per standing medical orders, and it should be administered immediately after the transfusion is stopped and IV access is maintained.

- b. Drawing labs is secondary after stabilizing the patient.
- c. Physician notification should follow initial emergency response.
- d. Labs like urinalysis and hemolysis panel are appropriate but not urgent.

SITUATION 23

C. Gabapentin
D. Amitriptyline

Neuropathic pain arises from damage or dysfunction in the nervous system, as in this case from diabetic peripheral neuropathy. It typically does not respond well to opioids alone, and requires a multimodal approach including adjuvant analgesics.

- c. Antiseizure drugs – Medications like gabapentin (Neurontin) or pregabalin (Lyrica) stabilize nerve activity and are effective for neuropathic pain. Gabapentin is already ordered and commonly used for diabetic neuropathy.
- d. Tricyclic antidepressants (TCAs) – Agents such as amitriptyline (Elavil) or nortriptyline (Pamelor) have analgesic properties in neuropathic pain by inhibiting reuptake of norepinephrine and serotonin in the pain pathway.

a. NSAIDs – These are useful for inflammatory or nociceptive pain, but have limited benefit in neuropathic pain and may add unnecessary risk postoperatively.
b. Fentanyl – This is a potent opioid, and increasing opioid dosage does not significantly improve neuropathic pain. It also increases the risk of sedation and respiratory depression.

SITUATION 24.1

D. Risk of respiratory depression

Mr. Harris is at high risk for respiratory depression due to multiple converging factors:

- He underwent general anesthesia, which suppresses respiratory drive.
- He has a known history of obstructive sleep apnea (OSA) — increasing the risk of postoperative airway obstruction and hypoventilation, especially while sedated or lying supine.
- Kidney failure affects the metabolism and excretion of many medications, including anesthetics and opioids, leading to accumulation and prolonged sedation.

Because airway and breathing are foundational to survival (per the ABCs of prioritization: Airway, Breathing, Circulation), respiratory depression is the top priority.

- a. Risk of pressure injury – While valid, it is not the immediate life-threatening concern in the early postoperative period.
- b. Risk of hyperglycemia – Blood glucose monitoring is essential but can be managed; it does not pose an acute, immediate threat.
- c. Risk of hypoglycemia – Also important, especially if on insulin, but not as urgent as airway compromise in a post-anesthesia patient with OSA.

SITUATION 24.2

A. Administer naloxone (Narcan) 0.1 mg IV as prescribed

Mr. Harris is showing classic signs of opioid-induced respiratory depression:

- Sedation with minimal arousability
- Depressed respiratory rate (<10/min)
- Decreased oxygen saturation
- No evidence of mechanical airway obstruction

Because he recently received opioids (hydromorphone) and is not breathing effectively, the priority intervention is to administer naloxone (Narcan) to reverse the opioid effects and restore respiratory effort.

b. Call the anesthesiologist STAT – Important, but secondary to addressing the life-threatening issue immediately.

c. Increase the oxygen flow rate – Oxygen alone won't improve respiratory drive in opioid overdose; ventilation must be restored pharmacologically.

SITUATION 25.1

A. Take the PCA button away from the patient

M. Lemoine is showing signs of early opioid-induced sedation and respiratory depression:

- Drowsiness
- Shallow breathing with pauses
- Respiratory rate at the lower limit (10 breaths/min)
- History of OSA and renal impairment (slower drug clearance)
-

Although his pain is well controlled at 2/10, continuing access to the PCA pump puts him at risk of worsening respiratory depression. Removing the PCA button prevents further opioid self-administration, which is the most immediate and non-invasive action the nurse can take.

- b. Increase oxygen flow – Might help O2 saturation, but doesn't address the underlying cause (sedation from opioids).
- c. Encourage incentive spirometry – Good for lung expansion but not effective or safe when the patient is drowsy.
- d. Administer naloxone – A reversal agent is not warranted yet, as the patient is stable and still arousable. Preventing further dosing is safer at this point.

SITUATION 25.2

B. How often he has taken the acetaminophen

To properly assess the effectiveness of Mr. Lemoine's pain management regimen, it is essential to know how often he has taken the acetaminophen. This information helps determine if the medication was taken as prescribed and if the dosage frequency is adequate to manage his pain. Since acetaminophen is a non-opioid analgesic with a ceiling effect, understanding its use frequency is crucial for evaluating its contribution to pain relief and avoiding potential overdose or inadequate pain control.
The exact time he took his last dose of hydromorphone is important for understanding opioid use but does not specifically address the effectiveness of acetaminophen. The presence of any side effects such as nausea or dizziness is relevant for monitoring adverse effects but does not directly assess pain relief.

The frequency and duration of his pain episodes provides context for pain assessment but does not specifically help evaluate the effectiveness of acetaminophen.

Therefore, determining how often Mr. Lemoine has taken the acetaminophen provides critical information for assessing whether the current pain management strategy is effective and appropriate.

SITUATION 25.3

B. Take the acetaminophen q 4-6 h regularly to maintain optimal serum levels.

Taking acetaminophen regularly every 4-6 hours as prescribed can help maintain optimal serum levels, providing consistent pain relief. By keeping a steady level of the medication in his system, Mr. Lemoine can manage his pain more effectively and avoid fluctuations in pain intensity. This approach helps maximize the analgesic effects of acetaminophen, which is important since he has opted not to use the stronger opioid medication.

Use cold packs on the surgical site every hour may provide some pain relief through local cooling effects, but it is not a substitute for systemic pain management and may not be appropriate for continuous use. Increase physical activity to distract from the pain is not advisable shortly after surgery, as it can exacerbate pain and potentially lead to complications. Wait until the pain becomes severe before taking acetaminophen is not recommended because it can lead to a cycle of insufficient pain control, as it is more challenging to manage severe pain once it occurs compared to preventing it.

The regular use of acetaminophen helps ensure consistent pain relief and is an effective strategy for managing pain, especially in the absence of opioid use.

SITUATION 25.4

A. "I'm sorry, but I can't share that information due to patient confidentiality."

The correct response is to inform the caller that you cannot share information due to patient confidentiality. Patient information, including discharge dates, cannot be disclosed without the patient's consent. This response ensures that the nurse maintains patient privacy and upholds professional and legal standards.

"He should be discharged in the next few days, but I can't give an exact date" implies sharing some information, which could be a breach of confidentiality.

"I'll transfer you to Mr. Lemoine's room so you can speak with him directly" might inadvertently disclose information about the patient's condition or whereabouts. While it may seem like a reasonable action, it is best to ask the patient first if they wish to receive a call.

"He is doing well, and we expect him to be discharged soon" still shares information about the patient's status, which is not permissible without consent.

Thus, the best course of action is to prioritize patient confidentiality and politely decline to provide any information.

SITUATION 26

A. Acetaminophen PO
C. Hydromorphone SC

- a. Acetaminophen PO: Although she received acetaminophen at 09:00, it is now 13:15, which is more than 4 hours later, making it eligible to be administered again. Acetaminophen is a co-analgesic that works synergistically with opioids, helping reduce overall opioid use and improve pain control.
- c. Hydromorphone SC: Since the oral route was used recently (12:00 dose), the SC PRN dose is appropriate for breakthrough or uncontrolled pain. It provides faster relief and avoids giving another oral dose too soon.
- b. Hydromorphone PO: Not appropriate at this time because she received a dose just 1 hour ago, and the order is q3h.
- d. Lorazepam SL: Not appropriate. While the patient reports being worried, there are no signs of significant anxiety (e.g., agitation, insomnia, panic). The concern about surgery can be better addressed through therapeutic communication, not medication at this point.

SITUATION 27

B. "Yes, it's generally safe to go home after local anesthesia, even if he hasn't urinated yet, unless he feels discomfort."

- Local anesthesia typically does not impair bladder function, so routine urination is not required before discharge unless the patient is experiencing urinary discomfort, distended bladder, or has a history of urinary retention.
- Since Mr. Martel is comfortable, alert, and has no urinary complaints, there is no need to delay discharge.
- Option a overgeneralizes and does not apply to procedures done under local anesthesia.
- Option c is overly cautious without clinical symptoms.
- Option d suggests an invasive intervention that is unnecessary in this situation.

SITUATION 28.1

C. Shoulder pain

Ms. Cloutier is not experiencing pain in her left hip, where she had surgery, but she is grimacing and moaning, which suggests she might be experiencing pain elsewhere. Given her history of severe osteoarthritis in her shoulders, it's important to evaluate her shoulder pain. This could be a significant source of discomfort and may require further intervention. Evaluating the shoulder pain will help determine if additional pain management is needed beyond what is being administered for the hip surgery.

SITUATION 28.2

A. The insertion site of the epidural catheter

Ms. Cloutier is experiencing a burning pain in her left hip that has escalated to a 6/10 rating. Since she is receiving epidural analgesia, it is essential to check the insertion site of the epidural catheter to ensure it is properly positioned and functioning. If there is any issue with the catheter, such as displacement, blockage, or infection, it could lead to inadequate pain relief. By assessing the insertion site, you can determine if the catheter is effectively delivering analgesia and address any potential complications.

SITUATION 28.3

C. Stop the epidural analgesia

When a patient exhibits a significant motor block, as indicated by a Bromage Scale score of 3 (unable to move both knee and foot), this is a sign that the epidural analgesia may be excessive and could potentially lead to complications such as nerve damage or respiratory depression. The first priority is to stop the epidural analgesia to prevent further worsening of the motor block. After stopping the analgesia, you should then notify the anesthesiologist to reassess the patient and adjust the treatment plan accordingly. Immediate action is necessary to ensure the patient's safety before further consultation.

SITUATION 28.4

A. Tylenol
B. MS Contin
C. Statex

Acetaminophen (TylenolTM) 650 mg PO at 08:00: This medication is scheduled for routine administration every 6 hours (qid). Since it is currently 07:45, it's almost time for the next dose. This helps in managing Ms. Cloutier's baseline pain.

Morphine sulfate (MS ContinTM) 15 mg PO at 08:00: This long-acting opioid is prescribed to be given twice daily. The morning dose at 08:00 is due, and administering it will provide continuous pain relief throughout the day, which is necessary given Ms. Cloutier's ongoing pain.

Morphine sulfate (StatexTM) 5 mg PO PRN: Although Ms. Cloutier received a dose last night, the PRN Statex can be administered again if the patient reports pain before the next scheduled MS ContinTM dose. Since she is experiencing burning pain in her left hip, a PRN dose can help manage breakthrough pain.

Note: The enoxaparin and pregabalin are not relevant to this immediate pain management decision as they serve other purposes (anticoagulation and neuropathic pain management, respectively) and are not due to be administered at this time.

SITUATION 29.1

B. Supine, with the residual limb supported with pillows

The residual limb is usually supported on pillows for the first 24 hours following surgery to promote venous

return and decrease edema. After the first 24 hours, the residual limb usually is placed flat on the bed to reduce hip contracture. Edema also is controlled by limb-wrapping techniques. In addition, it is important to check health care provider prescriptions regarding positioning following amputation.

SITUATION 29.2

D. No, because elevation may cause flexion contractures and should be avoided during the recovery period.

- After an above-the-knee amputation, elevating the residual limb for prolonged periods—especially after the first 24–48 hours—can lead to hip flexion contractures.
- These contractures make it more difficult to fit a prosthesis and hinder rehabilitation.
- Therefore, elevation of the limb is not recommended during the recovery phase, except during the immediate postoperative period if prescribed.
- Teaching the patient to lie prone periodically and to keep the limb flat promotes proper joint alignment and reduces the risk of complications.

SITUATION 29.3

A. "Lying on your stomach will help prevent contractures."

- After an above-the-knee amputation, clients are at risk of developing hip flexion contractures due to prolonged sitting or lying in the supine (on the back) position.
- Encouraging prone positioning (lying on the stomach) for 20–30 minutes several times a day helps maintain hip extension, preventing contractures and supporting successful prosthetic fitting later in rehabilitation.
- This is a key nursing intervention in postoperative amputee care.

SITUATION 29.4

C. "Gabapentin helps relieve nerve pain like the one you're describing in your missing limb."

Gabapentin is an anticonvulsant but is commonly prescribed off-label for neuropathic pain, especially phantom limb pain after amputation. Patient education is essential to ensure understanding and adherence. Options a, b, and d are incorrect or misleading in this context.

SITUATION 29.5

B. "It helps train your brain to forget that the missing limb is still in pain."

Mirror box therapy is a non-invasive technique used to relieve phantom limb pain. By using a mirror to reflect the intact limb, the brain is tricked into perceiving movement and presence in the amputated limb, which can retrain neural pathways and reduce pain. This visual feedback can gradually decrease the mismatch between motor intention and sensory feedback that contributes to phantom limb pain.

SITUATION 30

C. She is experiencing internal hemorrhage; notify the physician immediately.

Mrs. Gagnon is exhibiting classic signs of internal hemorrhage, including hypotension, tachycardia, pallor, abdominal distension, and severe pain without corresponding external bleeding. Internal bleeding is a life-threatening post-operative complication that requires immediate medical intervention. The nurse must remain with the patient, initiate emergency protocols, and notify the physician right away.

Administering oxygen, starting IV fluids as prescribed, and preparing for possible surgery are also essential follow-up steps.

MEDICINE

SITUATION 1.1

Scenario:
Ms. Latour, 86 years old, was admitted to the medical unit at 20:00 yesterday with right lower lobe pneumonia. Her history includes heart failure and atrial fibrillation. Her level of medical intervention includes cardiopulmonary resuscitation (full code). An intermittent peripheral IV is in place for antibiotic administration.

At 10:00 the next morning, you observe the following:

- She appears anxious and agitated
- Her skin is cold and pale
- Crackles are heard bilaterally on lung auscultation
- She must pause while speaking

Vital signs:

- BP: 105/54 mmHg
- Pulse: 110 bpm, irregular
- Respiratory Rate: 28/min, shallow
- Oxygen Saturation: 85% on 2 L/min nasal cannula
- Temperature: 37.7°C

You decide to place her in a high Fowler's position.

Question:
What is the rationale for placing Ms. Latour in high Fowler's position?
a. To improve venous return to the heart
b. To reduce cerebral pressure and prevent confusion
c. To increase after load
d. To decrease the preload

SITUATION 1.2

Scenario:
You plan to notify the physician, but first, you complete a thorough nursing assessment to gather all critical data.

Question:
What will you do next?
a. Assess for the presence of pedal pulses
b. Measure her blood glucose
c. Review her bowel movements overnight
d. Review her urine output since she was admitted

SITUATION 1.3

Scenario:
At 11:00, an orderly urgently calls for help to Ms. Latour's room. When you arrive, you find her unresponsive and pulseless. You immediately call a Code Blue. While the orderly begins chest compressions, you initiate 100% oxygen via a venti-mask as outlined in the collective prescription.

Question:
What will you do next?
a. Check the patency of the peripheral intravenous catheter
b. Retrieve the defibrillator
c. Elevate the legs to promote circulation
d. Apply warm blankets to prevent hypothermia

SITUATION 2.1

Scenario:
You are a nurse in a seniors' residence. One week ago, Mrs. Tremblay, 70 years old, was admitted due to locomotor issues and progressive loss of autonomy.

Medical History:

- Heart failure (10 years)
- Atrial fibrillation
- Beta-blocker intolerance

Medications:

- Digoxin (Lanoxin) 0.125 mg once daily at suppertime
- Ramipril (Altace) 5 mg BID (08:00 and 22:00)
- Furosemide (Lasix) 40 mg daily at 08:00
- Pravastatin (Pravachol) 40 mg at bedtime
- ASA (Aspirin) 81 mg daily at 08:00

You are about to administer Digoxin at 17:00.

Current vital signs:

- BP: 110/72 mmHg
- Pulse: 60/min, regular
- Respiratory rate: 18/min, regular and normal depth

Question:
Will you administer Mrs. Tremblay's Lanoxin (Digoxin) based on her current status?
a. Yes, because her vital signs are stable and her pulse is acceptable.
b. No, because the pulse is at the minimum limit and digoxin could cause bradycardia.
c. No, because digoxin must be given in the morning, not at suppertime.
d. Yes, because digoxin should be given regardless of pulse in atrial fibrillation.

SITUATION 2.2

Scenario:
Two weeks after her admission to the residence, Mrs. Tremblay, 70 years old, who has a history of heart failure and atrial fibrillation, tells you she has been feeling more breathless than usual over the past few days. She now has difficulty completing some of her activities of daily living (ADLs).

You immediately take her vital signs:

- BP: 95/55 mmHg
- Pulse: 112/min, regular
- Respirations: 22/min, regular, normal depth
- SpO2: 95% on room air

You suspect a possible deterioration of her heart failure.

Question:
During your clinical examination of Mrs. Tremblay, which two (2) additional findings would most likely confirm a deterioration of her heart condition?
a. Dry mucous membranes and skin tenting

b. Edema of the lower limbs and distended jugular veins
c. Flushed skin and bounding peripheral pulses
d. Pale conjunctivae and flat neck veins

SITUATION 2.3

Scenario:
Two days ago, her Lasix dose was increased to 80 mg daily due to signs of fluid overload.

This morning, she reports:
- Fatigue
- Loss of appetite (anorexia)
- Dizziness
- Muscle weakness
- Yellow-green visual disturbances

You review her lab results:
- Sodium (Na): 135 mmol/L (Normal: 135–145)
- Potassium (K): 3.4 mmol/L (Normal: 3.5–5.0)
- Chloride (Cl): 99 mmol/L (Normal: 100–106)
- Digoxin level: 2.6 mmol/L (Normal therapeutic range: 1.0–2.6)

Question:
Will you administer this morning's dose of Digoxin (Lanoxin)?
a. Yes, the digoxin level is still within the therapeutic range.
b. No, because she is presenting with signs of digitalis toxicity.
c. Yes, but only after rechecking her blood pressure.
d. No, because her sodium level is below the normal range.

SITUATION 2.4

Scenario:
One week later, Mrs. Tremblay, age 70, has recovered well from her previous condition. She is alert, in good spirits, and playing cards in the community room of the seniors' residence.

Suddenly, she puts a hand to her chest, becomes pale, and collapses in her chair. She is unresponsive to verbal commands and does not react to painful stimuli. You and another staff member gently place her on her back on a firm surface.

Question:
What is your priority intervention at this moment?
a. Begin chest compressions immediately.
b. Check for breathing and a pulse.
c. Call the physician for medical orders.
d. Administer oxygen via nasal cannula.

SITUATION 3.1

Scenario:
Mrs. Riendeau, 75 years old, was admitted this morning following a deterioration in her general condition.
Medical history:
- Myocardial infarction (2004)
- Chronic heart failure (since 2005)
- Weight gain of 3 kg in one week
- Hemoglobin today: 70 g/L (N: 120–160 g/L)

She received one unit of blood during the day. A second unit was completed at 21:00. Between units, she received furosemide (Lasix®) 20 mg IV at 17:00.

At 22:00, you find her sitting in a chair, stating she can't lie down due to shortness of breath.

Vital signs:
- BP: 165/85 mmHg
- HR: 85 bpm, regular
- RR: 26/min, shallow
- SpO2: 93%
- T: 36.9°C

Question:
Apart from auscultating for adventitious lung sounds, what clinical information would be most important to assess next to help identify a possible complication?
a. Measure urine output to check for positive fluid balance
b. Check capillary blood glucose
c. Reassess hemoglobin levels
d. Measure blood pressure in the other arm

SITUATION 3.2

Scenario:
At 22:30, Mrs. Riendeau remains seated in her chair, increasingly anxious and short of breath. You notice that she is using accessory muscles to breathe, and she must pause mid-sentence due to breathlessness. You auscultate her lungs and hear bilateral crackles in the lower lobes. She appears pale and diaphoretic, and her SpO2 has dropped to 88% on room air.

You review her fluid balance and note that her total intake exceeds her output by 1,100 mL in the past 24 hours.

Question:
What do you suspect is happening to Mrs. Riendeau?
a. Anemia
b. Hypoglycemia
c. Pulmonary edema
d. Pulmonary embolism

SITUATION 3.3

Scenario:
Based on your answer from the previous scenario. You administer oxygen via nasal prongs in accordance with the collective prescription in effect.

Question:
What will your next intervention be?
a. Take another set of vital signs
b. Raise the head of the bed
c. Notify the physician
d. Apply continuous pulse oximetry

SITUATION 4

Scenario:
Mr. Jean-Paul Gagnon, a 74-year-old man, is recovering on the surgical unit after undergoing thoracic lobectomy for early-stage lung cancer three days ago. His past medical history includes hypertension, type 2 diabetes, and paroxysmal atrial fibrillation. His anticoagulant therapy (apixaban) was held prior to surgery and has not yet been resumed. So far, his recovery has been uneventful—he's been alert, oriented, and mobile with assistance.

At 14:15, you are urgently called to his room. You find Mr. Gagnon confused, with right-sided facial drooping, slurred speech, and right arm weakness. His blood pressure is 164/92 mmHg and his heart rate is irregular at 102 bpm.

Question:
What do you suspect is happening to the patient?
a. Pulmonary embolism
b. Acute ischemic stroke
c. Postoperative delirium
d. Transient hypoglycemia

SITUATION 5.1

Scenario:
You are caring for Monsieur Jean Dupont, a 72-year-old patient in the medical ward known for heart failure. He has a hemoglobin level of 87 g/L. A blood transfusion has been prescribed and is currently in progress, expected to finish in an hour. The attending physician has placed a STAT order for a coronary angiography, and the appointment has been scheduled to occur in 30 minutes.

Question:
What is the best course of action?
a. Accompany Monsieur Dupont to the angiography suite while continuing the transfusion until completion.
b. Stop the transfusion immediately to prepare Monsieur Dupont for the STAT coronary angiography.
c. Increase the transfusion rate to complete it before the angiography.
d. Wait until the transfusion is finished and then transport Monsieur Dupont for the coronary angiography.

SITUATION 5.2

Scenario:
After the STAT coronary angiography, performed through the left femoral artery, Monsieur Jean Dupont returns to the ward. Upon assessment, you observe a hematoma at the puncture site, and the dressing is 100% soiled with blood.

Question:
What is the appropriate nursing intervention?
a. Loosen the compressive dressing in place.
b. Apply manual compression.
c. Notify the doctor.
d. Ask for your colleague's help.

SITUATION 6.1

Scenario:
Mr. Laurent Boucher, a 78-year-old patient with a history of chronic heart failure and atrial fibrillation, is under your care in the medicine unit. His usual medications include:

- Bisoprolol (Monocor®) 5 mg PO once daily
- Diltiazem (Cardizem®) 120 mg PO twice daily

At 08:00, you prepare his morning medications and assess his vital signs:

- Blood Pressure: 98/60 mmHg (previously 108/64 mmHg)
- Heart Rate: 58 bpm (previously 68 bpm), regular
- Respiratory Rate: 18 breaths/min
- O2 Saturation: 96% on room air

He is awake and alert, reports no dizziness, chest pain, or shortness of breath.

Question:
Will you administer Monocor (Bisoprolol) and Cardizem (Diltiazem)?
a. Yes, give both medications as prescribed.
b. Hold both medications and notify the physician.
c. Administer Monocor only.
d. Hold Monocor and reassess in one hour.

SITUATION 6.2

Scenario:
Following the earlier episode of pulmonary edema, Mr. Laurent Boucher remains under observation. His physician has prescribed Furosemide (Lasix®) 40 mg IV STAT to manage his fluid overload and relieve respiratory symptoms. You are preparing to administer the medication.

Question:
What should you evaluate first?
a. Blood glucose level
b. Presence of bowel sounds
c. Assess lung sounds
d. Pupil size and reaction

SITUATION 6.3

Scenario:
Mr. Laurent Boucher, who was admitted for worsening heart failure and pulmonary edema, is currently under a fluid restriction of 1.5 liters per day.

His daughter expresses concern and asks how she can help support her father during his hospitalization and at home.

Question:
What is the most appropriate advice to give to Mr. Boucher''s daughter to help monitor his fluid restriction?
a. Write down everything he eats as food.
b. Weigh him daily at the same time.
c. Observe the color and odor of his urine.
d. Monitor his oxygen saturation after each meal.

SITUATION 7

Scenario:
Mr. Laurent Boucher, a 74-year-old patient with a history of coronary artery disease, has just returned to the unit after undergoing a coronary angiography via the right femoral artery. The procedure was uneventful, and the physician has ordered bed rest for 6 hours with the right leg extended.
As his nurse, you are conducting routine post-procedure monitoring.

Question:
In addition to monitoring the insertion site for hematoma or bleeding, what other assessment is a priority?
a. Measure the patient's blood glucose level
b. Assess neurovascular status of the affected extremity
c. Monitor the patient's level of consciousness
d. Auscultate heart sounds every 15 minutes

SITUATION 8

Scenario:
You are caring for Mr. René Lafleur, a 69-year-old patient with chronic kidney disease (CKD) who receives hemodialysis three times per week. Today, during your assessment, he reports:

"I've been feeling more short of breath than usual, especially when lying down. My ankles seem more swollen too."

You note bilateral pedal edema, crackles at the lung bases, and his weight is 2.4 kg higher than it was after his last dialysis session.

Question:
Based on this assessment, what do you suspect?
a. Acute kidney failure
b. Hyperkalemia
c. Fluid overload

SITUATION 9

Scenario:
You are discharging Mr. Michel Fortin, a 62-year-old client newly started on continuous ambulatory peritoneal dialysis (CAPD). His wife expresses concern about doing the procedure at home and asks what signs they should watch for to know if something is wrong.

Question:
What will you teach Mr. Fortin and his wife to monitor as a sign of a complication that requires prompt medical consultation?
a. A clear pale-yellow outflow
b. Mild abdominal bloating after dialysis
c. Cloudy peritoneal dialysis effluent
d. A small amount of pink tinge in the first outflow after catheter insertion

SITUATION 10.1

Scenario:
Mr. Tremblay, a 65-year-old male, has been living with chronic kidney disease (CKD) and is being treated with hemodialysis via an arteriovenous fistula in his left forearm. His medical history includes hypertension (HTN), which is managed with medications. During your assessment, Mr. Tremblay reports feeling more breathless than usual. His vital signs are stable, but he mentions that his breathing difficulty has gradually increased over the past few days.

Question:
What symptom would justify an additional dialysis session?
a. Peripheral edema.
b. Hypotension.
c. Oliguria.
d. Dyspnea.

SITUATION 10.2

Scenario:
He is scheduled for hemodialysis this morning, and his daily dose of enalapril is due.

Question:
When should you administer the enalapril?
a. During dialysis
b. Just before dialysis
c. The day after dialysis
d. On return from dialysis

SITUATION 10.3

Scenario:
Mr. Tremblay, a 65-year-old client undergoing chronic hemodialysis via a left AV fistula, has just returned from his morning dialysis session. As you perform your post-dialysis assessment, you obtain the following vital signs:

- BP: 118/72 mmHg
- HR: 80 bpm, regular
- RR: 18/min
- SpO2: 97% on room air
- Temperature: 37.8°C

Mr. Tremblay reports feeling fine and is sitting comfortably in bed, reading the newspaper.

Question:
What is your appropriate nursing action?
a. Encourage fluids
b. Notify the physician
c. Continue to monitor vital signs
d. Monitor the site of the shunt for infection

SITUATION 10.4

Scenario:
He is now ready to order breakfast. You are reviewing his diet options with him.

His prescribed renal diet is low in potassium, phosphorus, and sodium, with moderate protein and fluid restriction.

His most recent labs show:

- K^+: 5.2 mmol/L (high-normal)
- Phosphorus: Elevated
- Creatinine and BUN: Consistent with CKD

He mentions he's feeling better after dialysis and is ready to eat.

Question:
Which of the following diet choices is best for this patient?
a. Scrambled eggs, English muffin, and apple juice
b. Cheese sandwich, tomato soup, and cranberry juice
c. Split-pea soup, whole-wheat toast, and nonfat milk
d. Oatmeal with cream, half a banana, and herbal tea

SITUATION 11.1

Scenario:
Mr. Sylvain Gagnon, a 63-year-old client with end-stage renal disease, is undergoing continuous ambulatory peritoneal dialysis (CAPD) at home. He arrives at the outpatient dialysis clinic for his regular assessment.

During your evaluation, he shows you the most recent dialysate drainage bag, which appears cloudy, although he has no fever or abdominal pain at the moment.

Question:
Which of the following is the best initial nursing action?
a. Send the peritoneal fluid to the laboratory for culture
b. Administer antibiotics
c. Do nothing, this is expected
d. Stop drainage of fluid

SITUATION 11.2

Scenario:
As you continue your assessment of Mr. Gagnon, he notices you checking his capillary blood glucose levels before his next dialysate exchange. Curious, he asks:

"Why do you keep checking my blood sugar? I don't even have diabetes."

Question:
Which of the following is the most appropriate response?
a. I have to check if you have diabetes mellitus
b. The dialysate contains glucose
c. The procedure may lower your blood glucose levels
d. It is a routine procedure for every client who undergoes the treatment

SITUATION 12.1

Scenario:
Mr. Michel Fortin, a 67-year-old client with chronic renal failure, receives hemodialysis treatments three times per week through an arteriovenous (AV) fistula in his left arm. You are preparing to complete your initial assessment during your shift.

Question:
Which intervention should you include?
a. Assess the AV fistula for a bruit and thrill.
b. Keep the AV fistula site dry.
c. Take the client's blood pressure in the left arm.
d. Keep the AV fistula wrapped in gauze.

SITUATION 12.2

Scenario:
As he prepares for discharge, you are providing him with teaching on how to protect the AV graft and avoid complications such as clotting or damage to the site.

Question:
Which action(s) will you include in your teaching to Mr. Fortin to avoid?
a. Carrying heavy items including purses or luggage with the left arm
b. Keeping the arm elevated on a pillow when sitting
c. Wearing loose-fitting clothing over the graft site
d. Sleeping with the left arm under the head or body

SITUAITON 13.1

Scenario:
Mr. Charbonneau, 64 years old, has a known history of peptic ulcer disease and was admitted for investigation of upper gastrointestinal bleeding. This morning, he underwent a diagnostic gastroscopy to identify the source of bleeding and assess the condition of his ulcer. The procedure was completed without immediate complications, and he returned to the unit with stable vital signs.

At 14:00, you assess Mr. Charbonneau and observe the following:

- He appears pale and slightly diaphoretic
- Reports sharp epigastric pain
- Has a temperature of 100°F (37.8°C)
- Suddenly experiences an episode of hematemesis (vomiting blood)

You review his medical chart and confirm he has no analgesia or anticoagulants administered post-procedure.

Question:
What do you suspect is happening, and what is your immediate intervention?
a. A perforated ulcer caused by the gastroscopy; notify the physician immediately
b. Rebleeding from the ulcer site; administer a proton pump inhibitor
c. Normal post-procedural discomfort; continue to monitor vital signs
d. Anxiety and mild gastritis; reassure the patient and reassess in 30 minutes

SITUATION 13.2

Scenario:
After Mr. Charbonneau's gastroscopy earlier this morning. He is now back on the unit in stable condition, but still drowsy. You inform the orderly that the patient

will need assistance when getting out of bed.

Question:
What other priority intervention should you instruct the orderly to do?
a. Encourage the patient to take deep breaths.
b. Offer the patient a warm beverage.
c. Ensure both top side rails are up and the bed is at the lowest position.
d. Monitor the patient's oxygen saturation every 30 minutes.

SITUATION 13.3

Scenario:
Mr. Charbonneau remains on the unit following his gastroscopy and biopsy. He had previously shown signs of upper GI bleeding, and now the physician has prescribed IV Sandostatin (octreotide) at 25 mcg/hour to help reduce gastrointestinal secretions and prevent further bleeding.

You are preparing the infusion. The pharmacy has provided Sandostatin at a concentration of 500 mcg/mL, diluted into a 100 mL bag of normal saline.

Question:
At what rate in mL/h will you set the IV pump to deliver the correct dose of 25 mcg/h?
a. 2.5 mL/h
b. 5 mL/h
c. 1 mL/h
d. 12.5 mL/h

SITUATION 13.4

Scenario:
Over the past 24 hours, he has remained stable, tolerating a clear fluid diet and showing no signs of rebleeding.

He is now scheduled for discharge. His wife has arrived to take him home.

Question:
What is your priority assessment before discharge, and what signs should you teach Mr. Charbonneau and his wife to monitor at home?
a. Check if Mr. Charbonneau voided and advise him to monitor his blood pressure
b. Assess his alertness and explain the need to report fever, black stools, or persistent abdominal pain
c. Ensure he completed his IV fluids and instruct him to monitor his weight
d. Confirm he had a bowel movement and advise him to avoid caffeine and spicy food

SITUATION 14

Scenario:
You are caring for Jean-Luc Dupont who has just had an upper GI endoscopy. The patient's vital signs must be taken every 30 minutes for 2 hours after the procedure. You assign a Licensed Practical Nurse (LPN) to take the vital signs. One hour later, the LPN reports the patient, who was previously afebrile, has developed a temperature of 38.8°C.

Question:
What should the nurse do in response to this reported assessment data?
a. Tell the LPN to change thermometers and retake the temperature.
b. Ask the LPN to bathe the patient with tepid water.
c. Plan to give the patient acetaminophen (Tylenol) to lower the temperature.
d. Promptly assess the patient for potential perforation.

SITUATION 14.2

Scenario:
Mr. Dupont's vital signs are stable, and the side rails on his bed are raised for safety. He is awake and alert, but he tells the nurse that he is very thirsty.

Question:
What is the nurse's best action?
a. Administer a small amount of ice chips only
b. Give the patient small sips of water through a straw
c. Check to see if the patient's gag reflex has returned
d. Keep the patient NPO for at least 4 hours

SITUATION 15.1

Scenario:
Ms. Isabelle Marchand is recovering on the surgical unit after a total thyroidectomy performed earlier today. Her surgery went smoothly, and she is currently stable with an IV running at maintenance rate and receiving postoperative monitoring.

Two hours into your shift, you notice intermittent muscle twitching, and Ms. Marchand reports numbness and tingling around her lips, fingers, and toes.

Question:
What do you suspect is happening to the patient?
a. She is developing a thyroid storm
b. She is experiencing hypocalcemia
c. She is having a reaction to anesthesia
d. She is experiencing early signs of a stroke

SITUATION 15.2

Scenario:
Given her numbness, tingling, and muscle twitching. You immediately notify the physician.

The physician gives a verbal order.

Medical orders:
- Draw serum calcium and magnesium levels STAT
- Administer calcium gluconate 1 g IV over 10 minutes if symptomatic
- Monitor cardiac rhythm continuously

Question:
What is your next priority intervention?
a. Prepare to administer IV calcium gluconate
b. Check the patient's vital signs

c. Elevate the head of the bed to 90 degrees
d. Offer the patient warm fluids to relieve tingling

SITUATION 15.3

Scenario:
The next morning, during your morning rounds, Ms. Marchand tells you:

"My voice feels hoarse and weak. Is that normal after this surgery?"

Question:
What is the most likely cause of her hoarseness?
a. Irritation of the vocal cords from the endotracheal tube
b. Edema of the glottis due to intubation
c. Laryngeal nerve damage during thyroid surgery
d. Post-operative fluid restriction

SITUATION 15.4

Scenario:
Ms. Marchand continues to speak in a strained and weak voice. She appears frustrated and tries to express herself, but speaking seems difficult. You want to ensure she can still communicate effectively while her voice is recovering.

Question:
What is the most appropriate nursing action to facilitate communication with Ms. Marchand?
a. Encourage the patient to keep trying to speak clearly
b. Offer the patient a pen and paper
c. Reassure the patient that this is expected and leave the room
d. Tell the patient to whisper instead of speaking out loud

SITUATION 15.5

Scenario:
Ms. Marchand is being discharged home following her thyroidectomy. Before leaving, she asks what she should and shouldn't do during her recovery at home.

Question:
What advice will you give her to support a safe and effective recovery? Choose TWO (2) answers
a. Resume a diet rich in seafood to support thyroid function
b. Avoid lifting heavy objects for several days
c. Whisper when speaking to avoid straining the voice
d. Avoid driving until cleared by the physician

SITUATION 15.6

Scenario:
During her follow up visit, she admits to stopping her Synthroid (levothyroxine) for the past two months.

She appears withdrawn, tearful, and expresses suicidal thoughts.

She also mentions that her boyfriend broke up with her on Facebook.

Question:
What do you suspect is happening to Ms. Marchand?
a. She is experiencing a situational emotional crisis due to the breakup.
b. She is having a panic attack triggered by social stress.
c. She is in a severe hypothyroid state affecting her mental status.
d. She is demonstrating manipulative behavior to gain attention.

SCENARIO 16.1

Scenario:
At 9:30, Noémie Lessard, age 2½, was transferred from the emergency room to your unit following an episode of bronchospasm. This is the third time she has been admitted for the same type of problem. Upon admission, Noémie presents with moderate xiphoid, subcostal, and lower intercostal retractions and an occasional dry cough. Her vital signs are: P 96/min, regular; R 46/min, regular; T° (rectal) 37.7°C. When you auscultate the lungs, you hear wheezing in both pulmonary areas. Her oxygen saturation (SpO2) is 92% on room air. Her mother mentions that Noémie's sleep has been disturbed and that she has been more tired than usual over the past few days.

Question:
What clinical signs would indicate that a complication is imminent? Choose TWO (2) answers.
a. Use of the accessory muscles
b. Finger clubbing
c. Peribuccal cyanosis or pale skin
d. Greenish sputum

SITUATION 16.2

Scenario:
Noémie weighs 12 kg. The doctor has prescribed the following:

- Prednisolone (Pediapred) 12 mg qd (corticosteroid)
- Salbutamol (Ventolin) 0.4 ml in 3 ml of normal saline q 2 h by nebulization
- Fluticasone (Flovent) 125 mcg, 3 puffs bid with a spacer and mask via nasal prongs at 1.5 L/min

Before she was hospitalized, Noémie wasn't taking any medication on a regular basis at home. Treatment was started as soon as the child arrived in the emergency room.

At 22:00, Noémie's mother says to you, "My daughter's breathing seems to have improved, but she is very restless and won't go to sleep. She's not usually like this."

Question:
Other than anxiety, what could explain the change in Noémie's behavior?
a. She is having an allergic reaction to the corticosteroid (Pediapred).
b. . She is experiencing hypoxia due to inadequate oxygen delivery.
c. It is a side effect of the medication: salbutamol

d. The nebulization treatment is causing excessive mucus production

SITUATION 16.3

Scenario:
Noémie will be discharged tomorrow. Her discharge prescription is as follows:

- Salbutamol (Ventolin) 100 mcg, 2 puffs every 4-6 hours
- Fluticasone (Flovent) 125 mcg, 2 puffs bid for 14 days, then discontinue completely Prednisolone (Pediapred) 12 mg qd in the morning for 4 days

Question:
Which medication (inhaler) must the mother administer first when both medications (inhalers) have to be given during an asthma attack?
a. Fluticasone (Flovent)
b. Salbutamol (Ventolin)
c. It doesn't matter which inhaler is given first
d. Administer both inhalers simultaneously

SITUATION 16.4

Question:
What is the rationale for administering salbutamol (Ventolin) first?
a. Salbutamol and Flovent work independently, so the order of administration does not matter.
b. Salbutamol prevents mucus buildup, which enhances the effect of Flovent.
c. Salbutamol reduces inflammation, making it easier for Flovent to work.
d. Salbutamol opens the airways, allowing Flovent to penetrate more deeply and be more effective.

SITUATION 16.5

Scenario:
Noémie's mother says to you, "My daughter is much better. But is it really important that I give her the Flovent for as long as prescribed?"

Question:
What information will you give Noémie's mother to help her understand why it is important to continue the treatment as prescribed?
a. Flovent works quickly, so she can stop the medication once Noémie feels better.
b. Flovent mechanism of action is slow and gradual, so it's important to continue the treatment as prescribed.
c. Flovent is only needed when symptoms are present, so it's fine to stop early.
d. Flovent prevents future asthma attacks, so it's okay to stop if she seems better.

SITUATION 17.1

Scenario:
Mr. Étienne Gagnon, a 52-year-old man with a history of asthma since childhood, is brought to the emergency department by his wife. She states that he started having difficulty breathing about an hour ago after working in the garage where he was exposed to dust and fumes. Upon arrival, Mr. Gagnon is in visible respiratory distress. He is sitting upright, using accessory muscles to breathe, and speaking in short sentences between breaths. He appears anxious and diaphoretic.
You quickly assess the following:

- Respiratory rate: 32 breaths/min, shallow
- Pulse: 116 beats/min, regular
- SpO2: 88% on room air
- Audible wheezing on exhalation
- No current medications administered

Question:
Which action should you take first?
a. Administer an inhaled corticosteroid.
b. Obtain a peak flowmeter reading.
c. Auscultate the client's lungs.
d. Determine when the shortness of breath began.

SITUATION 17.2

Scenario:
You auscultate Mr. Étienne Gagnon's lungs and note widespread expiratory wheezing with diminished air entry at the bases. He appears fatigued and anxious, and is unable to complete full sentences. His oxygen saturation has dropped to 86% on room air, and he is using accessory muscles to breathe.
Medical Orders (standing orders):

- Administer salbutamol 2.5 mg via nebulizer q 20 minutes PRN for respiratory distress (max 3 doses).
- Increase oxygen as needed to maintain SpO2 ≥ 92%.
- Notify physician if no improvement after 3 doses or condition worsens.

You administer the first dose of salbutamol 2.5 mg via nebulizer and increase oxygen to 4 L/min via nasal cannula. After 20 minutes, Mr. Gagnon reports slight relief, but he remains tachypneic and continues to use accessory muscles.

Question:
What will you do next?
a. Administer an inhaled corticosteroid.
b. Notify the physician of the client's current status.
c. Repeat the nebulizer treatment as prescribed.
d. Ask the client to perform a peak expiratory flow test.

SITUATION 18.1

Scenario:
Mr. Lemoine, 82 years old, has a medical history of chronic obstructive pulmonary disease (COPD). He is admitted for a pulmonary infection and is receiving intravenous antibiotics and prednisone. His target oxygen saturation, as per medical orders, is 88–92%.
During your shift, you observe the following:

- With no oxygen, his SpO2 is 88%.
- With 2 L/min, it increases to 91%.
- When increased to 3 L/min, his SpO2 reaches 93%.

You reduce the O2 back to 2L/min, and his saturation drops to 91%.

Question:
According to the prescription, what is the most appropriate nursing action?
a. Take off the O2
b. Decrease to 1 L/min
c. Leave at 2 L/min
d. Increase to 3 L/min

SITUATION 18.2

Scenario:
Later in your shift, you notice that Mr. Lemoine appears more tired and slightly confused. His respiratory rate is 24 breaths per minute, shallow but regular. You notify the physician, who orders an arterial blood gas (ABG) analysis.

You collect the sample and receive the following ABG results:

- pH: 7.30
- PaCO2: 55 mm Hg
- HCO_3^-: 24 mEq/L
- PaO2: 68 mm Hg
- SpO2: 90% on 2 L/min nasal cannula

Question:
Based on these results, how would you interpret Mr. Lemoine's acid-base status?
a. Respiratory alkalosis, uncompensated
b. Respiratory acidosis, fully compensated
c. Respiratory acidosis, uncompensated
d. Respiratory alkalosis, partially compensated

SITUATION 19.1

Scenario:
Mr. Ducet, 82 years old, has a history of chronic obstructive pulmonary disease (COPD). He was admitted to the hospital for increased shortness of breath and productive green sputum. He is currently being treated with IV prednisone and antibiotics for a suspected pulmonary infection.

During your shift, you assess Mr. Ducet. His oxygen saturation is 88% on room air. You follow the medical order to administer oxygen at 3 L/min via nasal cannula, with a target SpO2 of ≥90%. After a few minutes, his saturation improves to 92%.

An hour later, you observe that Mr. Ducet is wandering around the unit and appears restless. His daughter approaches you and says, "This is very unusual. At home, when he has difficulty breathing, he stays seated quietly. Why is he walking around like this?"

Although his SpO2 is technically within the prescribed range, you recognize that restlessness in elderly patients may signal a clinical change.

Question:
Aside from the pulmonary infection, what is the most likely cause of Mr. Ducet's restlessness and unusual behavior?
a. Decreased oxygen to the brain resulting in confusion
b. A sudden increase in oxygen saturation
c. The mixture of side effects from the antibiotic and corticosteroid therapy
d. Anxiety due to hospital surroundings

SITUATION 19.2

Scenario:
Later in the shift, Mr. Ducet, still on 3 L/min oxygen, appears more confused and restless. His oxygen saturation remains stable at 92%, and his respiratory rate is 24 breaths/min. He's oriented only to person and place.

His daughter, clearly concerned, asks:
"He doesn't act like this at home. Is he going to stay this way? Is this permanent?"

Question:
What is the most appropriate response to reassure Mr. Lemoine's daughter?
a. "This behavior is a side effect of his medications and may take time to resolve."
b. "This is usually reversible as his condition improves."
c. "He might be overactive now that he's getting more oxygen and feeling better."
d. "It's possible that he's developing dementia, and we'll need to assess this further."

SITUATION 20.1

Scenario:
Mr. Pascal Gendron, a 66-year-old patient, has been hospitalized for uncontrolled type II diabetes. During your morning rounds, he tells you:
"Ever since the beginning of summer, my blood sugar has been high no matter what I do."
You check his capillary blood glucose, which reads 9 mmol/L.

Question:
What clinical data would you prioritize obtaining to better evaluate Mr. Gendron'?
a. Glycated hemoglobin (HbA1c)
b. Ketonuria
c. Presence of tremors
d. Glycosuria

SITUATION 20.2

Scenario:
Later in the day, Mr. Pascal Gendron, who also underwent a diagnostic bronchoscopy earlier that morning, is transferred back to your unit from recovery. One hour post-procedure, you assess the patient and note the following:

- He appears slightly dyspneic and is using accessory muscles to breathe.
- He reports a dry, persistent cough and mild chest pain on the affected side.
- You auscultate his lungs and note decreased breath sounds on the right side.
- SpO2 is 91% on room air.
- His respiratory rate is 24 breaths per minute.

Question:
Based on the post-bronchoscopy findings, what do you suspect is the most likely complication?
a. Bronchospasm
b. Pneumothorax
c. Atelectasis
d. Pneumonia

SITUATION 21.1

Scenario:
Ms. Gascon, 48 years old, was admitted for cellulitis in her left forearm. Her medical record indicates a past history of type 2 diabetes, hypertension and dyslipidemia. Her BMI is 25 kg/m2 and she is not a smoker.

Since she was admitted, Ms. Gascon has been having episodes of hyperglycemia when she wakes up in the morning. The physician changed the medical orders yesterday:

- Humulin® R insulin at meals and 1/2 dose at bedtime, as per scale.
- Humulin® N insulin 16 units at breakfast and Humulin® N insulin 12 units at supper. Ms. Gascon eats a piece of cheese and two crackers at 21:00.

The next day, at 05:00, you observe that Ms. Gascon is trembling and that her skin is clammy. She tells you that she is having palpitations. You check her blood glucose with a glucometer: 3.0 mmol/L. Ms. Gascon drinks 175 ml of orange juice.

Fifteen minutes later, Ms. Gascon's blood glucose is 3.6 mmol/L. She says to you: "Can you get me a cracker with peanut butter? That's what I take to get my blood sugar level back to normal when I'm at home."

Question:
Will you agree to do as she asks?
a. Yes, because the carbohydrates raised her blood glucose and relieved her symptoms.
b. Yes, because eating protein will prolong the effect of the carbohydrates.
c. No, because this type of snack would slow down the absorption of carbohydrates.
d. No, because her blood glucose is still below 4.0 mmol/L.

SITUATION 21.2

Scenario:
Ms. Gascon's clinical condition has stabilized and you are talking with a nursing intern who is paired with you. She is wondering why Ms. Gascon had an episode of hypoglycemia this morning.

Question:
What is the most likely cause of her hypoglycemia?
a. The Humulin® R insulin she was given at supper.
b. The Humulin® R insulin she was given at bedtime.
c. The Humulin® N insulin she was given at breakfast.
d. The Humulin® N insulin she was given at supper.

SITUATION 22.1

Scenario:
Ms. Camille Boucher, a 28-year-old primiparous patient in her 30th week of pregnancy, has just been diagnosed with gestational diabetes following abnormal oral glucose tolerance test results. During your conversation, she appears anxious and says:

"My father has diabetes and he always talks about how strict his diet has to be. I'm scared I'll have to live like that forever too. I don't want this to be my life."

Question:
What is the most appropriate response to reassure and educate the patient?
a. Most women do not develop diabetes after childbirth.
b. If you follow a good diet, you will recover from gestational diabetes.
c. Gestational diabetes is not hereditary.

SITUATION 22.2

Scenario:
After a few weeks she has now given birth to a full-term baby boy via spontaneous vaginal delivery. Her blood glucose levels during pregnancy were moderately well-controlled through diet and occasional insulin.

A few hours after delivery, the newborn is placed under routine monitoring by the neonatal team.

Question:
Which complications could the newborn experience as a result of the mother's gestational diabetes? Choose TWO answers
a. Hypoglycemia
b. Hyperglycemia
c. Microsomia
d. Macrosomia

SITUATION 22.3

Scenario:
At 6 hours of life, while you are doing your routine check, the baby begins to show jerky movements and appears slightly irritable.

Question:
What is your initial nursing intervention?
a. Notify the physician immediately
b. Check the baby's blood glucose
c. Administer a feeding
d. Monitor the baby for one more hour

SITUATION 23.1

Scenario:
Gabrielle, a 19-year-old college student, was recently diagnosed with type 1 diabetes mellitus. While attending class, she develops a headache, reports blurred vision, and feels anxious and shaky. She realizes she forgot her portable blood glucose monitor in her dorm room. She seeks help from the campus health nurse, unsure of what to do.

Question:
What should the campus nurse advise Gabrielle to do?
a. Eat a piece of pizza.
b. Drink some diet pop.
c. Eat 15 g of simple carbohydrates.
d. Take an extra dose of rapid-acting insulin.

SITUATION 23.2

Scenario:
Fifteen minutes after giving 15 g of simple carbohydrates, Gabrielle's symptoms have improved. You check her capillary blood glucose, and the result is 4.2 mmol/L. The time is now 11:30 AM, and lunch will be served soon in the dining hall.

Question:
What is your next nursing intervention?
a. Send her back to class
b. Give another 15 g of simple carbohydrate
c. Ask her to eat her lunch now
d. Give a dose of rapid-acting insulin

SITUATION 24.1

Scenario:
Mr. Laurent, a 24-year-old patient with a history of epilepsy, is admitted for seizure monitoring.
He has been stable since admission and is on prescribed medication. His medical orders include:

- Phenytoin (Dilantin) 100 mg PO bid
- Lorazepam (Ativan) 2 mg IV PRN for seizure lasting more than 5 minutes

While on your evening shift, you hear the bed alarm and rush to his room. You find Mr. Laurent actively seizing in bed. He is having a tonic-clonic seizure: his body is stiff, shaking, his eyes are rolling upward, and there is drooling from his mouth. The padded side rails are already up.

Question:
What is your next priority intervention?
a. Notify the physician
b. Administer PO phenytoin (Dilantin)
c. Administer Ativan IV PRN
d. Place the patient in a lateral safety position

SITUATION 24.2

Scenario:
The next day, Mr. Laurent, the same 24-year-old patient with epilepsy, begins to tremble and complains of a headache.

He appears confused, has difficulty with balance, and shows mild nystagmus.
Lab results indicate:

- Potassium: 3.2 mmol/L (reference range: 3.5-5 mmol/L)
- Phenytoin (Dilantin) level: 80 micromol/L (reference range: 40–80 micromol/L)

Question:
What do you suspect is happening to the patient?
a. Dilantin toxicity
b. Hypokalemia
c. Another seizure episode
d. Status epilepticus

SITUATION 24.3

Scenario:
Mr. Laurent, now stabilized and seizure-free, is being prepared for discharge. He will continue phenytoin (Dilantin)therapy at home as per the neurologist's orders. As part of your discharge teaching, you explain the importance of monitoring for long-term side effects of the medication.

During teaching, Mr. Laurent says, "I read somewhere this medication can affect my gums. Is that true?"

Question:
What is your best response regarding discharge teaching?
a. "That's not something to worry about unless you already have dental problems."
b. "You can prevent gum problems by brushing only once a day to avoid irritating the gums."
c. "Yes, phenytoin can cause gum swelling. Make sure to see your dentist once a year."
d. "Yes, phenytoin can cause gum overgrowth. Practicing good oral hygiene can help prevent it."

SITUATION 25.1

Scenario:
In perinatal care, a mother of Inuit origin waited 3 days before seeking consultation for her baby, who has been experiencing respiratory difficulties (bronchiolitis) for 5 days. She had previously been seen at the CLSC by your nursing colleague, who made her feel judged by saying, "You waited too long to come in."

Question:
What do you do?
a. Give her the complaints department number.
b. Ask, "What alternative (medicinal) measures did you use before coming?"
c. Ask, "How long has your baby had these symptoms?"
d. Say, "I will take the time to teach you the signs of deterioration."

SITUATION 25.2

Scenario:
You ask the mother, "What alternative (medicinal) measures did you use before coming?" She responds calmly that she used smoke from burning traditional plants and breast milk drops in the baby's nose, as taught by her grandmother. She adds that she was waiting to see if these would help before coming to the clinic.

She appears hesitant to make eye contact and gently rocks her baby in her arms.

Question:
Which is the most appropriate next nursing action?

a. Reassure her that traditional remedies have no medical evidence and educate her on scientific treatments.
b. Thank her for sharing and ask if she'd be open to combining traditional practices with medical treatment.
c. Encourage her to stop using traditional practices and come to the clinic sooner next time.
d. Document her use of traditional remedies and report it to social services for delayed care.

SITUATION 25.3

Scenario:
The mother nods slightly when you ask if she'd be open to combining traditional practices with medical care. You thank her again for trusting you with that information and explain gently:

"We want to work together with you to help your baby get better. If there are traditional things you'd like to continue doing at home, we can talk about how they can be used safely alongside treatment."

She visibly relaxes and begins asking questions about the baby's breathing and the treatments offered.
You assess the infant: nasal flaring, wheezing, and mild chest retractions are noted. The baby's O2 saturation is 91% on room air.

You explain that the baby may need supportive care for bronchiolitis, possibly including humidified oxygen, nasal suctioning, and frequent monitoring, but no antibiotics are needed at this point since it is viral.

Question:
What is your next best culturally sensitive nursing action?
a. Inform her that bronchiolitis requires hospital admission and she cannot use any traditional remedies here.
b. Allow time for the mother to ask questions, explain each step of the treatment plan clearly, and offer to involve an Indigenous liaison or interpreter.
c. Emphasize that traditional practices are not recommended and may interfere with medical treatment.
d. Proceed with medical orders without further discussion, as time is critical for respiratory distress.

SITUATION 26

Scenario:
Mr. Gérard Moreau, 72 years old, is hospitalized for management of a hypertensive crisis. His medical history includes longstanding hypertension, type 2 diabetes, and dyslipidemia. He is alert, oriented, and reports no current symptoms. During your morning shift, you perform a routine assessment and review the medical orders:
Current Medical Orders:

- Amlodipine 10 mg PO daily at 08:00
- Hydralazine 10 mg PO PRN if systolic BP >180 mmHg
- Metformin 500 mg PO BID
- Atorvastatin 40 mg PO HS
- Accu-check AC & HS
- Vital signs Q4H
- Low sodium, diabetic diet
- Notify physician if systolic BP remains >180 mmHg despite PRN intervention

At 08:00, you administer Amlodipine 10 mg PO as ordered.

At 08:30, you reassess Mr. Moreau's condition:
Vital signs at 08:30:

- BP: 186/94 mmHg
- HR: 82 bpm, regular
- RR: 18 breaths/min
- T: 36.7°C (oral)
- SpO2: 96% on room air
- Blood glucose (Accu-check): 7.4 mmol/L

Mr. Moreau remains calm and comfortable, with no complaints of chest pain, headache, or visual disturbances.

Question:
What is your next priority intervention?
a. Wait another 30 minutes to allow the Amlodipine to reach full therapeutic effect
b. Administer Hydralazine 10 mg PO PRN
c. Notify the physician immediately, even if no symptoms are present
d. Ask the patient to lie flat and recheck the blood pressure in one hour

SITUATION 27

Scenario:
Mr. Rodrigue Allard, a 56-year-old male, is admitted to the intensive care unit with a hypertensive crisis. His blood pressure on admission was 240/130 mm Hg. He is alert but complains of a severe headache and blurred vision. He has no known history of hypertension, and this is his first hospitalization. IV antihypertensives have been started as per protocol. The medical team is closely monitoring for signs of target organ damage.

As the bedside nurse, you begin your hourly assessments.

Question:
What is your priority assessment during the first hour of care?
a. Heart rate
b. Pedal pulses
c. Lung sounds
d. Pupil responses

SITUATION 28.1

Scenario:
Mr. Félix Boudreau, 79 years old, has advanced-stage lung cancer and is under palliative care. He is no longer receiving curative treatment. He has a "Do Not Resuscitate" (DNR) status and is being kept comfortable with medications as needed for pain and respiratory

symptoms.

At 10:15 during your morning round, you find Mr. Boudreau sitting upright in bed, visibly short of breath, struggling to complete full sentences, and appearing anxious. His oxygen saturation is 92% on 2 L/min by nasal cannula, respiratory rate is 28/min, and he is using accessory muscles to breathe.

He received his last dose of furosemide (Lasix) at 07:00, and the next dose is scheduled at 12:00.

Medical orders (palliative protocol):

- Furosemide (Lasix) 40 mg IV q6h
- Scopolamine 0.4 mg SC q4h PRN for respiratory secretions
- Midazolam (Versed) 1 mg SC q2h PRN for anxiety/restlessness
- Morphine 2.5 mg SC q1h PRN for dyspnea and pain
- Oxygen 2–4 L/min via nasal cannula to maintain comfort

Question:
Which medication will you administer?
a. Administer Lasix 40 mg IV q6h
b. Administer Scopolamine 0.4 mg SC q4h PRN
c. Administer Morphine 2.5 mg SC PRN
d. Administer Midazolam (Versed) 1 mg SC q2h PRN

SITUATION 28.2

Scenario:
It's now 12:30 PM. Mr. Félix Boudreau is resting more comfortably after receiving morphine for dyspnea earlier. His respiratory rate is now 20/min, and his O2 saturation is 94% on 2 L/min via nasal cannula. He is alert and calm, though slightly fatigued. His daughter brings in a small container of pizza and fries, smiling and saying, "Dad's been asking for this all week."

Mr. Boudreau looks at you and says, "It may not be the healthiest, but I just want a few bites. Is it okay?"

Question:
As the nurse, what is the most appropriate response?
a. "No, your diet is restricted due to your condition."
b. "I'll need to check with the doctor before you eat that."
c. "Let's wait until your appetite improves before eating rich food."
d. "Yes, you can have some if you feel up to it."

SITUATION 28.3

Scenario:
You return to check on Mr. Félix Boudreau. Now, he is asleep, but you begin to notice wet, congested breathing sounds." His oxygen saturation is 92% on 2 L/min nasal cannula, respiratory rate is 20 breaths/min, and there are no signs of acute respiratory distress or pain, but the sound is concerning to his family.

Question:
What is your next priority intervention?
a. Administer morphine again for comfort.
b. Suction the patient gently.
c. Reposition the patient and wait.
d. Administer scopolamine as per protocol.

SITUATION 29.1

Scenario:
Mr. Jean-Marc Thibault, 67 years old, has a history of liver cirrhosis secondary to chronic alcohol use. He is admitted with increasing abdominal distension and shortness of breath. On assessment, you note that his abdomen is tense and distended, and he is visibly uncomfortable when lying flat.

The physician diagnoses ascites and prescribes a therapeutic paracentesis, which is performed in the procedure room. A total of 4 liters of fluid is drained, and the patient returns to the unit stable.

Question:
What is the most appropriate assessment to confirm the effectiveness of the paracentesis?
a. Monitor serum albumin levels
b. Measure the patient's weight
c. Measure abdominal girth
d. Assess liver enzyme levels

SITUATION 29.2

Scenario:
Mr. Jean-Marc Thibault, a 67-year-old man with liver cirrhosis and a history of esophageal varices, is under observation in the medical unit. He is afebrile, but today his white blood cell (WBC) count is 12.3 × 109/L (normal: 4.0 – 11.0 × 109/L) and his hemoglobin (Hgb) is 172 g/L (normal: 135 – 170 g/L for males).

This morning, he had a bowel movement and appears slightly pale and more fatigued than usual.

Question:
Which of the following questions should you ask Mr. Thibault?
a. "Did your stool appear black and tarry?" (melena)
b. "Did your stool float or appear oily?" (steatorrhea)
c. "Was there bright red blood in your stool?" (hematochezia)
d. "Did you have diarrhea?"

SITUAITON 29.3

Scenario:
Mr. Jean-Marc Thibault, diagnosed with liver cirrhosis and a history of esophageal varices, has been on a soft diet since his hospital admission. Today, he asks the nurse:

"Why do I have to eat only soft foods? I've been here a few days, and I haven't had any regular meals."

Question:
Which explanation is the most appropriate?
a. To prevent aspiration
b. To prevent bleeding

c. To prevent constipation
d. To help with digestion

SITUATION 30

Scenario:
You are a nurse working in the post-operative care unit. Your patient, a 55-year-old individual with a history of end-stage renal failure, recently underwent a kidney transplant. During your assessment, you notice the following signs and symptoms:
Temperature: 101.8°F (38.8°C)
Blood Pressure: 160/95 mmHg
Urine Output: Reduced to 20 mL/hr
Pain: Tenderness and swelling over the transplanted kidney site

Lab Findings: Elevated serum creatinine (3.2 mg/dL), and a decrease in urine specific gravity to 1.010

Other Symptoms: Fatigue, nausea, and generalized malaise

Question:
Given these findings, what do you suspect is happening?
a. Kidney Transplant Rejection
b. Acute Pyelonephritis
c. Hypovolemic Shock
d. Urinary Tract Infection (UTI)

SITUATION 31

Scenario:
M. Pierre Leclerc, a 50-year-old male, has recently undergone a successful kidney transplant and is now in the post-operative recovery phase. As part of his care plan, you, the nurse, are responsible for educating M. Leclerc on recognizing the signs and symptoms of renal transplant rejection, a critical aspect of post-transplant management.

During your teaching session, you explain the importance of early detection and prompt reporting of any symptoms that might indicate rejection.

Question:
Which of these signs and symptoms should be reported immediately to the physician?
a. Palpitations and thirst
b. Weight gain and fever
c. Flank pain and pyuria
d. Thrill and bruit over the fistula

SITUATION 32.1

Scenario:
Mr. Tremblay, age 65,was admitted with pneumonia.

At 7:00, you notice that Mr. Tremblay is diaphoretic. He says to you: "I've had a very bad heartburn for around 5 minutes and it won't go away no matter what I do". He rates his pain at 7/10; iT is a burning pain and does not radiate. He tells you that the pain came on after his associate called and told him about their firm's financial problems. He adds that the pain is so bad that he is afraid he is going to die.

His vital signs are: BP: 120175 mmHg, P: 110 beats/min., regular, R: 24 breaths/min., depth normal, SpO2: 95%, T: 37.4" C.

His medication Profile includes:
- pantoprazole (Pantoloc) 40 mg/tab, 1 tab PO daily (7:00)
- aluminium hydroxide / magnesium hydroxide (Diovol), 30 ml PO tid PRN, no dose administered today
- nitroglycerin (Nitrolingual) 0.4 mg/spray, 1 spray SL x 3 PRN, no dose administered today
- lorazepam (Ativan), 0.5 mg/tab, 1 tab SL bid PRN and HS PRN, no dose administered today

Question:
Which medication will you administer to Mr. Tremblay?
a. Pantoprazole (Pantoloc)
b. Aluminium hydroxide / magnesium hydroxide
c. Nitroglycerin (Nitrolingual)
d. Lorazepam (Ativan)

SITUATION 32.2

Scenario:
Later during your shift, Mr. Tremblay receives a phone call from one of his business associates. After the call, he sighs and says:

"I know I have to manage my stress, but it's not easy."

He looks visibly tense and rubs his chest lightly, although he denies any current pain.

Question:
What specific recommendation should you give Mr. Tremblay to reduce the risk of experiencing another angina episode?
a. Set clear boundaries between work and personal life, such as avoiding business calls during rest periods
b. Continue to manage stress as best as he can
c. Practice breathing techniques during breaks
d. Incorporate light physical exercise daily

SITUATION 32.3

Scenario:
A few hours after your initial intervention resolved Mr. Gérard Tremblay's chest pain, he reports a return of mild pressure in the chest, accompanied by nausea and sweating. You notify the physician, who prescribes a repeat ECG.

His blood pressure is 138/78 mmHg, heart rate is 88/min and regular, and oxygen saturation is 95% on room air.

Question:
What result could justify Mr. Tremblay's chest pain?
a. Sodium level: 140 mmol/L (Normal: 136–145 mmol/L)
b. Potassium level: 3.4 mmol/L (Normal: 3.5–5 mmol/L)

c. Troponin level: 1.2 ng/L (Normal: 0–0.4 ng/L)
d. Platelet count: 130,000/mm³ (Normal: 150,000–300,000/mm³)

SITUATION 33

Scenario:
Mr. Jean-Paul Dufresne, 67 years old, underwent abdominal surgery three days ago for a perforated appendix. During your shift, he reports increasing abdominal pain that is now constant and more severe than before. He appears pale and slightly diaphoretic. He states, "My stomach feels very tight and sore, worse than yesterday."

You perform an abdominal assessment and find that his abdomen is hard and distended. He winces with even light palpation. His temperature is 38.6°C, pulse 108/min, blood pressure 100/64 mmHg, and respiratory rate 24/min.

Laboratory results show:
- WBC count: 22,000/mm³ (Normal: 4,500–11,000/mm³)
- Potassium: 3.9 mmol/L (Normal: 3.5–5.0 mmol/L)
- Hemoglobin: 14 g/dL (Normal: 135–175 g/L for men)

Question:
Which assessment data support the nurse's suspicion of peritonitis?
a. Absent bowel sounds and potassium level of 3.9 mmol/L
b. Abdominal cramping and hemoglobin of 14 g/dL
c. Profuse diarrhea and stool specimen shows Campylobacter
d. Hard, rigid abdomen and white blood cell count of 22,000/mm³

SITUATION 34.1

Scenario:
Mr. Michel Beaudry, 79 years old, is admitted to the telemetry unit for monitoring after complaining of palpitations and lightheadedness. He has a history of hypertension and coronary artery disease. You are reviewing his cardiac monitor during your shift. Suddenly, his cardiac rhythm changes. The monitor now shows the following:
- No visible P waves
- Fine, wavy lines between the QRS complexes
- QRS complexes are narrow, measuring 0.08 seconds
- The ventricular rate is 120 beats/min and the rhythm is irregular

Question:
What do you suspect is happening to the patient?
a. Sinus tachycardia
b. Atrial fibrillation
c. Ventricular fibrillation
d. Ventricular tachycardia

SITUATION 34.2

Scenario:
Following the episode of atrial fibrillation, the physician reviews Mr. Beaudry's condition and prescribes metoprolol (Lopressor) to help control his heart rate.

The order reads:
Metoprolol 25 mg PO bid.

You are now preparing to administer the first dose.

Question:
Which monitoring is essential when administering this medication?
a. ST segment
b. Heart rate
c. Troponin
d. Myoglobin

SITUATION 34.3

Question:
In addition to metoprolol, what medication does the nurse expect to administer?
a. Heparin
b. Atropine
c. Dobutamine
d. Magnesium sulfate

SITUATION 34.4

Scenario:
Later in the shift, you come in to administer warfarin (Coumadin) to Mr. Michel Beaudry. He looks confused and says,

"I'm already on blood thinner. Why are you giving me this pill now too? I'm worried I might bleed."

Question:
What is your best response to Mr. Beaudry?
a. "You're right to be concerned, let me call the doctor to stop the medication."
b. "Warfarin and heparin work differently but have the same effect, so we always give both."
c. "This pill is just a backup in case the heparin doesn't work."
d. "It takes 3–5 days for warfarin to reach its full effect, so we give both until it becomes therapeutic."

SITUATION 34.5

Scenario:
As part of his discharge teaching, you begin reviewing important information about dietary considerations while taking warfarin.

When you explain that vitamin K can affect how warfarin works, Mr. Beaudry becomes concerned and says:

"Oh no, I eat a lot of broccoli. I love it—should I stop eating it now that I'm on this medication?"

Question:
What is the best response to give Mr. Beaudry?
a. "Yes, you'll need to stop eating broccoli completely."
b. "Eat as much broccoli as you want—it doesn't really

affect your medication."
c. "You don't need to stop eating broccoli, but it's important to keep your intake consistent."
d. "Just eat broccoli only on the days you don't take your medication."

SITUATION 34.6

Scenario:
Mr. Michel Beaudry asks you another question:
"I usually have grapefruit or grapefruit juice with breakfast—should I still drink that now that I'm taking warfarin?"

Question:
What is the best response to give Mr. Beaudry?
a. "It's fine as long as you drink it in the evening, not in the morning."
b. "It's best to avoid grapefruit products while on warfarin."
c. "Grapefruit is high in vitamin K, so you just need to eat less of it."
d. "You can continue as long as your INR is normal."

SITUATION 34.7

Scenario:
Mr. Michel Beaudry expresses concern about bleeding risk now that he's taking warfarin. He says:

"I'm worried I might bleed easily. Are there things I should change in my daily routine—like when I shave or brush my teeth?"

Question:
What is the most appropriate recommendation to reduce bleeding risk during hygiene care?
a. "Use a soft-bristled toothbrush and an electric razor."
b. "Use regular floss and a straight razor, just be gentle."
c. "Switch to mouthwash only and avoid shaving completely."
d. "No changes needed, just continue your usual routine carefully."

SITUATION 34.8

Scenario:
While reviewing his home medications, he says:

"At home, I sometimes take Aspirin 325 mg when I have a headache or some joint pain. I also use St. John's Wort for stress. Can I continue those?"

Question:
What is your best response?
a. "Yes, both are safe with warfarin since they are over-the-counter."
b. "Stop St. John's Wort but continue taking aspirin to manage pain."
c. "Avoid both aspirin and St. John's Wort unless approved by your doctor."
d. "You can continue taking both if you take warfarin at a different time of day."

SITUATION 34.9

Scenario:
Before Mr. Michel Beaudry leaves the unit, you review the final discharge instructions with him. He nods as you go over his warfarin dose and dietary advice, but then asks:

"How will I know if something's wrong with this medication? What should I be watching for at home?"

Question:
Which signs or symptoms should Mr. Beaudry report immediately?
a. Mild bruising on arms and legs
b. A missed dose of warfarin
c. Bleeding gums after brushing teeth
d. Brown urine or black, tarry stools

SITUATON 35.1

Scenario:
Madame Gisèle Moreau, 62 years old, is hospitalized for a cystostomy, scheduled for the following morning. She has a history of angina pectoris and gastric ulcer.
Medical Orders:

- Acetaminophen (Tylenol) 325 mg/tab, 1–2 tabs PO q4h PRN for pain
- Aluminum hydroxide / magnesium hydroxide (Diovol) 30 mL PO PRN for gastric pain
- Lorazepam (Ativan) 1 mg/tab, 1 tab PO hs PRN the night before surgery
- Dextrose 5% IV, to be started the morning of surgery to keep the vein open

If retrosternal pain:

- ECG stat
- Oxygen at 3 L/min via nasal prongs
- Nitroglycerin sublingual spray q5 min × 3 PRN

At 21:00, Madame Moreau says:
"I've had a squeezing pain in my stomach for the last five minutes, and it's radiating to my left shoulder. I'm a little nervous about tomorrow."

Question
What is the next priority assessment question you must ask?
a. If the pain radiates
b. The factors that contributed to the onset of the pain
c. The quality of the pain
d. The severity of the pain from 0–10

SITUATION 35.2

Scenario:
After your initial assessment, angina is your leading hypothesis. You follow the medical orders: you administer oxygen at 3 L/min via nasal prongs, and Madame Moreau self-administers sublingual nitroglycerin.

She remains slightly anxious, and you are preparing to give her lorazepam (Ativan) as prescribed. However, you know that reducing myocardial oxygen demand is your immediate priority.

Question:
Before administering the lorazepam, which single intervention should you carry out to best help decrease Madame Moreau's myocardial oxygen needs?
a. Put the patient in upright (high Fowler's) position.
b. Assess the patient's vital signs especially her oxygen saturation.
c. Obtain an ECG as per hospital protocol.
d. Notify the physician immediately.

SITUATION 35.3

Scenario:
Later in the evening, Madame Moreau is feeling much better. Her chest discomfort has subsided following rest and nitroglycerin administration. As part of her discharge education, you begin reviewing important information about angina and myocardial infarction (MI).

She asks, "How can I know next time if it's just angina or something more serious like a heart attack?"

Question
What is the major difference between angina and the pain associated with myocardial infarction (MI)?
a. Angina is relieved with nitroglycerin and rest.
b. Angina can be fatal.
c. MI pain always radiates to the left arm or jaw.
d. MI pain cannot be treated.

SITUATION 36.1

Scenario:
Madame Moreau, 62 years old, admitted for pre-operative care, presented earlier with angina-like chest pain radiating to her left shoulder. As per medical orders, you administered O2 at 3 L/min via nasal cannula and Nitroglycerin sublingual (0.4 mg) at 21:15.
At 21:30, you reassess the patient:

- Blood pressure: 88/48 mmHg
- Heart rate: 84 bpm
- SpO2: 96% on 3 L/min O2
- Chest pain: still present
- Cardiac monitor: shows T-wave inversion

Question:
What is your next priority nursing intervention?
a. Hold further doses of Nitroglycerin and notify the doctor immediately for further orders
b. Administer Morphine IV and place the patient in reverse Trendelenburg position
c. Administer Nitroglycerin and monitor the patient's blood pressure
d. Encourage the patient to rest and take deep breaths

SITUATION 36.2

Rationale:
She has been prescribed Nitroglycerin sublingual tablets for management of stable angina. During your medication teaching session, she tells you:

"Sometimes I take more than one tablet when the pain doesn't go away quickly. But then I get a bad headache. Should I be worried?"

Question:
What should you explain to Madame Moreau?
a. Headache is a common side effect due to the vasodilating effects of the medication.
b. A headache indicates that a person is allergic to the nitroglycerin.
c. The experience of headache means that the levels of nitroglycerin are toxic.
d. The experience of a headache likely means that the tablets have passed their expiration date.

SITUATION 37

Scenario:
Monsieur Claude Gagnon, 68 years old, has been prescribed enalapril, an angiotensin-converting enzyme (ACE) inhibitor, to help manage his hypertension.

This morning, he calls the clinic nurse and says:
"This dry cough just won't go away. It's really annoying. I've had it ever since I started this new blood pressure medication."

Question:
The nurse should respond by making which statement?
a. "The medication may need to be changed."
b. "The cough must be the start of a respiratory infection."
c. "The medication needs to be taken with large amounts of water to prevent the cough."
d. "This sometimes happens, and you will need to take a cough medication with each dose of medication."

SITUATION 38.1

Scenario:
Monsieur Jean-Philippe Moreau, 68 years old, was admitted 3 days ago for atrial fibrillation. As per medical orders, he is receiving an infusion of Dextrose 5% 500 mL + Heparin 25,000 units to run at 19 mL/h via a volumetric pump.
At the beginning of your shift at 16:00, you verify the IV pump and notice that the infusion is running at 39 mL/h, instead of the prescribed rate.
You assess his vital signs:

- Blood Pressure: 132/78 mmHg
- Heart Rate: 74 bpm, irregular
- Respiratory Rate: 18/min, regular, normal depth

You instruct Monsieur Moreau to remain in bed until further notice.

Question:
What is your priority intervention at Mr. Moreau's bedside before calling the physician?
a. Stop the infusion and flush the IV line with saline
b. Reset the flow rate of the pump to 19 mL/h, as per medical orders
c. Ask the patient if he changed the pump settings
d. Assess for bruising or active bleeding

SITUATION 38.2

Question:
Once the error has been discovered, what will your priority be in terms of clinical monitoring?
a. Monitor the patient's electrolyte levels
b. Monitor the patient's blood pressure every hour
c. Observe for signs of bleeding
d. Monitor the IV site for signs of infiltration

SITUATION 39

Scenario:
Mr. Gibeau who suffered an acute Myocardial Infarction was admitted to your unit. The following day, the dextrose 5% 500ml + heparin 20, 000 units infusion is set at 23 ml/h on the volumetric pump.

At 7:00, the patient had a venous puncture for aPTT. His result was 162 seconds.

Question:
After consulting the nomogram, which interventions you must carry out?
a. Set the flow rate to 19 ml/h.
b. Set the flow rate to 17 ml/h.
c. Hold the infusion for 6 hours.
d.. Repeat aPTT the next morning

HEPARIN INFUSION NOMOGRAM
THERAPEUTIC OBJECTIVE: Activated partial thromboplastin time of 50-80 seconds

aPTT	Bolus (units)	Hold infusion (minutes)	Adjust infusion (ml/h)	Repeat aPTT (after rate change)
<30	5000	0	2	6h
30-39.9	2500	0	2	6h
40-49.9	0	0	2	6h
50-80	0	0	0	Next morning
80.1-89.9	0	0	-2	Next morning
90-109.9	0	30	-2	6h
110-129.9	0	60	-3	6h
130-149.9	0	60	-4	6h
>150	0	60	-6	6h

Notify attending physician or the health care team if aPTT >150 or <50 or if a surgical procedure is scheduled.

SITUATION 40

Scenario:
Mr. Émile Gagnon, a 67-year-old man undergoing chemotherapy treatment for colorectal cancer, is being discharged home today. During your discharge education session, Mr. Gagnon appears concerned and says:

"My daughter is pregnant. She often comes by to help me around the house. How can I protect her while I'm on chemotherapy?"

You explain that chemotherapy drugs can be harmful not only to cancer cells but also to healthy individuals, particularly vulnerable people such as pregnant women.

Question:
Which action should the nurse counsel the client to perform after receiving chemotherapy that would most likely protect those who live with the client?
a. Flush the toilet twice with the lid down after using
b. If the client vomits, close the door to the area and allow it to dry before cleaning
c. Wash all clothes that have body fluids on them by hand
d. Use a separate set of flatware and dishes that are not used by others in the family

SITUATION 41

Scenario:
Mme. Claudine Bérubé, 71 years old, underwent a bowel resection two days ago for diverticulitis. The surgery was uneventful, and she is now in the postoperative recovery unit. She is receiving IV fluids and pain medication as prescribed. On your shift, Mme. Bérubé tells you:

"I still haven't passed gas, and my stomach feels bloated."

You note that her abdomen is slightly distended, and she has not yet had a bowel movement. Bowel sounds are hypoactive. Her vital signs are stable, and she is tolerating clear fluids. The medical team is monitoring her closely for signs of postoperative ileus.

Question:
What is the best intervention to help stimulate Mme. Bérubé's bowel activity postoperatively?
a. Increase her IV fluid rate
b. Encourage deep breathing exercises hourly
c. Offer her a warm blanket to relax the abdominal muscles
d. Provide sugar-free chewing gum

SITUATION 1.1

D. To decrease the preload

In the context of acute decompensated heart failure, placing the patient in high Fowler's position promotes venous pooling in the lower extremities, which helps reduce preload—the volume of blood returning to the heart. This reduces the workload on a failing heart and can improve pulmonary congestion and oxygenation.

- Option a is incorrect: Increasing venous return would increase preload, worsening heart failure symptoms.
- Option b is not the clinical priority in this case.
- Option c is incorrect: Increasing afterload would increase the resistance against which the heart has to pump, which could worsen cardiac output in a patient with compromised cardiac function.

SITUATION 1.2

D. Review her urine output since she was admitted

In the context of heart failure and possible fluid overload, urine output is a key indicator of renal perfusion and cardiac function. Decreased output may suggest worsening heart failure, reduced renal perfusion, or evolving acute kidney injury. Before notifying the physician, this information helps determine the severity of the patient's fluid status and guides potential diuretic therapy.

- Option a (pedal pulses) is useful but not as urgent.
- Option b (blood glucose) is not the priority in a patient with respiratory compromise and possible fluid overload.
- Option c (bowel movements) is not relevant to the current situation.

SITUATION 1.3

A. Check the patency of the peripheral intravenous catheter

In a cardiac arrest situation, IV access is essential to administer emergency medications such as epinephrine and fluids. Since Ms. Latour already has a peripheral IV catheter in place, your next priority is to confirm it is patent and functional so that the code team can immediately use it without delay. Ensuring IV access supports effective and timely resuscitation.

- Option b (retrieve the defibrillator) would be handled simultaneously or by another team member—your role at the bedside is to support airway, circulation, and medication readiness.
- Option c (elevating the legs) is not a priority in cardiac arrest.
- Option d (warm blankets) is irrelevant during a full arrest when circulation is absent.

SITUATION 2.1

A. Yes, because her vital signs are stable and her pulse is acceptable.

Digoxin can be safely administered if the patient's heart rate is ≥60 bpm and stable. In this case, the pulse is right at the threshold (60/min), regular, and her blood pressure and overall condition are stable. Therefore, there is no immediate contraindication to giving the medication.

- Option b is incorrect: While caution is important, 60 bpm is an acceptable lower limit for Digoxin if the patient is otherwise stable.
- Option c is incorrect: Digoxin can be scheduled at various times depending on the prescription; in this case, it's clearly ordered at suppertime.
- Option d is incorrect: Even in atrial fibrillation, nurses must assess the pulse before giving digoxin, as bradycardia remains a risk.

SITUATION 2.2

B. Edema of the lower limbs and distended jugular veins

These are classic signs of right-sided heart failure and indicate fluid overload:

- Peripheral edema suggests poor venous return and fluid retention.
- Distended jugular veins indicate elevated central venous pressure, which is a marker of worsening heart function.
- Option a (dry mucous membranes and skin tenting) points to dehydration, not fluid overload.
- Option c (flushed skin, bounding pulses) suggests vasodilation or high cardiac output, not worsening CHF.
- Option d (pale conjunctivae, flat neck veins) points to anemia or hypovolemia, not fluid overload.

SITUATION 2.3

B. No, because she is presenting with signs of digitalis toxicity.

Even though the digoxin level is at the upper limit of the therapeutic range, toxicity can still occur, especially when potassium is low, which increases the heart's sensitivity to digoxin.

Mrs. Tremblay is showing classic signs of digitalis toxicity:

- Yellow-green visual disturbances
- Fatigue and anorexia
- Muscle weakness and dizziness

In this context, with a K+ of 3.4 mmol/L, the risk is significant. The digoxin dose should be held, and the physician should be notified immediately.

- Option a is incorrect: While the level is "technically" within range, clinical symptoms take priority.
- Option c is incorrect: BP is not the deciding factor here.
- Option d is incorrect: The sodium is low-normal but not critical and not the main concern in digoxin toxicity.

SITUATION 2.4

B. Check for breathing and a pulse.

Before initiating CPR, it is critical to confirm that the

patient is not breathing and has no pulse. This ensures the correct sequence of interventions as per Basic Life Support (BLS) protocols:

1. Check responsiveness → Already done.
2. Check for breathing and pulse for no more than 10 seconds.
3. If no pulse and no breathing, start chest compressions (CPR) immediately.
4. Call for help / activate emergency response (e.g., Code Blue, AED, 911 depending on facility).

- Option a is incorrect if breathing and pulse haven't been checked yet.
- Option c delays urgent life-saving measures.
- Option d is not appropriate for an unresponsive, pulseless patient — oxygen doesn't take priority over CPR in cardiac arrest.

SITUATION 3.1

A. Measure urine output and calculate fluid balance

In patients with heart failure and recent transfusion, signs such as orthopnea, increased RR, and drop in SpO2 are red flags for fluid overload.

The priority is to assess for positive fluid balance, which may indicate worsening heart failure or early pulmonary edema.

- b. Blood glucose may be relevant but is not a priority unless symptomatic.
- c. Hemoglobin was already recently checked and transfused accordingly.
- d. BP recheck is good practice but not the most urgent step to confirm fluid overload.

SITUATION 3.2

C. Pulmonary edema

Mrs. Riendeau is exhibiting classic signs of acute pulmonary edema, a complication of fluid overload in a patient with pre-existing heart failure. Key indicators include:

- Inability to lie flat
- Bilateral crackles
- Shortness of breath and hypoxia
- Positive fluid balance
- History of cardiac disease
- Recent blood transfusions, which can exacerbate volume overload

Immediate management may include oxygen support, elevating the head of the bed, and diuretic therapy.

SITUATION 3.3

C. Notify the physician

The patient is demonstrating progressive signs of acute pulmonary edema despite oxygen administration. Her position is already optimized (sitting upright), and vital signs were just taken. The next priority is to notify the physician without delay to obtain medical orders for further management, such as:

- IV diuretics (e.g., furosemide)
- Possibly morphine to reduce preload
- Close monitoring or transfer to a monitored unit if needed

Prompt medical intervention is critical to prevent further deterioration.

SITUATION 4

b. Acute ischemic stroke

The sudden onset of neurological signs—facial asymmetry, slurred speech, and limb weakness—are hallmark signs of stroke. Mr. Gagnon's atrial fibrillation puts him at high risk for embolism, especially since his anticoagulation has been paused. While postoperative delirium is possible in older adults, the focal neurological signs point more directly to a cerebrovascular event.

Pulmonary embolism would likely present with dyspnea, chest pain, and desaturation, not focal deficits. Hypoglycemia can cause confusion but does not typically cause unilateral weakness or facial droop.

SITUATION 5.1

B. Stop the transfusion immediately to prepare Monsieur Dupont for the STAT coronary angiography.

In this scenario, the STAT nature of the coronary angiography indicates an urgent need for the procedure, possibly due to concerns such as myocardial infarction or unstable angina. The priority is to ensure Monsieur Dupont's safety and readiness for the procedure without any ongoing medical interventions that could interfere with the angiography. Stopping the transfusion allows for a safer transition to the angiography, as it minimizes the risk of complications such as transfusion reactions or volume overload, particularly in a patient with heart failure. It is generally advisable to have a waiting period after a blood transfusion before proceeding with another invasive procedure. This allows time for any delayed transfusion reactions to manifest and be treated appropriately. Additionally, it gives healthcare providers a clearer baseline of the patient's status post-transfusion.

Wait until the transfusion is finished and then transport Monsieur Dupont for the coronary angiography and accompany Monsieur Dupont to the angiography suite while continuing the transfusion until completion would delay or complicate the urgent procedure, while increasing the transfusion rate to complete it before the angiography could lead to potential complications due to the rapid infusion rate, especially in a patient with compromised cardiac function (Heart Failure). Therefore, stopping the transfusion is the safest and most appropriate action in this urgent context.

SITUATION 5.2

B. Apply manual compression.

The priority in this situation is to manage the bleeding and prevent further complications. Applying manual compression directly over the puncture site helps to stop the bleeding, reduce the size of the hematoma, and prevent further blood loss. This is an immediate intervention that should be performed as soon as excessive bleeding or a hematoma is identified, especially when the dressing is fully saturated.
Notify the doctor: While it is important to inform the physician of the situation, the first step should be to control the bleeding. Notifying the doctor can follow once the immediate risk is managed.

Loosen the compressive dressing: This would be inappropriate as it could worsen the bleeding. The compressive dressing is meant to help control bleeding by providing pressure at the puncture site.

Ask for your colleague's help: While seeking assistance may be necessary if the situation escalates or additional hands are needed, the immediate priority is to apply manual pressure to control the bleeding.
In this scenario, applying manual compression is the most appropriate and immediate action to ensure the patient's safety and prevent further complications.

SITUATION 6.1

B. Hold both medications and notify the physician.

Both Bisoprolol (a beta-blocker) and Diltiazem (a calcium channel blocker) have negative chronotropic effects—they slow the heart rate. Given the borderline low blood pressure and a heart rate of 58 bpm, administering these medications may cause bradycardia or hypotension severe enough to reduce cardiac output, especially in a patient with heart failure.

Although the patient is currently asymptomatic, the trend in vital sign deterioration (from 108/68 to 98/58 and from 68 to 58 bpm) warrants caution and physician notification before proceeding.

SITUATION 6.2

C. Assess lung sounds

When caring for a patient with pulmonary edema, assessing lung sounds before administering a diuretic like Furosemide (Lasix®) helps determine the extent of fluid accumulation in the lungs. This baseline is crucial for comparing lung status after diuresis and evaluating the effectiveness of the treatment.
You should also evaluate vital signs and serum electrolytes, but in this case, lung sounds provide direct respiratory status insight, which is most relevant to the indication for Lasix.

SITUATION 6.3

B. Weigh him daily at the same time.

In patients with heart failure on fluid restriction, daily weight monitoring is one of the most accurate and practical ways to detect fluid retention. A sudden increase in weight may indicate that the patient is retaining fluid and could be at risk for worsening heart failure or pulmonary edema. Weighing at the same time each day (preferably in the morning, after urinating and before eating) ensures consistent and reliable measurements.

- Option a (recording food) is helpful for dietary tracking but does not monitor fluid overload.
- Option c (urine assessment) can reflect hydration but is subjective and not as accurate for volume status.
- Option d (oxygen saturation after meals) is not relevant to monitoring fluid intake.

SITUATION 7

B. Assess neurovascular status of the affected extremity

After a femoral artery catheterization, there is a risk of impaired blood flow to the lower limb. It is essential to assess circulation, movement, and sensation (CMS) in the affected extremity, including pedal pulses, capillary refill, skin temperature, and color. This helps identify complications like arterial occlusion or compartment syndrome early.

SITUATION 8

C. Fluid overload

Patients with CKD are at high risk of fluid retention between dialysis sessions. Signs such as dyspnea, edema, weight gain, and crackles indicate fluid overload, which is common when ultrafiltration during hemodialysis is insufficient or the interdialytic weight gain is excessive. This is not indicative of acute kidney injury, which would require further labs, nor is hyperkalemia the most likely cause of dyspnea.

SITUATION 9

C. Cloudy peritoneal dialysis effluent

Cloudy outflow is a key early sign of peritonitis, the most common and serious complication of peritoneal dialysis. It may also be accompanied by abdominal pain, fever, or malaise. Immediate consultation with a physician is necessary, as untreated peritonitis can lead to sepsis and dialysis failure.

Clear or slightly pink fluid can be normal immediately after insertion, and mild bloating may occur during adaptation. However, cloudy effluent always warrants medical attention.

SITUATION 10.1

D. Dyspnea

Dyspnea, or shortness of breath, in a patient with CKD who is undergoing hemodialysis could indicate fluid overload. Fluid overload is a common complication in patients with CKD, especially when the kidneys are not able to remove excess fluid effectively. In such cases,

an additional dialysis session may be necessary to remove the excess fluid and alleviate the symptoms of dyspnea.

Oliguria (reduced urine output) is often present in CKD patients, but by itself, it does not necessarily indicate the need for an extra dialysis session unless it is accompanied by signs of fluid overload or electrolyte imbalance.

Hypotension is generally a contraindication for dialysis rather than an indication, as dialysis can lower blood pressure further.

Peripheral edema is a sign of fluid retention but may not be as immediately concerning as dyspnea, which can be a sign of pulmonary edema— a potentially life-threatening condition.

SITUATION 10.2

D. On return from dialysis

ACE inhibitors like enalapril can cause hypotension (low blood pressure), and dialysis itself can lower blood pressure due to fluid removal. Giving enalapril just before or during dialysis increases the risk of intradialytic hypotension, which can lead to dizziness, fainting, or even cardiac complications.

The safest practice is to administer antihypertensive medications like enalapril after the dialysis session, once the patient's blood pressure is stable.

SITUATION 10.3

C. Continue to monitor vital signs.

The patient may have an elevated temperature following dialysis because the dialysis machine warms the blood slightly. If the temperature is elevated excessively and remains elevated, sepsis would be suspected and a blood sample would be obtained as prescribed for culture and sensitivity determinations.

SITUATION 10.4

A. Scrambled eggs, English muffin, and apple juice

Scrambled eggs would provide high-quality protein, and apple juice is low in potassium. Cheese is high in salt and phosphate, and tomato soup would be high in potassium. Split-pea soup is high in potassium, and dairy products are high in phosphate. Bananas are high in potassium, and the cream would be high in phosphate.

SITUATION 11.1

A. Send fluid to the laboratory for culture

Cloudy diasylate indicates infection (peritonitis). Culture of the fluid must be done to determine the microorganism present.

SITUATION 11.2

B. The dialysate contains glucose

Most peritoneal dialysis solutions contain glucose, which can be absorbed systemically through the peritoneal membrane, potentially raising blood glucose levels even in clients without diabetes. Monitoring ensures early detection of hyperglycemia.

SITUATION 12.1

A. Assess the AV fistula for a bruit and thrill.

A bruit (whooshing sound) and thrill (vibration) over the AV fistula indicate that the fistula is patent and functioning properly. This assessment should be done routinely before each dialysis session.

- b. Keep the AV fistula site dry. Keeping it dry is not a specific requirement unless there is a dressing or fresh surgical site. Once healed, the site can be gently washed with soap and water.
- c. Take the client's blood pressure in the left arm. Never take blood pressure, draw blood, or insert IVs in an arm with an AV fistula, as it can damage the access.
- d. Keep the AV fistula wrapped in gauze. A mature fistula does not need to be wrapped, as it should be open to air unless otherwise ordered (e.g., if freshly created).

SITUATION 12.2

A. Carrying heavy items including purses or luggage with the left arm
D. Sleeping with the left arm under the head or body

- a. Carrying heavy items including purses or luggage with the left arm. This can compress the graft and impede blood flow, increasing the risk of thrombosis or damage to the access site.
- d. Sleeping with the left arm under the head or body. This position can also put pressure on the graft, reducing circulation and potentially causing clotting or collapse of the access.
- b. Keeping the arm elevated on a pillow when sitting. Elevation may be encouraged postoperatively to reduce swelling; it is not harmful.
- c. Wearing loose-fitting clothing over the graft site. This is actually recommended, as tight clothing may restrict blood flow.

Note: Avoid also having blood pressure measurements in the affected arm and getting venipuncture in the affected arm.

SITUATION 13.1

A. A perforated ulcer caused by the gastroscopy; notify the physician immediately

While gastroscopy is generally safe, a known peptic ulcer increases the risk of gastric or duodenal perforation, especially during endoscopic manipulation. The sudden onset of epigastric pain,

fever, and hematemesis are red flags for gastric perforation or ulcer rebleed, both of which are medical emergencies. Prompt notification of the physicianis essential to initiate further diagnostics (like an abdominal X-ray or CT scan) and potential surgical intervention

SITUATION 13.2

C. Ensure both top side rails are up and the bed is at the lowest position.

After a gastroscopy with biopsy, patients may remain drowsy due to sedatives used during the procedure. There is a risk of falls or injury due to impaired balance or alertness. Instructing the orderly to ensure safety measures — such as raising side rails, putting the bed at the lowest position, and keeping the call bell accessible — is a priority to prevent injury while the patient recovers. While monitoring oxygen saturation and respiratory status is important, it is nursing responsibility, not something delegated to the orderly in most settings.

SITUATION 13.3

B. 5 mL/h

Formula to calculate infusion rate:

$$\text{Infusion Rate (mL/h)} = \frac{\text{Prescribed Dose (mcg/h)}}{\text{Concentration of Solution (mcg/mL)}}$$

Step-by-step:

- Prescribed Dose = 25 mcg/h
- Available drug = 500 mcg/mL
- Diluted into 100 mL

$$\text{New Concentration} = \frac{500 \text{ mcg}}{100 \text{ mL}} = 5 \text{ mcg/mL}$$

$$\text{Infusion Rate (mL/h)} = \frac{25 \text{ mcg/h}}{5 \text{mcg/mL}} = 5 \text{ mL/h}$$

SITUATION 13.4

B. Assess his alertness and explain the need to report fever, black stools, or persistent abdominal pain

Before discharge, the priority is to ensure Mr. Charbonneau is alert and oriented, and able to understand discharge instructions. The nurse must educate both the patient and his wife to watch for signs of complications after a gastroscopy with biopsy and GI bleeding, including:

- Fever (potential sign of infection)
- Black or tarry stools (possible rebleeding)
- Persistent abdominal pain (may suggest ongoing irritation or bleeding)
- Vomiting blood (hematemesis)

These signs should prompt immediate medical attention.

SITUATION 14.1

D. Promptly assess the patient for potential perforation.

A sudden spike in temperature following an endoscopic procedure may indicate perforation of the GI tract. The nurse should promptly conduct a further assessment of the patient, looking for further indicators of perforation, such as a sudden onset of acute upper abdominal pain; a rigid, board-like abdomen; and developing signs of shock. Telling the LPN to change thermometers is not an appropriate action and only further delays the appropriate action of assessing the patient. The nurse would not administer acetaminophen without further assessment of the patient or without a physician's order; a suspected perforation would require that the patient be placed on nothing-by-mouth status. Asking the LPN to bathe the patient before any assessment by the nurse is inappropriate.

SITUATION 14.2

C. Check to see if the patient's gag reflex has returned

After an endoscopy, patients are at risk of aspiration because the procedure often involves sedation and the use of anesthetics that can impair the gag reflex. Before allowing the patient to consume any food or fluids, it is crucial for the nurse to assess whether the patient's gag reflex has returned. This reflex is a protective mechanism that helps prevent aspiration by ensuring that the patient can swallow safely. Once the nurse confirms that Jean-Luc's gag reflex is intact, it may be safe to give him ice chips or small sips of water. However, until then, giving fluids could lead to aspiration, which is a potentially serious complication. Administering ice chips or water without confirming the return of the gag reflex could increase the risk of aspiration. Keeping the patient NPO for an extended period is unnecessary if the gag reflex returns, and could unnecessarily delay hydration and comfort. Therefore, the best action is to assess the gag reflex first.

SITUATION 15.1

B. She is experiencing hypocalcemia

After a thyroidectomy, especially a total thyroidectomy, accidental removal or trauma to the parathyroid glands may lead to hypocalcemia. Signs include:

- Numbness and tingling around the mouth and extremities
- Muscle twitching or spasms
- Positive Chvostek's or Trousseau's sign (if assessed)

This is a priority situation as hypocalcemia can progress to laryngospasm or seizures. The nurse should notify the physician and be prepared to administer IV calcium gluconate if prescribed.

SITUATION 15.2

A. Prepare to administer IV calcium gluconate as per order

Ms. Marchand is symptomatic, and treatment for hypocalcemia should begin immediately to prevent complications such as laryngospasm, seizures, or cardiac arrhythmias. Administering IV calcium gluconate is the most urgentintervention.

SITUATION 15.3

C. Laryngeal nerve damage during thyroid surgery

Hoarseness of voice after a thyroidectomy may indicate injury to the recurrent laryngeal nerve, which is located near the thyroid gland. This is a known surgical risk and should be monitored and reported to the physician. While mild hoarseness can occur due to intubation, persistent or worsening symptoms point to nerve involvement.

SITUATION 15.4

B. Offer the patient a pen and paper

Providing a non-verbal method of communication such as pen and paper allows the patient to express needs without straining her voice, while reducing anxiety. Whispering actually puts more strain on the vocal cords and should be avoided during recovery.

SITUATION 15.5

B and D

- b. Lifting heavy objects can strain neck muscles and disrupt healing—patients are advised to avoid this.
- d. Driving is discouraged until pain and neck mobility are improved and the patient is no longer taking medications that impair alertness.
- a. After a thyroidectomy, iodine from seafood is not beneficial for the removed thyroid and may interfere with follow-up treatment like radioactive iodine, if needed.
- c. Whispering can strain the vocal cords more than normal speech; patients should rest their voice and communicate by writing if needed.

SITUATION 15.6

C. She is in a severe hypothyroid state affecting her mental status.

Discontinuation of Synthroid in a patient with hypothyroidism can lead to severe depressive symptoms, lethargy, cognitive slowing, and even suicidal ideation. Emotional stress (like the breakup) can aggravate symptoms, but the underlying cause is physiological—an uncorrected hypothyroid state. This is a serious medical and psychiatric concern requiring immediate intervention.

SCENARIO 16.1

A. Use of the accessory muscles
C. Peribuccal cyanosis or pale skin

The answers must indicate the two most relevant clinical signs to look for during the patient's physical examination that would indicate a complication. Blue lips (peribuccal cyanosis) and extremities (hands and feet) may be a good indicator as to whether or not the client is having difficulty breathing and the quality of his oxygenation.

Also, use of the accessory muscles and retractions are indicative of respiratory effort that may be associated with obstruction of the airways by secretions or narrowing of the airways due to edema.

SITUATION 16.2

C. It is a side effect of the medication: salbutamol (Ventolin).

It is a side effect of the medication: salbutamol (Ventolin): Salbutamol, a bronchodilator, can cause side effects such as restlessness, agitation, and difficulty sleeping, especially in children. These symptoms are likely related to the administration of Ventolin.

She is experiencing hypoxia due to inadequate oxygen delivery: This would likely present with symptoms such as cyanosis or increased respiratory effort, rather than restlessness alone.

She is having an allergic reaction to the corticosteroid (Pediapred): An allergic reaction would more commonly present with symptoms such as rash, hives, or difficulty breathing, rather than just restlessness.
The nebulization treatment is causing excessive mucus production: Nebulization with salbutamol generally helps to clear mucus by opening the airways, not increasing its production.

SITUATION 16.3

B. Salbutamol (Ventolin)

Salbutamol is a bronchodilator that works by relaxing the muscles in the airways, making it easier to breathe. Administering Ventolin first helps to open the airways, allowing the subsequent medication, Fluticasone, to be more effectively absorbed into the lungs.

Fluticasone (Flovent): Fluticasone is a corticosteroid that reduces inflammation in the airways. However, it should be administered after the airways are opened with Ventolin for better effectiveness.

It doesn't matter which inhaler is given first: The order of administration is important for the effectiveness of the treatment, with Ventolin needing to be given first. Administer both inhalers simultaneously: Administering both inhalers simultaneously is not effective as the bronchodilator (Ventolin) needs to be given first to open the airways.

SITUATION 16.4

D. Salbutamol opens the airways, allowing Flovent to

penetrate more deeply and be more effective.

Salbutamol opens the airways, allowing Flovent to penetrate more deeply and be more effective: Salbutamol is a bronchodilator that relaxes the muscles around the airways, helping them to open up. By administering salbutamol first, the airways are expanded, which allows the subsequent corticosteroid, Fluticasone (Flovent), to reach deeper into the lungs and be more effective in reducing inflammation.

SITUATION 16.5

B. Flovent mechanism of action is slow and gradual, so it's important to continue the treatment as prescribed.

The mechanism of action of inhaled corticosteroids is slow and gradual, so it's important to continue the treatment as prescribed: Inhaled corticosteroids like Fluticasone (Flovent) work over time to reduce inflammation in the airways. The effects are not immediate, and stopping the medication prematurely can result in a return of symptoms or inadequate control of the condition. It's essential to continue the treatment for the full duration prescribed to ensure that the medication has time to work effectively.
Even if there is no symptoms, there is still inflammation in the respiratory tract, it is therefore important to respect the recommended length of treatment.

SITUATION 17.1

C. Auscultate the client's lungs.

In a client showing signs of an acute asthma attack, the nurse must first assess the severity of airway compromise. Auscultation provides critical information—such as the presence and quality of wheezing or absence of breath sounds (which could indicate a life-threatening obstruction). Only after this immediate respiratory assessment should the nurse proceed with interventions, such as administering medications or obtaining additional history.

SITUATION 17.2

C. Repeat the nebulizer treatment as prescribed.

The client shows partial improvement, and the standing orders allow salbutamol to be repeated every 20 minutes, up to three times, before requiring physician notification. Continuing with a second dose is the appropriate action.

SITUATION 18.1

C. Leave at 2 L/min

The target saturation range is 88–92%. At 2 L/min, the patient's SpO2 is within this range (91%), which is appropriate for a patient with COPD to avoid suppressing their respiratory drive.
Although 3 L/min gives a higher saturation (93%), it exceeds the prescribed maximum. Therefore, maintaining O2 at 2 L/min is the safest and most appropriate choice.

SITUATION 18.2

C. Respiratory acidosis, uncompensated

- pH 7.30: Below normal → indicates acidemia
- PaCO2 55 mm Hg: Elevated → CO2 retention → respiratory acidosis
- $HCO3^-$ 24 mEq/L: Normal → no evidence of renal compensation
- Conclusion: The kidneys have not begun buffering the respiratory acidosis yet → uncompensated.

SITUATION 19.1

A. Decreased oxygen to the brain resulting in confusion

Even with a SpO2 of 92%, an elderly patient with underlying COPD and infection may experience cerebral hypoxia, especially if there is a sudden shift in oxygen levels or perfusion.

- Delirium and restlessness are early signs of decreased oxygen delivery to the brain.
- This is common in older adults and may be mistaken for agitation or behavioral changes, but it can indicate worsening respiratory compromise or evolving hypoxemia.
- It's essential to continue close monitoring, assess for progression, and notify the physician if mental status changes persist or worsen.

SITUATION 19.2

B. "This is usually reversible as his condition improves."

Mr. Ducet's restlessness and confusion are likely signs of hypoxia-induced delirium, a common and reversible condition in older adults with respiratory illness.

- Once oxygenation stabilizes and the underlying infection is treated, cerebral oxygenation improves, and mental status typically returns to baseline.
- This answer provides accurate education and reassurance to the family.
- Option a incorrectly attributes the behavior to medication (no steroids or antibiotics are known to cause delirium this early).
- Option c downplays the seriousness of the symptoms.
- Option d is premature and may unnecessarily alarm the family.

SITUATION 20.1

A. Glycated hemoglobin (HbA1c)

- HbA1c reflects the average blood glucose level over the past 2 to 3 months and is the best indicator of long-term glycemic control.
- Ketonuria is more relevant in cases of suspected diabetic ketoacidosis (DKA), typically in type 1 diabetes or extremely high glucose levels.
- Tremors may suggest hypoglycemia, which isn't supported by this context.
- Glycosuria may occur at elevated glucose levels but is not a reliable or specific measure of diabetic control.

SITUATION 20.2

B. Pneumothorax

- Pneumothorax is a known rare but serious complication of bronchoscopy, especially if a biopsy was taken.
- The presence of dyspnea, chest pain, and decreased breath sounds are classic signs of a possible lung collapse (pneumothorax).
- While bronchospasm may cause wheezing and tightness, it would typically not cause decreased breath sounds on one side.
- Atelectasis may cause decreased breath sounds but is less likely to present this suddenly.
- Pneumonia develops more gradually and is typically associated with fever and productive cough.

SITUATION 21.1

C. No, because this type of snack would slow down the absorption of carbohydrates.

Do not give Ms. Gascon the foods she has asked for because giving foods that contain protein or fat would slow the body's absorption of carbohydrates.

SITUATION 21.2

D. The Humulin® N insulin she was given at supper.

The hypoglycemia this morning was caused by the higher dose of Humulin® N insulin at supper because it is an intermediate-acting insulin with a time to peak action of 4 to 12 h.

SITUATION 22.1

A. Most women do not develop diabetes after childbirth.

- Gestational diabetes (GDM) is typically a temporary condition that develops during pregnancy due to hormonal changes affecting insulin sensitivity.
- Most women return to normal glucose tolerance postpartum, especially if they maintain a healthy lifestyle during pregnancy.
- However, GDM is a risk factor for developing type 2 diabetes later in life, which is why monitoring and prevention education are key after delivery.
- Option b oversimplifies the condition—while diet helps manage GDM, recovery isn't guaranteed just by diet alone.
- Option c is incorrect—genetics and family history do increase the risk for both GDM and type 2 diabetes.

SITUATION 22.2

A. Hypoglycemia and D. Macrosomia

- A. Hypoglycemia:

After birth, the baby is no longer exposed to maternal glucose but may still produce high levels of insulin, which can lead to neonatal hypoglycemia—a common complication in infants born to mothers with gestational diabetes.

D. Macrosomia:

- High maternal glucose levels cross the placenta and stimulate fetal insulin production, promoting fat storage and resulting in a larger-than-average baby (macrosomia). This can lead to complications during delivery, such as shoulder dystocia or the need for cesarean section.

SITUATION 22.3

B. Check the baby's blood glucose

Jerky movements in a neonate can be an early neurological sign of hypoglycemia, especially in infants of diabetic mothers. The initial priority is to confirm or rule out low blood glucose by performing a capillary blood glucose test.

- If hypoglycemia is confirmed, feeding or IV glucose may follow as interventions.
- Notifying the physician comes after assessment.
- Waiting without acting could lead to delayed treatment and possible neurologic damage.

SITUATION 23.1

C. Eat 15 g of simple carbohydrates

Gabrielle is showing classic signs of hypoglycemia (headache, anxiety, blurred vision, shaky). In the absence of a glucometer, it's safest to treat as if she is hypoglycemic.

- 15 g of simple carbohydrates (like 175 mL juice, 3 glucose tablets, or regular soda) is the recommended initial treatment.
- Diet soda contains no sugar and won't help.
- Pizza is high in fat and protein and is too slow to correct a hypoglycemic event.
- Giving insulin without knowing her blood glucose could worsen the situation dangerously.

SITUATION 23.2

C. Ask her to eat her lunch now

After treating hypoglycemia with 15 g of simple carbohydrates (like juice or glucose tablets), the next step is to follow up with 15 g of complex carbohydrates (e.g., whole grain toast, crackers with peanut butter, or a balanced meal) once the blood glucose is in the normal range, to maintain blood glucose stability and prevent another drop.

Since Gabrielle's blood glucose is now 4.2 mmol/L, and it's already lunchtime, there's no need for an additional snack. Eating lunch now serves as the complex carbohydrate source needed to sustain normal glucose levels.

Examples of complex carbohydrates:

- Whole wheat sandwich
- Rice and vegetables
- Pasta with lean protein
- Oatmeal with milk

This prevents another hypoglycemic episode and ensures her energy and glucose levels remain stable throughout the afternoon.

SITUATION 24.1

D. Place the patient in a lateral safety position

The immediate priority is to maintain airway patency and safety during the seizure. Placing the patient in a lateral position allows secretions to drain, reduces the risk of aspiration, and helps protect the tongue. Medication (Ativan IV) is administered if the seizure is prolonged, but safety comes first. Phenytoin PO is not appropriate during active seizures, and notifying the physician is not the priority in the acute phase.

SITUATION 24.2

A. Dilantin toxicity

Despite being at the upper end of the normal therapeutic range, some patients may show signs of toxicity due to individual sensitivity, low albumin, or other interacting factors such as electrolyte imbalances. The presence of tremors, nystagmus, and ataxia are typical early signs. The low potassium may contribute to other symptoms but is not the primary cause in this scenario.

SITUATION 24.3

D. "Yes, phenytoin can cause gum overgrowth. Practicing good oral hygiene can help prevent it."

Phenytoin is associated with gingival hyperplasia, a common side effect, especially in younger patients or those with poor oral hygiene. Teaching includes:

- Brushing teeth twice daily
- Daily flossing
- Regular dental check-ups
- Using a soft-bristled toothbrush
- Rinsing with non-alcoholic mouthwash if recommended

SITUATION 25.1

B. Ask, "What alternative (medicinal) measures did you use before coming?"

The best choice is to Ask, "What alternative (medicinal) measures did you use before coming?"as it shows respect for the mother's cultural background and acknowledges that she may have used traditional or alternative remedies before seeking medical help. This approach opens up a dialogue, allowing the nurse to understand the mother's perspective and incorporate her cultural practices into the care plan, which is essential for providing culturally competent care. It also helps the nurse assess what has been done so far to manage the child's condition, ensuring a holistic understanding of the situation.

SITUATION 25.2

B. Thank her for sharing and ask if she'd be open to combining traditional practices with medical treatment.

This answer reflects cultural humility and respect, key principles in cultural safety. It encourages collaborative care without judgment, builds trust, and allows integration of traditional knowledge with evidence-based practice—especially important when working with Indigenous populations. It also addresses past harm from judgmental attitudes that may lead to delayed future care-seeking.

SITUATION 25.3

B. Allow time for the mother to ask questions, explain each step of the treatment plan clearly, and offer to involve an Indigenous liaison or interpreter.

This continues to build trust and safety in the care relationship. It centers the mother's role, acknowledges her cultural identity, and invites her into shared decision-making. Involving an Indigenous liaison supports trauma-informed, anti-racist, and culturally responsive care.

SITUATION 26

B. Administer Hydralazine 10 mg PO PRN as prescribed for systolic BP >180 mmHg

Though Amlodipine has been administered, it is a long-acting calcium channel blocker and does not act immediately. The PRN order for Hydralazine, a direct-acting vasodilator, is specifically intended to treat breakthrough elevated blood pressure. Since Mr. Moreau's systolic BP is above 180 mmHg, and he remains asymptomatic, the next appropriate step is to follow the standing order and administer the PRN medication. This aligns with both the medication protocol and patient safety.

SITUATION 27

D. Pupil responses

In a hypertensive crisis, there is a risk of hypertensive encephalopathy, stroke, or increased intracranial pressure. Neurological status must be closely monitored, and pupil response is a key early indicator of potential brain involvement. Other vital signs are important, but the immediate concern is detecting life-threatening complications like intracranial bleeding or brain herniation.

SITUATION 28.1

C. Administer Morphine 2.5 mg SC PRN

In palliative care, morphine is the drug of choice to relieve dyspnea. It reduces the sensation of air hunger by decreasing respiratory drive and anxiety, easing the patient's breathing effort and distres. s. Mr. Boudreau is not currently presenting with signs of fluid overload or increased secretions, so Lasix or Scopolamine are not indicated at this time. Versed may be helpful later if anxiety persists, but the priority now is symptom relief of breathlessness, which morphine effectively addresses.

SITUATION 28.2

D. "Yes, you can have some if you feel up to it."

In a palliative care setting, nutritional choices are often based on the patient's comfort and preferences, rather than strict medical diets. There are no active contraindications such as aspiration risk or nausea, and Mr. Boudreau is alert, oriented, and stable. Allowing him to enjoy familiar foods supports his autonomy and emotional well-being, which are central goals in palliative nursing care.

SITUATION 28.3

D. Administer scopolamine as per protocol.

In palliative care, Scopolamine is an anticholinergic medication commonly used to reduce terminal secretions that cause noisy, wet-sounding breathing. This is a comfort measure and helps minimize distress for both the patient and their family. Suctioning is not recommended in most palliative cases, as it can be uncomfortable and ineffective for deep secretions. Repositioning may help slightly but is not sufficient on its own. Morphine has already been administered and is not indicated for secretion management in this case.

SITUATION 29.1

C. Measure abdominal girth

Measuring abdominal girth before and after a paracentesis is the most direct and reliable method to evaluate reduction in fluid accumulation. A significant decrease in girth indicates that the procedure was effective. Additionally, improved breathing and decreased abdominal discomfort are clinical signs of successful fluid removal. While monitoring weight is helpful, changes may take longer to reflect. Albumin and liver enzymes are important in chronic management but do not immediately reflect the success of the paracentesis.

SITUATION 29.2

A. "Did your stool appear black and tarry?" (melena)

Patients with esophageal varices are at risk for upper gastrointestinal bleeding. Melena, or black tarry stools, typically results from partially digested blood originating from the esophagus or stomach.

- Hematochezia (bright red blood) is more typical of lower GI bleeding.
- Steatorrhea (fatty stools) suggests malabsorption, not bleeding.
- Diarrhea is nonspecific and not strongly linked to variceal rupture.

SITUATION 29.3

B. To prevent bleeding

Patients with esophageal varices are at high risk for gastrointestinal bleeding, especially if the delicate blood vessels in the esophagus rupture due to irritation. A soft diet is prescribed to minimize trauma to the esophageal lining, reducing the chance of mechanical irritation or rupture during swallowing.

- Aspiration risk is not the main concern unless there are swallowing difficulties.
- Constipation is more associated with fluid restrictions or opioid use.
- Digestion is not the primary reason for a soft diet in this case.

SITUATION 30

A. Kidney transplant rejection

The elevated temperature, high blood pressure, reduced urine output, tenderness over the transplant site, and elevated serum creatinine are consistent with signs of kidney transplant rejection.

Acute pyelonephritis typically presents with fever, flank pain, and urinary symptoms, but the tenderness over the transplant site and specific lab findings point more towards rejection.

A urinary tract infection might present with fever and dysuria, but it generally doesn't account for the severe decrease in urine output and high serum creatinine seen here.

Hypovolemic shock is characterized by low blood pressure and rapid, weak pulse, but the symptoms here are more indicative of rejection.

SITUATION 31

B. Weight gain and fever

Symptoms of transplant rejection include fever, edema, weight gain, leukocytosis, tenderness over the graft site, and returning symptoms of uremia. Thrill and bruit over the fistula indicate a positive outcome for the fistula. Palpitations and thirst may be symptoms of fluid volume deficit, which is not found in the renal failure patient. Flank pain and pyuria are symptoms of pyelonephritis.

SITUATION 32.1

C. Nitroglycerin

The answer must indicate the most appropriate medication to administer given the client's clinical condition. In the scenario, Mr. Tremblay's signs and symptoms, such as the sudden onset of pain triggered by stress, a heart rate over 100 beats/min., the severity of the pain and a fear of dying are typical of retrosternal pain. Therefore, the administration of sublingual nitroglycerin is indicated for this client.

SITUATION 32.2

A. Set clear boundaries between work and personal life, such as avoiding business calls during rest periods

Mr. Tremblay already acknowledges the need to manage his stress, but his angina episode is linked to ongoing work-related stressors, as shown by his reaction after the business call. The most effective intervention is to encourage specific behavioral changes, such as:

- Not taking calls from work during recovery
- Turning off his phone during personal time
- Delegating tasks when possible

These steps directly address psychological and physiological triggers of angina.

b. Manage stress → too vague, already acknowledged by patient
c. Breathing techniques → helpful but not sufficient or targeted enough for preventing work-triggered episodes
d. Physical exercise → beneficial long-term, but not the most immediate, context-specific solution

SITUATION 33

D. Hard, rigid abdomen and white blood cell count of 22,000/mm³

A hard, rigid abdomen with a significantly elevated WBC count is classic for peritonitis, which is a serious intra-abdominal infection that can develop after surgery. These findings reflect peritoneal inflammation and systemic infection. The other options either show normal or unrelated findings (e.g., potassium and hemoglobin levels within normal limits, or infectious diarrhea unrelated to post-op peritonitis).

SITUATION 34.1

B. Atrial fibrillation

Atrial fibrillation is characterized by absent P waves, replaced by irregular, fine fibrillatory waves (wavy baseline), a narrow QRS complex, and an irregularly irregular ventricular rate. A rate of 120 bpm is consistent with uncontrolled atrial fibrillation.

- Sinus tachycardia would still show identifiable P waves.
- Ventricular fibrillation is chaotic with no identifiable QRS complexes and is a medical emergency.
- Ventricular tachycardia has wide QRS complexes and is usually regular in rhythm.

SITUATION 34.2

B. Heart rate

Metoprolol is a beta-blocker that reduces the heart rate and myocardial oxygen demand. It is essential to assess the patient's apical pulse prior to administration. If the heart rate is below 50–60 bpm, the dose may be withheld and the prescriber notified.

- ST segment is important in myocardial ischemia, not directly impacted by metoprolol.
- Troponin and myoglobin are cardiac biomarkers for myocardial injury, but not routinely monitored for beta-blocker therapy.

SITUATION 34.3

A. Heparin

Patients with atrial fibrillation, especially when newly diagnosed or with episodes lasting more than 48 hours, are at increased risk of thrombus formation due to blood pooling in the atria.
Heparin, an anticoagulant, is often initiated to reduce the risk of stroke or systemic embolism until long-term anticoagulation (e.g., warfarin, apixaban) is started.

- Atropine is used for bradycardia, which is not the issue here.
- Dobutamine is used for heart failure with low cardiac output.
- Magnesium sulfate is given in cases like torsades de pointes or hypomagnesemia—not applicable here.

SITUATION 34.4

D. "It takes 3 to 5 days for warfarin to reach its full effect, so we give both until it becomes therapeutic."

Warfarin (Coumadin) does not provide immediate anticoagulation. It inhibits vitamin K–dependent clotting factors, which have a long half-life. Therefore, IV heparin is used as a bridge therapy to provide rapid anticoagulation while warfarin slowly becomes effective. Both are given concurrently until the INR reaches the therapeutic range (usually 2–3), at which point heparin is discontinued.

SITUATION 34.5

C. "You don't need to stop eating broccoli, but it's important to keep your intake consistent."

Vitamin K–rich foods like broccoli, spinach, kale, and other leafy greens can interfere with warfarin's anticoagulant effect. However, the key teaching point is not to eliminate these foods, but rather to maintain a consistent intake from day to day. This helps stabilize the INR and ensures warfarin works effectively without increasing the risk of clotting or bleeding.

SITUATION 34.6

B. "It's best to avoid grapefruit products while on warfarin."

Grapefruit and grapefruit juice can interfere with the metabolism of many medications, including warfarin, by affecting liver enzymes such as CYP450. This interaction may lead to increased warfarin levels, putting the client at higher risk of bleeding. Patients should be advised to avoid grapefruit products entirely unless approved by their healthcare provider.

SITUATION 34.7

A. "Use a soft-bristled toothbrush and an electric razor."

Clients on anticoagulant therapy such as warfarin are at higher risk of bleeding, even from minor cuts or abrasions. To minimize bleeding risk, patients should:

- Use a soft-bristled toothbrush to avoid damaging gums.
- Shave using an electric razor instead of a blade to reduce the risk of cuts.
- Avoid flossing aggressively unless advised otherwise by a dental professional.
- Report any signs of unusual bleeding, such as

bruising, bleeding gums, or blood in urine/stool.

SITUATON 34.8

C. "Avoid both aspirin and St. John's Wort unless approved by your doctor."

- Aspirin increases the risk of bleeding when combined with warfarin, unless it is specifically prescribed by the physician for dual therapy (e.g., after a cardiac event).
- St. John's Wort can interfere with warfarin metabolism, potentially reducing its anticoagulant effect and increasing the risk of clot formation.
- All prescription, over-the-counter, and herbal medications should be reviewed by the prescribing physician or pharmacist to avoid interactions that could compromise safety.

SITUATION 34.9

D. Brown urine or black, tarry stools

- Brown (tea-colored) urine or black, tarry stools (melena) may indicate internal bleeding, which is a medical emergency while on anticoagulation therapy.
- Other urgent signs to report include:
  - Vomiting blood or "coffee-ground" emesis
  - Sudden severe headache or dizziness (may indicate intracranial bleeding)
  - Nosebleeds that don't stop within a few minutes
  - Bleeding from gums or cuts that lasts more than 10 minutes
- Mild bruising or a missed dose should be discussed, but they are not emergencies unless persistent or recurrent.

SITUATION 35.1

D. The severity of the pain from 0–10

Madame Moreau has already described the quality of her pain (squeezing) and the radiation (to the left shoulder), and she also mentioned feeling anxious about her surgery — a possible contributing factor to her discomfort. However, to complete a pain assessment and determine urgency, you must now ask her to rate the severity of her pain using a 0–10 scale. This is essential to decide whether to initiate the protocol for retrosternal pain, which may suggest cardiac ischemia.

SITUATION 35.2

A. Put the patient in upright (high Fowler's) position.

Placing the patient in High Fowler's position promotes lung expansion, improves oxygenation, and helps reduce preload, all of which contribute to decreasing myocardial oxygen demand—the primary goal in the management of angina.

While vital signs, ECG, and physician notification are all important, they do not directly reduce oxygen demand like positioning does. High Fowler's offers immediate clinical benefit in relieving cardiac workload and supporting oxygenation.

SITUATION 35.3

A. Angina is relieved with nitroglycerin and rest.

The key distinction is that angina is typically relieved by rest and/or nitroglycerin, whereas MI pain persists despite these measures.

- MI may radiate to the left arm or jaw, but not always, so that alone is not a reliable differentiator.
- Angina is rarely fatal when well managed, and MI pain can be treated, though it requires emergency medical intervention.

SITUATION 36.1

A. Hold further doses of Nitroglycerin and notify the doctor immediately for further orders

Nitroglycerin causes vasodilation and can lead to severe hypotension, as seen in this case. A BP of 88/48 is too low to safely administer a second dose. The priority is to withhold further nitroglycerin and notify the physician immediatelyfor further evaluation and treatment orders (e.g., fluid bolus, IV morphine if indicated, ECG interpretation, cardiac enzymes, etc.).

SITUATION 36.2

A. Headache is a common side effect due to the vasodilating effects of the medication.

Nitroglycerin works by dilating blood vessels, which helps relieve angina by improving oxygen delivery to the heart. However, this same vasodilation can cause a headache, especially when multiple doses are taken. This is a known and expected side effect — not a sign of allergy or toxicity. The nurse should reassure the patient and recommend taking acetaminophen if the headache is bothersome, and to avoid exceeding the prescribed number of doses.

SITUATION 37

A. "The medication may need to be changed."

A persistent dry, nonproductive cough is a well-known side effect of ACE inhibitors due to the accumulation of bradykinin in the respiratory tract. This side effect can be severe enough to warrant discontinuation. The nurse should inform the client that the medication may need to be switched to an angiotensin receptor blocker (ARB), which does not cause this cough. Options b, c, and d do not address the true cause or appropriate management.

SITUATION 38.1

B. Reset the flow rate of the pump to 19 mL/h, as per medical orders

When an error is detected in the flow rate of a heparin infusion, the priority is to correct the rate immediately to prevent further overdose. The infusion must be reset to the prescribed rate of 19 mL/h.

You should not discontinue the heparin unless ordered, especially in patients with atrial fibrillation where anticoagulation is essential. The infusion must continue at the correct rate while you notify the physician and await aPTT results and further instructions.

SITUATION 38.2

C. Monitor the aPTT and observe for signs of bleeding

After a heparin infusion error, your clinical priority is to monitor the patient's coagulation status using aPTT (activated partial thromboplastin time) and to observe closely for any signs of bleeding, such as:

- bruising
- hematuria
- bleeding gums
- blood in stool
- hypotension or tachycardia

This allows you to detect early complications from heparin overdose and report promptly.

SITUATION 39

B. Set the flow rate to 17 ml/h.

Following the protocol, the infusion should be stop for 60 minutes then restarts at 9:30 with a flow rate of 17 ml/h (¯ 6 ml/h). After adjusting the infusion rate at 9:30 an aPTT should be done 6 hours later which is at 15:30. The physician should be notified as indicated in the protocol.

SITUATION 40

a. Flush the toilet twice with the lid down after using

Chemotherapy is excreted in urine, stool, and vomit for up to 48 hours. Flushing twice with the lid down helps prevent aerosolization of droplets, protecting others—especially pregnant individuals—from exposure.

- Vomit should be cleaned immediately, wearing gloves—not allowed to dry.
- Clothes contaminated with body fluids can be machine washed separately using regular detergent and hot water.
- Chemotherapy is not transmitted through shared dishes, so separate flatware is not necessary.

SITUATION 41

D. Provide sugar-free chewing gum

Chewing sugar-free gum stimulates the digestive system through a process called sham feeding, which activates gastrointestinal motility by mimicking eating. This simple, low-risk intervention has been shown to help reduce the duration of postoperative ileus.

- Increasing IV fluids or using warming techniques may help with comfort, but they do not directly stimulate bowel activity.
- Deep breathing helps with lung expansion, not bowel movement.

GERIATRICS

SITUATION 1.1

Scenario:
Mr. Gignac, an 80-year-old man, was admitted to a CHSLD one week ago due to Alzheimer's-type major neurocognitive disorder (NCD). While he could follow simple instructions, he frequently forgot recent events. His initial assessment indicated a history of multiple falls at home, and a recent fall risk evaluation confirmed balance issues when standing up.

During the shift report, the night nurse mentioned that Mr. Gignac had pulled his call bell off the wall three times and was found attempting to wrap it around himself. When the nurse checked on him, he had done it again.

Your nursing colleague suggests removing the call bell to prevent further incidents.

Question:
Should you follow your colleague's suggestion?
a. Yes, Mr. Gignac does not use the call bell properly.
b. Yes, the call bell presents a risk of injury for Mr. Gignac
c. No, the call bell is a mandatory piece of safety equipment.
d. No, the call bell must be available in the event of an emergency.

SITUATION 1.2

Scenario:
The next morning, Mr. Gignac experiences a fall while attempting to get up, resulting in a laceration on his left eyebrow. In the afternoon, his daughter is in his room and is concerned about his safety. She asks if the nurse can keep the bed rails raised during his nap to prevent another fall, citing her concern as Mr. Gignac's legal representative.

Question:
Will you follow Mr. Gignac's daughter's request to keep the bed rails raised during his nap?
a. No, using bed rails will interfere with the quality of Mr. Gignac's sleep.
b. Yes, keeping the rails raised will give Mr. Gignac's daughter peace of mind about his safety.
c. Yes, raising the bed rails will help prevent Mr. Gignac from falling out of bed.
d. No. raising the bed rails increases the risk of falls and is considered a restraint.

SITUATION 1.3

Scenario:
After his afternoon nap, Mr. Gignac shows reluctance to get out of bed. He clings to your uniform sleeve with a frightened look, is stiff, resists standing by bending his knees, and leans his body backward. Clinical examination reveals that he is not in pain.

Question:
What do you suspect is happening to Mr. Gignac?
a. Early signs of a stroke.
b. Medication side effect.
c. Post-fall syndrome.
d. Acute anxiety disorder.

SITUATION 2.1

Scenario:
Mr. Beaulieu, 96 years old, has been living in a long-term care centre (CHSLD) for four years. He has a diagnosis of Alzheimer's-type major neurocognitive disorder (NCD).

Yesterday, Mr. Beaulieu was diagnosed with pneumonia. His children are worried about the situation and they make sure there is always someone at his bedside.

Today, Mr. Beaulieu is lying on his left side. He opens his eyes when his name is called and pulls his arm away when you try to take his vital signs. He stiffens and moans when you turn and position him in his bed. After Mr. Beaulieu's physical exam, you suspect that he is in pain.

Question:
How will you complete your assessment of the pain?
a. Use a visual analog scale
b. Question the family member present at the bedside
c. Use a behavioral observation scale
d. Compare the respiratory rate with previous rates

SITUATION 2.2

Scenario:
Three days later, Mr. Beaulieu's overall condition is deteriorating. The physician meets with Mr. Beaulieu's children. It is decided to change the level of medical intervention to comfort care only. The physician changes the medical orders in view of this objective.

You consult the updated medication administration record.

- Scopolamine hydrobromide (Scopolamine TM) 0.4 mg/mL, 0.4 mg (1 mL) subcutaneously q 4 h PRN for bronchial rales
- HYDROmorphone (DilaudidTM) 2 mg/mL, 0.5 mg (0.25 mL) subcutaneously q 1 h PRN for pain or dyspnea
- Midazolam (VersedTM) 5 mg/mL, 2.5 mg (0.5 mL) subcutaneously q 4 h PRN for agitation

Distress protocol max. 3 administrations per 24 h
Administer simultaneously:

- Scopolamine hydrobromide (Scopolamine TM) 0.4 mg/mL, 0.4 mg (1 mL) subcutaneously q 15 min. PRN
- Midazolam (VersedTM) 5 mg/mL, 5 mg (1 mL) subcutaneously q 15 min. PRN
- HYDROmorphone (DilaudidTM) 2 mg/mL, 1 mg (0.5 mL) subcutaneously q 15 min. PRN

In the room, you notice that Mr. Beaulieu is holding onto the bed rails and is continually moving his head from left to right. His respiration is 40 breaths/min., rhythm irregular and depth shallow. You decide to administer the distress protocol, but Mr. Beaulieu's son

who is at the bedside refuses, stating: "You will make him die right away. My sister, who is the legal representative, has not arrived yet. She will be here in an hour."

Question:
What will you do?
a. I suggest administering hydromorphone while waiting for the legal representative
b. I call the legal representative to obtain their consent
c. I communicate with the doctor to determine the course of action
d. I explain that the distress protocol aims to relieve the suffering of her father

SITUATION 2.3

Scenario:
The next day, Mr. Beaulieu is calm and unconscious. His son has been at his bedside since the day before. He says he is tired. He says his father has one visitor after another. He cries and says he has regrets. There are things he would have liked to have said to his father, but he feels he has not had the opportunity to do so.

Question:
What will you propose to Mr. Beaulieu's son?
a. Provide some private time so that he can talk to his father.
b. Suggest that he write a letter to his father.
c. Encourage him to go home and get some rest.
d. Advise him to limit visitors to allow for more personal time.

SITUATION 3.1

Scenario:
Mrs. Gagné, 86 years old, was admitted with a urinary retention problem 24 hours ago. This morning, you observe that she is alert and is cooperative during her hygiene care.

At lunch, you observe that Mrs. Gagné is drowsy. She wakes up when you speak to her and falls asleep at the end of the discussion. She pays little attention to what you are saying and responds to simple commands after several attempts, moving her limbs slowly. Motor strength in the upper and lower limbs is adequate and equal. Pupil size and reactivity are normal. Her vital signs are: BP: 136/78 mmHg, P: 78 beats/min., rhythm regular, R: 18 breaths/min., rhythm regular, depth normal, T: 37.5°C.

One hour after lunch, Mrs. Gagné is walking in the corridor with her daughter. The daughter says that her mother is doing much better than at lunchtime.
In the late afternoon, Mrs. Gagné presents with the same clinical signs as at lunchtime. Her vital and neurological signs are similar to those taken earlier. Her urinary catheter has drained 500 ml of straw-coloured urine since this morning.

Question:
What do you suspect regarding Mrs. Gagné's clinical condition?
a. Clinical manifestations of hypoactive delirium.
b. Clinical manifestations of a urinary tract infection.
c. Clinical manifestations of cerebral ischemia.
d. Clinical manifestations of a sleep disorder.

SITUATION 3.2

Question:
Given your assessment of Mrs. Gagné's condition, what will you do as a priority?
a. Notify the attending physician.
b. Review the medication profile.
c. Stimulate Mrs. Gagné during the next meal.
d. Create a walking program.

SITUATION 3.3

Scenario:
The next day, in the late afternoon, you observe that Mrs. Jomas, Mrs. Gagné's roommate, is angry with her. In fact, she caught her using her toothbrush that she had put away in her drawer. The orderly put Mrs. Gagné in a chair with a tray table attached to stop her from going through her roommate's personal belongings. He placed the call bell nearby, is monitoring her closely and left her a newspaper and towels to fold to keep her busy.

Question:
Do you agree with the use of the tray table?
a. Yes, because it is a measure that respects Mrs. Gagné's dignity and comfort.
b. Yes, because it is not very constraining for Mrs. Gagné.
c. No, because it is a measure that must be prescribed by Mrs. Gagné's physician.
d. No, because there is no imminent risk for Mrs. Gagné in this context.

SITUATION 4.1

Scenario:
Mrs. McDonald, 89 years old, has been living alone since her husband died six months ago. She was admitted to the medicine unit to have an investigation regarding a loss of autonomy.
During the data collection, her son tells you that he found her with her hair uncombed, no make-up on and in her bathrobe, which is not like her. He said that she has difficulty moving around and that she moves more slowly, which has prevented her from doing her activities for the past week.

During the assessment, Mrs. McDonald says that she fell, three days ago, when she was doing her housework. She did not want to bother her son. An X-ray has been scheduled to rule out a fracture.
When Mrs. McDonald gets up to go to the toilet, she moves slowly. When you ask her if she is in pain, she replies impatiently: "No, no, I'm fine."

Question:
What do you suspect regarding Mrs. McDonald's clinical condition and what information is your hypothesis based on?
a. Hypothesis: unrelieved pain. Rationale: history of falls.
b. Hypothesis: onset of delirium. Rationale: sudden loss of autonomy.
c. Hypothesis: presence of depressed mood. Rationale: neglected hygiene.
d. Hypothesis: manifestation of bereavement. Rationale: her husband's recent death.

SITUATION 4.2

Scenario:
The next day, at 08:15, Mrs. McDonald goes to the washroom and has a fall.

During the physical examination, you assess Mrs. McDonald's pain using a numeric scale. Mrs. McDonald rates her pain at 3/10. You notice that her non-verbal behaviour does not match the severity of the pain reported.

Question:
What will you do as a priority?
A. I will complete the fall history.
B. I will assess for the presence of reckless behaviour.
C. I will use a visual analog scale.
D. I will fill out an incident or accident report form.

SITUATION 4.3

Scenario:
Mrs. McDonald is diagnosed with a femoral head fracture. The surgery is scheduled for tomorrow morning.

At 13:15, during your assessment, you observe that Mrs. McDonald is in unbearable pain and that she says she is worried about the surgery tomorrow.

You consult the excerpt from her medication record:

- Hydromorphone (Dilaudid®) 1 mg/tab., 1 tab. (1 mg) PO q 3 h (Last given at 11:00)
- Acetaminophen (Tylenol®) 500 mg/tab., 1 tab. (500 mg) PO q 4 h PRN (Last given at 09:00)
- Hydromorphone (Dilaudid®) 2 mg/ml, 0.125 ml (0.25 mg) subcutaneously q 4 h PRN
- Lorazepam (Ativan®) 0.5 mg/tab., 1 tab. (0.5 mg) SL q 6 h PRN

Question:
Which medication(s) will you administer?
a. Acetaminophen (Tylenol®) PO.
b. Hydromorphone (Dilaudid®) PO.
c. Hydromorphone (Dilaudid®) subcutaneously.
d. Lorazepam (Ativan®) SL.

SITUATION 5

Scenario:
Mrs. Dubois is an 82-year-old patient recently admitted to the nursing unit. She has a history of depression and is currently being treated with two prescribed SSRIs.

In addition, she is given Ativan (lorazepam) at bedtime (HS) to help with anxiety and insomnia, and Laxaday as needed (PRN) to manage occasional constipation.
Given her advanced age and current medication regimen, the nursing team is preparing a Therapeutic Nursing Plan (TNP) to ensure her safety and well-being during her stay.

Question:
Considering Mrs. Dubois's age, medical history, and current medications, what is the most important risk to address in her Therapeutic Nursing
a. Risk of weight gain
b. Risk of constipation
c. Risk of falls
d. Risk of dehydration

SITUATION 6

Scenario:
Marie Dubois, a 62-year-old female, has recently undergone knee replacement surgery. She has been prescribed Percocet for pain management.
During her postoperative recovery, Marie reported her pain as 7/10. The nurse administered Percocet to alleviate her pain. Marie's vital signs are stable, with a blood pressure of 128/82 mmHg, heart rate of 76 bpm, respiratory rate of 16 breaths/min, temperature of 98.7°F (37°C), and oxygen saturation of 97% on room air. She is alert and oriented, and her incision site appears clean with minimal swelling.

Question:
After administering Percocet for pain, which intervention would be of highest priority for the nurse to complete before leaving the patient's room?
a. Ensure that documentation of intake and output is accurate.
b. Leave the overbed light on at a low setting.
c. Ensure that the upper two side rails are raised.
d. Offer to turn on the television to provide distraction.

SITUATION 7.1

Scenario:
Mr. Gérard Tremblay, age 76, was admitted to the hospital following a fall in his apartment. His wife, Mme Ginette Côté, says he had been sleeping more during the day and at times appeared groggy and unsteady at night. He had stood up to go to the bathroom and lost his balance, falling sideways. No head trauma occurred, but he complained of hip pain.
His medical history includes type II diabetes, hypertension, depression, and insomnia.

As per his MAR, he is prescribed the following medications:

Mr. G. Tremblay:

- Diabeta (glyburide) – for diabetes
- Glucophage (metformin) – for diabetes
- Serax (oxazepam) – since the death of his brother
- Lopressor (metoprolol) – for hypertension
- Celexa (citalopram, an SSRI) – for depression

Medication found in the patient's drawer that the patient is taking:
Mme Ginette Côté (wife):

- Tylenol – over-the-counter, for mild pain
- Ativan (lorazepam) – for insomnia

Question:
Which two medications are most likely to have contributed to his fall?
a. Diabeta and Glucophage
b. Serax and Ativan
c. Lopressor and Tylenol
d. Celexa and Diabeta

SITUATION 7.2

Scenario:
As part of his discharge teaching, the nurse must emphasize safe medication practices.

Question
What is the most important teaching the nurse should give Mr. Tremblay?
a. Do not take medications prescribed to other people.
b. Benzodiazepines can cause dependence.
c. Try not to nap during the day so you'll sleep better at night.
d. Take your medication with milk to avoid stomach upset.

SITUATION 8

Scenario:
You are caring for Mrs. Thérèse Marchand, a patient with a neurocognitive disorder who is currently hospitalized in a long-term care unit. Her husband, Mr. Paul Marchand, is her legal representative and both of them signed the consent form for her annual influenza vaccination during the admission process.
During your morning medication rounds, you enter Mrs. Marchand's room to administer the vaccine. She appears alert and cooperative but firmly refuses to receive the injection, stating: "No, I don't want that needle." You reassure her and decide to return later.
You come back 20 minutes later, and she continues to refuse the vaccination, stating again: "I said no."

Question:
What is the most appropriate nursing action at this point?
a. Ask her husband to convince her to receive it.
b. Accept and document her refusal.
c. Explain the benefits and drawbacks of the vaccination.
d. Administer it despite her refusal.

SITUATION 9.1

Scenario:
Mr. Fernand Leblanc, an 82-year-old patient with Alzheimer's disease (Major Neurocognitive Disorder), is brought to the emergency department by his wife, Mrs. Cécile Leblanc, who is also his legal representative and primary caregiver.
Upon arrival, she tells you, "He's been agitated for three days, and his behavior is getting harder to manage." Before entering the room, you overhear Mrs. Leblanc shouting, "I am tired!" Moments later, as you walk into the room, she quickly apologizes and explains: "I haven't slept for three nights… He keeps waking me up." Mr. Leblanc appears calm but disoriented. You observe no signs of physical harm or injury on either of them.

Question:
What do you suspect is happening in this situation?
a. Caregiver role strain/burnout
b. Fatigue
c. Depression
d. Domestic abuse

SITUATION 9.2

Scenario:
A few days after being transferred to the short-stay geriatric unit, Mr. Gérard Leblanc is stable and under observation. His wife, Mme Cécile Leblanc, visits daily but appears exhausted. She confides in you and says, "I haven't been sleeping well. I still feel like I need to be there for him all the time… What if something happens while I'm away?"

Question:
What is the best response to provide Mme Leblanc?
a. "We understand it's hard. You can stay overnight here if you prefer."
b. "You should try distracting yourself by doing chores at home."
c. "You can go home and rest; the healthcare team will take care of Mr. Leblanc and contact you if there's any change."
d. "If you're this tired, maybe your husband should be transferred to long-term care."

SITUATION 9.3

Scenario:
Mr. Leblanc becomes increasingly agitated during your shift while Mme Cécile Leblanc is away on respite.
He enters another patient's room and refuses to leave. He raises his voice, appears disoriented, and is visibly angry when asked to return to his room. The other patient is distressed and asks for help.

Medical Orders:

- Haldol 0.5 mg PO PRN q8h for agitation
- Ensure 1.5 bottles daily with meals
- Tylenol 325 mg PO PRN q4h for pain
- Routine vital signs every shift

Question:
What is your priority intervention?
a. Approach the patient calmly, speak slowly using short, simple phrases, guide him gently back to his room and reassure him
b. Administer Haldol immediately to prevent harm
c. Give Haldol with Tylenol to promote comfort
d. Call the physician immediately to change his medication

SITUATION 10

Scenario:
You are caring for Mme. Lucie Tremblay, an 84-year-old long-term care resident with moderate Alzheimer's disease. She has been stable on her routine medications, including donepezil (Aricept).

This evening, during your rounds, you find Mme. Tremblay restless and agitated, pacing back and forth in the hallway, trying to open the exit door, and mumbling incoherently. She seems more confused than usual and keeps asking for her late husband. Her PRN lorazepam (Ativan) is still available.

Question:
What is the nurse's initial action?
a. Administer the PRN dose of lorazepam (Ativan).
b. Reorient the patient to time and place.
c. Assess the patient for anything that might be causing discomfort.
d. Have a nursing assistant stay with the patient to ensure safety.

SITUATION 11.1

Scenario:
Mr. Henri Dubois, an 82-year-old man diagnosed with a major neurocognitive disorder (dementia), has been refusing hygiene care for the past several days in the long-term care facility.

Despite several strategies, including:
- Changing the nursing assistant assigned to him,
- Providing care with two staff members, and
- Adjusting the timing of his bath,

Mr. Dubois continues to resist care, often becoming verbally aggressive and swearing at staff.
Team members are growing frustrated and concerned about the impact on his hygiene and well-being.

Question:
What is the most appropriate next action by the nurse?
a. Convene an interdisciplinary meeting.
b. Suggest to the family to change his living environment.
c. Inform the facility manager.
d. Talk to the social worker.

SITUATION 11.2

Scenario:
Despite all previous interventions, Mr. Henri Dubois, continues to refuse hygiene care.
The care team has already:
- Assigned different staff members to increase comfort and trust,
- Modified bathing times to match his mood and routine,
- Provided care in pairs to ensure safety,
- Attempted verbal de-escalation using calm, reassuring communication,
- Held an interdisciplinary meeting to explore further strategies,
- Offered hygiene alternatives like sponge baths and grooming in small steps.
- Informed the facility manager, who authorized care protocols in line with legal guidelines

However, Mr. Dubois has persistently refused all hygiene efforts.

Now, other residents in the unit have begun to complain of foul odor, and staff are concerned about the risk of skin breakdown, infection, and social isolation for Mr. Dubois.

Question:
What is your next appropriate nursing action?
a. Perform the hygiene care despite the refusal, using the least restrictive approach.
b. Suggest to the family to change his living environment.
c. Reattempt the bath using a different staff member and delay the care.
d. Document the refusal and wait for the next interdisciplinary meeting.

SITUATION 12.1

Scenario:
Mrs. Chan, 90 years old, was admitted with pneumonia that is being treated with intravenous antibiotics. Her medical record indicates mild Alzheimer's-type major neurocognitive disorder (NCD).

This morning, the orderly suggests to Mrs. Chan that she get up. She insists on staying in bed because she says she is too weak to get up and go to the toilet. The orderly puts incontinence briefs on her so that she would be comfortable.

Four days after her admission, Mrs. Chan's respiratory condition has improved but she has urinary incontinence. At meals, she has a few mouthfuls of her main dish as well as a serving of liquid protein. She drinks an average of 600 mL of water a day. She gets about with the orderly's help. She says to you, in tears: "I don't like this diaper."

Question:
What information will you give Mrs. Chan about the course of her clinical condition?
a. Your urinary incontinence is caused by a loss of sphincter tone.
b. Your urinary incontinence is a condition that may be reversible.
c. Your urinary incontinence is related to the Alzheimer's-type major NCD

SITUATION 12.2

Question:
What other intervention will you plan to provide clinical follow-up for Mrs. Chan?
a. Encourage her to drink 1.5 L of fluids daily.
b. Limit fluids to 1 L daily.
c. Check the incontinence briefs every two hours

SITUATION 13.1

Scenario:
Mr. Émile Bouchard, a 77-year-old man with a diagnosis of major neurocognitive disorder (moderate stage), has been living in an intermediate care facility for the past 6 months. He requires assistance with most of his daily activities, including wound care for a chronic pressure ulcer.

During your afternoon rounds, you enter his room to perform a routine dressing change. Upon entering, you find Mr. Bouchard engaging in a masturbatory act while seated in his chair.

Question:
What is your best nursing intervention in this situation?
a. Divert his attention to perform the dressing change.
b. Ask him to stop.
c. Give him privacy and return later to change the dressing.

SITUATION 13.2

Scenario:
The following morning, you enter Mr. Émile Bouchard's room again to check on his wound and hygiene. Once again, he is engaging in a masturbatory act. The licensed practical nurse (LPN) informs you that this behavior has been occurring daily, especially in the mornings. It is always done in the privacy of his room, and he does not exhibit this behavior in public spaces.

Some new staff members have expressed discomfort, and there is concern about how to manage this behavior respectfully and professionally.

Question:
What is your best action in this situation?
a. Inform the family because this behavior is not tolerated in the facility.
b. Ask him to stop as it is distressing to other patients/staff.
c. Do nothing as it does not affect his health.
d. Notify the manager of the facility.

SITUATION 14.1

Scenario:
Mr. Henri Gagnon, 79 years old, underwent hip replacement surgery two days ago. He has a history of hypertension and type 2 diabetes. Since surgery, he has become disoriented, confused, and occasionally hallucinates. He was cognitively intact before the operation. His daughter approaches the nurse and asks, "Will my father stay like this forever?"

Question:
How should the nurse respond to reassure her?
a. No, because postoperative delirium is usually temporary.
b. No, because his mental state was normal before surgery.
c. Yes, because he's showing signs of permanent decline.
d. Yes, because older patients don't recover fully.

SITUATION 14.2

Question:
Which intervention is most appropriate to help prevent postoperative delirium?
a. Maintain a quiet, well-lit environment with orientation cues like clocks and calendars.
b. Limit fluid intake to avoid urinary incontinence and confusion.
c. Administer sleep medications regularly to ensure uninterrupted rest.
d. Discourage family visits to reduce overstimulation.

SITUATION 15

Scenario:
Mr. Louis Bouchard, an 82-year-old male with a diagnosis of chronic obstructive pulmonary disease (COPD), was admitted for a pulmonary infection. He is currently receiving:

- IV prednisone 50 mg daily
- IV antibiotics (piperacillin-tazobactam)
- Oxygen via nasal cannula at 3 L/min to maintain O2 saturation ≥90%.
- His current O2 sat is 92%, and he is walking around his room, although his daughter notes that at home he usually remains seated due to dyspnea.
- He is also being evaluated for possible delirium, as he is more restless and agitated than usual.
- A new medical order is received to administer IV potassium chloride 20 mEq in 100 mL NS over 2 hours to correct mild hypokalemia.

You assess that the current IV line is being used for prednisone and antibiotics.

Question:
As the nurse, what is your best intervention before administering the potassium chloride?
a. Administer the potassium chloride through the same IV line to avoid delay
b. Pause the prednisone infusion and administer the potassium through the line
c. Administer the potassium chloride only if the daughter gives verbal consent
d. Use a separate IV line or confirm compatibility before administering potassium chloride

SITUATION 16.1

Scenario:
Mr. Paul Tremblay, 68 years old, has paraplegia following a spinal cord injury. He performs intermittent self-catheterization several times daily to empty his bladder. Recently, he developed signs of a urinary tract infection (UTI), including fever, cloudy urine, and burning sensation during catheterization. He asks the nurse, "Why did I get an infection even though I catheterize myself?"

Question:
What is the best explanation to give Mr. Tremblay about why he developed a urinary tract infection?

a. Self-catheterization can introduce bacteria into your bladder despite best practices.
b. Your bladder infection is because you don't catheterize often enough.
c. The infection happens because your body is weak from paralysis.
d. This infection is normal and expected with catheter use.

SITUATION 16.2

Scenario:
A few hours after noticing symptoms of a urinary tract infection, Mr. Paul Tremblay starts to shiver and feels very cold. His temperature is 39°C, and he appears increasingly unwell.

Question:
Given these new symptoms, what is the most likely diagnosis?
a. Cystitis
b. Pyelonephritis
c. Bladder spasms
d. Prostatitis

SITUATION 17

Scenario:
Mr. Albert Desjardins, 87 years old, lives in a long-term care facility. He has moderate-stage Alzheimer's dementia. Before retirement, he was a furniture mover, and after retiring, he regularly participated in a local walking club. For the past week, Mr. Desjardins has been waking up in the middle of the night or very early in the morning. He has been observed shuffling through the hallways, entering other residents' rooms, and rearranging chairs and small tables. His actions have caused complaints and sleep disturbances among other residents.

Question:
What is the most appropriate intervention to help reduce these behaviors?
a. Encourage Mr. Desjardins to help clean or organize safe areas of the unit during the day.
b. Allow Mr. Desjardins to nap for long periods during the afternoon to reduce nighttime wandering.
c. Reprimand the behavior gently and redirect him back to bed when it happens.
d. Implement a walking routine with Mr. Desjardins during the day to provide structured physical activity.

SITUATION 18.1

Scenario:
Mme. Suzanne Gauthier, 82 years old, has moderate dementia and was admitted to the hospital for pneumonia. Her husband holds power of attorney for medical decisions. During your medication round, Mme. Gauthier categorically refuses to take her prescribed oral antibiotics. You explain their purpose clearly, but she remains firm in her refusal. You attempt to contact her husband to inform him and possibly help with consent, but he is not answering his phone.

Question:
What is the most appropriate nursing action at this time?
a. Chart that Mme. Gauthier refused her medication and monitor her condition.
b. Hide the medication in applesauce to ensure she takes it.
c. Wait 30 minutes and try to give the medication again without telling her.
d. Call the doctor to request medication be given intravenously.

SCENARIO 18.2

Scenario:
Later, the unit phone rings, and the caller identifies himself as Mme. Gauthier's husband and asks for an update on her condition.

Question:
What is the most appropriate action before giving any medical information over the phone?
a. Confirm the caller's identity before sharing any patient information.
b. Give the update immediately since he has power of attorney.
c. Transfer the call to the unit clerk to handle.
d. Refuse to speak to anyone over the phone due to privacy laws.

SITUATION 19.1

Scenario:
Mr. Émile Robitaille, 81 years old, was recently admitted following a 5 kg unintentional weight loss over the past month. He has been eating and drinking less since the death of his spouse. He has been diagnosed with late-onset depression. Lab results show:

- Albumin: low
- Glycated hemoglobin (HbA1c): high
- Fasting blood glucose: normal

The interdisciplinary team includes a nutritionist who will be assessing the patient's nutritional status.

Question:
Which laboratory value should the nurse prioritize sharing with the nutritionist?
a. Low albumin
b. High glycated hemoglobin (HbA1c)
c. Normal fasting glucose
d. Recent sodium levels

SITUATION 1.1

B. Yes, the call bell presents a risk of injury for Mr. Beaulieu.

In the scenario, the call bell is a potentialhazard for Mr. Gignac. Since he has Alzheimer's-type dementia, Mr. Gignac tends to be forgetful, including forgetting how to use the call bell. The call bell then becomes an item that is cluttering up his environment and is not the ideal tool for letting nursing staff know that he needs to get up. Other tools would be more suitable, such as a bed sensor mat (motion detector).

SITUATION 1.2

D. No. raising the bed rails increases the risk of falls and is considered a restraint.

The rails must not be raised du.ring Mr. Gignac's nap because they are considered a control measure and are a known risk factor for more severe fall-related injuries.

SITUATION 1.3

C. Post-fall syndrome.

Post-fall syndrome occurs when a patient experiences fear and reluctance to move following a fall, despite not having physical pain. This is consistent with Mr. Gignac's behavior of being stiff, frightened, and resistant to getting out of bed.

While Mr. Gignac appears frightened, the specific symptoms of stiffness and resistance to movement are more indicative of post-fall syndrome rather than a generalized anxiety disorder.

There are no other symptoms present, such as sudden weakness, speech difficulties, or confusion, which are commonly associated with a stroke.

Mr. Gignac's clinical examination shows no signs of pain or distress related to medication side effects, making this less likely.

SITUATION 2.1

A. Use a behavioural observation scale.

Mr. Beaulieu has a major neurocognitive disorder (Alzheimer's disease), which likely limits his ability to communicate pain verbally or reliably use a visual analog scale. Given his condition and the observed behaviors (e.g., moaning, stiffening), a behavioral observation scale is the most appropriate tool to assess his pain. These scales are designed to evaluate non-verbal cues and behaviors, such as facial expressions, body movements, and vocalizations, to determine the presence and intensity of pain in individuals who cannot self-report effectively. This method is more reliable in this context than questioning family members or comparing respiratory rates.

SITUATION 2.2

D. I explain that the distress protocol aims to relieve the suffering of her father

In this situation, Mr. Beaulieu is exhibiting signs of distress, including shallow and irregular breathing, and his behavior suggests he may be in pain or experiencing discomfort. The distress protocol is designed to alleviate suffering and provide comfort care, which aligns with the goal of enhancing Mr. Beaulieu's quality of life during this phase.

It's essential to communicate clearly with the family about the intent of the medication administration, emphasizing that the goal is to relieve suffering rather than hasten death.

This explanation can help address the son's concerns and provide reassurance that the focus is on comfort. While obtaining consent is important, the ethical principles of beneficence (acting in the best interest of the patient) and non-maleficence (avoiding harm) support the use of the distress protocol to manage Mr. Beaulieu's symptoms effectively.

SITUATION 2.3

A. Provide some private time so that he can talk to his father.

Providing private time for Mr. Beaulieu's son allows him the opportunity to express his feelings and thoughts to his father, which can be therapeutic for both. This setting fosters a more intimate environment where he can share his regrets and thoughts, potentially offering him closure. Additionally, it acknowledges his emotional needs during a difficult time, reinforcing the importance of family connections and communication in end-of-life care. While the other options may also be beneficial in different contexts, the immediate need for emotional expression makes option A the most appropriate choice in this

SITUATION 3.1

A. Clinical manifestations of hypoactive delirium.

Mrs. Gagné has clinical manifestations that developed suddenly and fluctuate over time
(a disturbance in her level of consciousness that appears to fluctuate over the day, reduced psychomotor activity, difficulty with attention and impaired cognitive function).
She also has a urinary catheter, which is considered a risk factor for the development of delirium in older adults.

SITUATION 3.2

A. Notify the attending physician.

Mrs. Gagné is an older adult who has had worrying clinical manifestations since this morning. During the last assessment, she exhibited drowsiness, reduced psychomotor activity, difficulty with attention and

impaired cognitive function. Late treatment could lead to a greater loss of autonomy.

The priority intervention, i.e., notify the physician, for delirium is considered a geriatric emergency.

SITUATION 3.3

D. No, because there is no imminent risk for Mrs. Gagné in this context.

A tray table attached to a chair is considered a control measure if it is not serving a utilitarian purpose (for example, during meals). The MSSS has set out six guiding principles on the use of control measures:

1. control measures are taken to ensure safety in a situation where there is an imminent risk;
2. control measures are considered as a last resort;
3. control measures, when justified, must be used in a manner that is the least constraining possible;
4. control measures must be applied with respect, with a regard for the person's dignity, safety and comfort and must be closely supervised;
5. control measures must be applied in accordance with the rules of the institution;
6. the use of control measures must be evaluated by the bodies designated for that purpose.

SITUATION 4.1

A. Hypothesis: unrelieved pain. Rationale: history of falls.

Mrs. McDonald, an older adult, has been living alone since her husband died. Her son reports that he has observed a change in her habits (her personal hygiene is neglected, she has stopped doing activities, etc.). Mrs. McDonald said that she had a fall and seems to have difficulty getting around. She is impatient and denies being in pain.

Pain in an older adult often presents with atypical symptoms, such as a decrease in activities and a loss of functional autonomy. Many older adults are reluctant to say that they are in pain because they are afraid of bothering their family and friends.

Furthermore, due to changes in perception, older adults have difficulty describing the characteristics of their pain.

SITUATION 4.2

C. I will use a visual analog scale.

The assessment of Mrs. McDonald's pain indicates that there is a discrepancy between her non-verbal behaviour and the severity of the pain reported. At this stage, the care priority is to examine this discrepancy before continuing with Mrs. McDonald's clinical assessment.

In older adults, a pain assessment must take their capacities into account. If there is a discrepancy between the results of the pain assessment done using a numeric scale and non- verbal behaviour, a different scale must be used, namely, a visual analog scale, faces scale or descriptive scale.

SITUATION 4.3

A. Acetaminophen (Tylenol®) PO.
C. Hydromorphone (Dilaudid®) subcutaneously.

Mrs. McDonald's pain is unbearable despite the regular administration of hydromorphone (Dilaudid®). She can be given a PRN analgesic subcutaneously. Acetaminophen is indicated for use as a co-analgesic with opioid analgesics. Lorazepam is prescribed for severe anxiety.

SITUATION 5

C. Risk of falls

Mrs. Dubois is at a high risk of falls due to several factors. Firstly, her use of Ativan, a benzodiazepine, can cause sedation, dizziness, and impaired coordination, which significantly increases the risk of falls in elderly patients. Additionally, her depression might contribute to decreased physical activity and increased fall risk.

Although SSRIs are generally safer than other antidepressants, they can still cause side effects such as dizziness and sedation, further exacerbating the risk of falls. Therefore, the most critical risk to address in Mrs. Dubois's Therapeutic Nursing Plan is the risk of falls to ensure her safety and prevent any potential injuries.

SITUATION 6

C. Ensure that the upper two side rails are raised.

Ensure that the upper two side rails are raised: After administering Percocet (oxycodone/acetaminophen), which is an opioid analgesic, it is crucial to prioritize patient safety. Opioids can cause dizziness, sedation, and impaired coordination, increasing the risk of falls. Raising the upper two side rails helps prevent the patient from accidentally falling out of bed, ensuring her safety while the medication takes effect.

Leave the overbed light on at a low setting: While providing a low light setting can be comforting, it does not directly address the immediate safety concerns associated with opioid administration.

Offer to turn on the television to provide distraction: Distraction can help with pain management, but it is not a priority intervention compared to ensuring the patient's physical safety.

Ensure that documentation of intake and output is accurate: Accurate documentation is important, but it is not the highest priority immediately after administering an opioid. Ensuring patient safety takes precedence over documentation in this scenario.

SITUATION 7

B. Serax and Ativan

Serax (oxazepam) and Ativan (lorazepam) are both benzodiazepines that act as sedatives. These drugs are known to cause drowsiness, confusion, muscle weakness, and impaired coordination — all of which significantly increase fall risk in older adults. Taking them together amplifies these effects. In this scenario, Mr. Tremblay had excessive daytime sleepiness and nighttime unsteadiness, both hallmark side effects of benzodiazepine use in the elderly.
Additionally, polypharmacy is a critical factor. Mr. Tremblay is taking six medications, and multiple CNS depressantsincrease the chance of adverse effects and drug interactions.
Lopressor (metoprolol), a beta-blocker, may also contribute to falls due to orthostatic hypotension (a drop in blood pressure when changing positions), which can cause dizziness or lightheadedness. However, the two benzodiazepines present the strongest and most direct risk for his fall in this case.

- Diabeta and Glucophage: While Diabeta can cause hypoglycemia, there's no clinical indication of it here.
- Tylenol belongs to Mme Côté and is irrelevant in this patient's case.
- Celexa (SSRI) may increase fall risk, but not as significantly as the benzodiazepines.

SITUATION 7.2

A. Do not take medications prescribed to other people.

Taking medications not prescribed for you is dangerous and unsafe. Ativan (lorazepam) is a potent benzodiazepine, and combining it with another sedative like Serax (oxazepam) can lead to excessive sedation, confusion, falls, and even respiratory depression, especially in older adults.
Even though Mr. Tremblay and his wife both take benzodiazepines, prescribed doses and medical indications differ. This situation must be clearly addressed with strict instruction: never take another person's medication, even if it seems similar.

Options b, c, and d may be true or helpful in general, but they are not the nurse's top teaching priority in this context.

SITUATION 8

B. Accept and document her refusal.

Even if a legal representative signed the initial consent, a patient who is oriented and clearly refusing a treatment or intervention must have her decision respected, especially after repeated attempts to obtain consent. Autonomy takes precedence if the patient is capable of understanding the situation in the moment, even in the context of a neurocognitive disorder.

- Option a is inappropriate, as trying to coerce the patient through another person violates her autonomy.
- Option c, while often part of the nursing process, was already performed earlier in the shift.
- Repeating explanations after a clear refusal may be interpreted as pressuring the patient.
- Option d is unethical and illegal. Administering a treatment against a capable patient's will constitutes assault.

The correct response is to accept and document the refusal, and inform the medical team.

SITUATION 9.1

A. Caregiver role strain/burnout

The scenario describes a caregiver who is emotionally and physically exhausted, sleep-deprived, and exhibiting signs of overwhelm and frustration while caring for a loved one with complex needs. These are classic indicators of caregiver role strain or burnout, a common situation in caregivers of individuals with progressive cognitive decline like Alzheimer's.

- Fatigue (option b) is a component of caregiver strain, but not the most complete or accurate nursing diagnosis.
- Depression (option c) is not clearly evidenced by the caregiver; her behavior is reactive and situational.
- Domestic abuse (option d) must always be ruled out, but in this context, no signs of harm or pattern of abuse are present, and the caregiver is seeking help.

As a nurse, your next steps should include supportive listening, assessing caregiver needs, and initiating referrals(e.g., respite care, home support, counseling).

SITUATION 9.2

C. "You can go home and rest; the healthcare team will take care of Mr. Leblanc and contact you if there's any change."

This response addresses caregiver fatigue compassionately and promotes self-care without guilt. It also reinforces trust in the healthcare team's role and reassures her that she will be informed of any significant developments. Encouraging her to rest supports both her well-being and her ability to continue being present in her husband's care over time.

- a. Allowing overnight stays may encourage continued exhaustion rather than rest.
- b. Minimizes her fatigue and doesn't provide meaningful emotional support.
- d. May come across as abrupt or dismissive of her efforts and situation.

SITUATION 9.3

A. Approach the patient calmly, speak slowly using short, simple phrases, guide him gently back to his room and reassure him

The first nursing priority when dealing with an agitated patient with dementia is to use a calm and reassuring approachto avoid escalation and prevent distress. The

best way to do this is by:

- Maintaining eye contact
- Speaking slowly and clearly using simple phrases
- Avoiding confrontation or commands
- Using gentle physical guidance (e.g., lightly placing a hand on the elbow)
- Reorienting by name and surroundings (e.g., "Mr. Leblanc, let's go back to your room. It's safe and quiet there.")

These techniques help reduce confusion and agitation without medication, which is important because patients with dementia are more sensitive to the side effects of antipsychotics like Haldol (e.g., sedation, falls, extrapyramidal symptoms).
Medication should only be considered if non-invasive efforts have failed and the patient continues to be a risk to themselves or others.

- b. Immediate medication is not the first-line approach in behavioral disturbances.
- c. Tylenol is not indicated; there's no sign of pain.
- d. Calling the physician is premature; nursing measures must be tried first unless the situation becomes unsafe.

SITUATION 10

In dementia care, behavioral changes such as agitation and restlessness often signal unmet needs or physical discomfort. The initial nursing action should be to assess for:

- Pain (e.g., untreated arthritis)
- Infection (e.g., UTI or respiratory)
- Hunger or thirst
- Full bladder or constipation
- Unfamiliar environment or overstimulation

Agitation may be the patient's only way of expressing discomfort due to cognitive decline.

- a. Medication is not the first-line response. PRNs like lorazepam are only used when non-pharmacologic interventions fail or the patient poses a risk.
- b. Reorientation may help, but it must come after assessing the cause of the behavior.
- d. Ensuring safety is important, but it's not the first step. You must determine why the agitation is happening.

SITUATION 11.1

A. Convene an interdisciplinary meeting.

In patients with major neurocognitive disorder, persistent behavioral symptoms like refusal of care and agitation—despite tailored interventions—warrant a team-based approach.

By convening an interdisciplinary meeting, the care team can:

- Review and adjust the care plan,
- Identify possible unmet needs or medical triggers,
- Develop personalized strategies that respect Mr. Dubois' dignity and routine.

The team may include:

- Nursing
- Physician or NP
- Social worker
- Occupational therapist
- Family (if appropriate)

This approach is both proactive and respectful, reducing unnecessary escalation or burnout.
b. Suggesting relocation is a last resort, not an initial response.
c. Informing management is appropriate only after clinical options have been exhausted.
d. Involving the social worker is helpful but not as comprehensive as a full team discussion.

SITUATION 11.2

A. Perform the hygiene care despite the refusal, using the least restrictive approach.

While adults have the right to refuse care, exceptions exist in situations that:

- Pose a risk to the individual (skin breakdown, infection),
- Affect others (odor, hygiene-related complaints),
- Involve individuals unable to make informed decisions (e.g., dementia).

Since Mr. Dubois's hygiene refusal now jeopardizes both his health and unit harmony, and all alternatives have been attempted, you are ethically and legally justified in proceeding with care under institutional protocol.

Best practices include:

- Explain the process to Mr. Dubois calmly and clearly
- Use the least restrictive method possible
- Maintain dignity and privacy at all times
- Document everything: interventions tried, patient's response, rationale, and care provided
- b. Changing the environment doesn't resolve the immediate health issue
- c. Reattempting with another staff delays necessary care that's already been ethically justified
- d. Delaying care again allows for potential harm and does not prioritize patient safety

SITUATION 12.1

B. Your urinary incontinence is a condition that may be reversible.

Mrs. Chan is an older adult who has acute urinary incontinence, that is, incontinence that develops suddenly and is associated with a health problem. This type of incontinence is generally reversible. The use of incontinence briefs appears to be affecting Mrs. Chan.

SITUATION 12.2

A. Encourage her to drink 1.5 L of fluids daily.

Acute incontinence usually resolves with treatment; support mobility and fluid intake to reduce risks.

SITUATION 13.1

C. Give him privacy and return later to change the dressing.

Masturbation is a natural behavior and may still occur in individuals with neurocognitive disorders. Unless the behavior is inappropriate (e.g., occurring in public or affecting others), it should be respected as a private act. In this scenario, the most respectful and ethical approach is to maintain Mr. Bouchard's dignity by allowing him privacy. Once the behavior ceases, you can return to provide the necessary care.

SITUATION 13.2

D. Notify the manager of the facility.

While this behavior is not harmful to Mr. Bouchard's health and is occurring in private, it is a repeated behavior that affects the staff's comfort and may require an individualized care plan. Notifying the facility manager ensures that the interdisciplinary team can meet and determine the most respectful and appropriate approach, such as care planning, staff education, or setting up boundaries for personal care times.

Family should only be informed if clinically relevant or if it affects consented care plans. Telling Mr. Bouchard to stop without a plan may violate his dignity.

SITUATION 14.1

A. No, because postoperative delirium is usually temporary.

Postoperative delirium is a temporary and reversible condition, especially when the patient was cognitively intact before surgery. Early identification and management typically lead to full recovery.

- Option b is partially correct, but doesn't address the condition directly.
- Options c and d are incorrect and defeatist, lacking evidence and compassion.

SITUATION 14.2

A. Maintain a quiet, well-lit environment with orientation cues like clocks and calendars.

Environmental orientation and calm surroundings help prevent delirium by reducing sensory confusion and promoting a sense of time and place.

- Option b can lead to dehydration, which increases delirium risk.
- Option c is risky—sleep medications can worsen delirium.
- Option d is incorrect—family presence can provide comfort and orientation.

SITUATION 15

D. Use a separate IV line or confirm compatibility before administering potassium chloride

Potassium chloride is high-alert and vein-irritating medication. It should not be mixed or run concurrently with other medications unless compatibility is confirmed. IV corticosteroids and certain antibiotics are often incompatible with potassium chloride. Administering it in the same line may cause precipitation, chemical interaction, or vein damage.

If no second IV line is available, the nurse must:

- Stop the current infusion
- Flush the line properly
- Check institutional compatibility charts or consult pharmacy

Administering potassium safely is a critical nursing responsibility, especially in elderly patients with COPD, who are already at risk for complications such as arrhythmias and confusion.

SITUATION 16.1

A. Self-catheterization can introduce bacteria into your bladder despite best practices.

Even with proper technique, catheterization can introduce bacteria into the urinary tract, leading to infections. Strict hygiene and catheter care reduce but do not eliminate the risk.

- Option b is incorrect; more frequent catheterization doesn't necessarily prevent infection.
- Option c is inaccurate; paralysis itself doesn't cause infection directly.
- Option d is misleading; infections are not normal or expected but are a known risk.

SITUATION 16.2

B. Pyelonephritis

Shivering, high fever, and systemic symptoms indicate an upper urinary tract infection (pyelonephritis), which involves the kidneys and is more severe than cystitis (lower UTI).

- Cystitis typically causes localized bladder symptoms without systemic signs like high fever or chills.
- Bladder spasms cause discomfort but no fever or chills.
- Prostatitis can cause systemic symptoms but is less likely in this scenario focused on catheter-related UTI.

SITUATION 17

D. Implement a walking routine with Mr. Desjardins during the day to provide structured physical activity.

Engaging Mr. Desjardins in structured physical activity like walking during the day helps reduce restlessness and nocturnal wandering — a common symptom in people with dementia. This approach respects his life history and routines (retired mover, walking club member), provides meaningful engagement, and can help regulate his sleep–wake cycle.

- Option a is partially appropriate but may increase stimulation without addressing his need for

structured activity.

- Option b is not recommended — long daytime naps can worsen nighttime wakefulness.
- Option c (reprimanding) is not therapeutic and may increase agitation or confusion.

SITUATION 18.1

A. Chart that Mme. Gauthier refused her medication and monitor her condition.

Even when a person has been declared incapable, categorical refusal must be respected. Ethical and legal principles require that you do not deceive or force medication unless under specific legal authority (e.g., court order, emergency protocol). The right action is to document the refusal, monitor the patient, and continue efforts to reach the substitute decision-maker (husband).

- Option b is unethical and violates informed consent.
- Option c also lacks transparency and violates patient autonomy.
- Option d is not appropriate at this moment without reassessment or consent.

SITUATION 18.2

A. Confirm the caller's identity before sharing any patient information.

Before disclosing any personal health information, even to someone with legal authority like a power of attorney, the nurse must verify the caller's identity (e.g., asking security questions, calling back a known number). This protects the patient's confidentiality under privacy laws.

- Option b is premature—power of attorney does not override the need to confirm identity.
- Option c is inappropriate; nurses are responsible for clinical communication.
- Option d is too restrictive—phone communication is allowed with proper verification

SITUATION 19.1

A. Low albumin

Albumin is a key indicator of nutritional status, especially in elderly patients experiencing weight loss and reduced oral intake. A low albumin level may signal protein-energy malnutrition, which is relevant for the nutritionist to assess and address.

- HbA1c reflects long-term glucose control but is less urgent in this context if the fasting glucose is normal.
- Fasting glucose is normal, so not a current concern.
- Sodium levels may be relevant for hydration but were not reported in this scenario.

PSYCHIATRY

SITUATION 1.1

Scenario:
Mme. Josée Morin, 34 years old, recently experienced a stillbirth at 38 weeks gestation. In the weeks following, she has complained of various physical symptoms such as fatigue, body aches, and headaches, despite no medical findings. She has also isolated herself from friends and family, avoids communication, and has resigned from her job without giving a clear reason.

Question:
What is the most likely explanation for Mme. Morin's current condition?
a. Adjustment disorder (unspecified)
b. Postpartum depression
c. Major depressive disorder
d. Conversion disorder

SITUATION 1.2

Scenario:
Now, the patient is currently hospitalized for monitoring and emotional support. The care team wants to implement appropriate nursing interventions to support her adjustment and emotional recovery.

Question:
What is the most appropriate nursing intervention at this stage?
a. Encourage Mme. Morin to express her feelings and provide a supportive, non-judgmental presence.
b. Recommend she begin a structured exercise program to promote endorphin release.
c. Encourage her to avoid talking about the stillbirth to minimize emotional distress.
d. Suggest she resumes work or volunteering immediately to restore routine.

SITUATION 2

Scenario:
Mr. Denis Caron, 40 years old, has been extremely anxious and emotionally distressed since a fatal accident he caused while driving under the influence of alcohol. He has been having difficulty sleeping, avoiding social contact, and expressing ongoing guilt.

The care team is assessing whether he meets the criteria for an adjustment disorder.

Question:
Within what timeframe should the nurse expect Mr. Caron's symptoms to appear?
a. Within 24 hours of the event
b. Within 7 days of the event
c. Within 1 month of the event
d. Within 3 months of the event

SITUATION 3

Scenario:
Mr. Émile Robitaille, 81 years old, has been diagnosed with late-onset depression following the loss of his spouse. He has unintentionally lost 5 kg in the past month and reports decreased appetite and energy. He is currently prescribed the following medications:

- Citalopram 20 mg once daily (SSRI)
- Mirtazapine 15 mg at bedtime (antidepressant with appetite-stimulating and sedative effects)
- Lorazepam (Ativan) 0.5 mg at bedtime as needed for sleep
- Polyethylene glycol (Lax-A-Day) PRN for constipation
- You are updating his therapeutic nursing plan.

Question:
Which priority problem and corresponding directive should be added to Mr. Robitaille's therapeutic nursing plan?
a. Risk of weight gain – Weigh the patient daily.
b. Risk of constipation – Administer Lax-A-Day regularly once daily.
c. Risk of fall – Check blood pressure lying and standing twice daily (BID).

SITUATION 3.2

Scenario:
Two weeks after starting citalopram and mirtazapine, Mr. Émile Robitaille, 81 years old, appears visibly improved. He is now smiling, more talkative, eating better, and is described by staff as "almost unrecognizable" compared to admission. The nurse is reassessing his mental status.

Question:
What is the priority evaluation at this stage of his treatment?
a. Suicidal risk
b. Presence of hallucinations
c. Presence of delusions
d. Short-term memory deficits

SITUATION 4

Scenario:
Mr. Léo B., 29 years old, is hospitalized and currently under suicide risk monitoring following a recent suicide attempt. His family visits and brings him a bag of personal effects, including clothing, toiletries, and small items from home.

Question:
As the nurse, what is the most appropriate action to take?
a. Allow the patient to keep the items to help him feel supported
b. Ask the patient to choose which items he wants to keep
c. Inform the family that the patient cannot receive any personal effects
d. Inspect all personal effects carefully before giving them to the patient

SITUATION 5.1

Scenario:
Mr. Lesplante 47-year-old was admitted to the psychiatric unit following a suicide attempt by abdominal stabbing. He is currently under preventive

confinement. Over the past three months, he experienced several major life stressors:

- He was laid off from his job in construction, which he held for 7 years.
- He is going through a separation from his partner of 10 years, with whom he shares custody of a young child.
- He has started drinking heavily in the evenings, stating "it's the only thing that helps me sleep."
- He also reports feeling like a burden and says, "nothing's working out for me anymore."
-

The team has initiated suicide prevention measures, and you are assessing his risk factors.

Question:
Which two factors in Mr. Lesplante's situation are known to increase suicide risk?
a. Substance use (alcohol)
b. Recent job loss and financial stress
c. Shared custody of a child
d. Being male and under 50

SITUATION 5.2

Scenario:
While reviewing his psychosocial history, you learn that Mr. Lesplante lives alone in a condominium downtown. He shares the space with his pet cat, Felix, whom he refers to as "my best buddy." He also tells you that, no matter what's going on in his life, he still makes it a point to attend church every Sunday, even if he doesn't stay for the entire service.

Though he has limited contact with his family and recently separated from his partner, he mentions that the neighbors in his building occasionally check in on him, and that the doorman knows him by name.

Question:
Which two of the following are considered protective factors that may reduce Mr. Lespante's risk for suicide?
a. Living alone in a condo
b. Having a pet cat named Felix
c. Attending weekly church services
d. Being checked on occasionally by neighbors
e. Being single after a separation

SITUATION 6.1

Scenario:
Mr. Brodeur, 22 years old, was hospitalized last evening following a relapse of paranoid schizophrenia. Since admission, he has received two IM doses of haloperidol 5 mg to manage agitation. At 14:00 today, he was also given lorazepam (Ativan) 2 mg PO, which helped calm him slightly.

Now at 16:15, you observe that Mr. Brodeur appears:

- Anxious and restless
- Unable to sit still (akathisia)
- Complaining of neck and limb stiffness
- Mistrustful, tense, and isolating himself

His current medical orders include:

- Risperidone (Risperdal) 2 mg PO bid
- Haloperidol 5 mg PO or IM q4h PRN if agitated
- Lorazepam (Ativan) 2 mg PO or SL q4h PRN if anxious
- Chloral hydrate 500 mg PO at bedtime
- Benztropine mesylate 2 mg PO or IM PRN if extrapyramidal symptoms (EPS)

Question:
Based on Mr. Brodeur's current presentation, which medication should the nurse administer?
a. Haloperidol 5 mg IM
b. Lorazepam 2 mg PO
c. Chloral hydrate 500 mg PO
d. Benztropine mesylate 2 mg PO

SITUATION 6.2

Question:
Which two clinical signs observed in Mr. Brodeur justify the administration of benztropine?
a. Muscle stiffness in the neck and limbs
b. Elevated temperature and flushed skin
c. Inability to sit still or remain calm
d. Paranoia and social withdrawal

SITUATION 6.3

Scenario:
At 10:30 AM, Mr. Brodeur, 22 years old, hospitalized for paranoid schizophrenia, is visibly anxious and irritable. He is:

- Pacing rapidly, knocking objects over as he passes
- Holding his hands over his ears and mumbling unintelligibly
- Becoming increasingly aggressive: he threatens, shoves the nurse, and clenches his fists
- His face is flushed, and he appears very tense

Earlier at 08:30, Mr. Brodeur received lorazepam (Ativan) 2 mg PO for anxiety, with little effect.

His current PRN orders include:

- Haloperidol 5 mg PO or IM q4h PRN if agitated
- Lorazepam 2 mg PO or SL q4h PRN if anxious
- Benztropine mesylate 2 mg PO or IM PRN if extrapyramidal symptoms

Question:
What is the most appropriate medication to administer now?
a. Benztropine mesylate 2 mg PO
b. Lorazepam 2 mg PO
c. Haloperidol 5 mg IM
d. Chloral hydrate 500 mg PO

SITUATION 6.4

Question:
What is the most important action the nurse must take before administering the medication?
a. Attempt to reason with the patient one last time
b. Take the patient's vital signs
c. Ask for assistance from another staff member
d. Document the patient's behavior in the chart

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Which two of the following are considered protective factors that may reduce Mr. Lespante's risk for suicide?
a. Living alone in a condo
b. Having a pet cat named Felix
c. Attending weekly church services
d. Being checked on occasionally by neighbors
e. Being single after a separation

SITUATION 6.1

Scenario:
Mr. Brodeur, 22 years old, was hospitalized last evening following a relapse of paranoid schizophrenia. Since admission, he has received two IM doses of haloperidol 5 mg to manage agitation. At 14:00 today, he was also given lorazepam (Ativan) 2 mg PO, which helped calm him slightly.

Now at 16:15, you observe that Mr. Brodeur appears:

- Anxious and restless
- Unable to sit still (akathisia)
- Complaining of neck and limb stiffness
- Mistrustful, tense, and isolating himself

His current medical orders include:

- Risperidone (Risperdal) 2 mg PO bid
- Haloperidol 5 mg PO or IM q4h PRN if agitated
- Lorazepam (Ativan) 2 mg PO or SL q4h PRN if anxious
- Chloral hydrate 500 mg PO at bedtime
- Benztropine mesylate 2 mg PO or IM PRN if extrapyramidal symptoms (EPS)

Question:
Based on Mr. Brodeur's current presentation, which medication should the nurse administer?
a. Haloperidol 5 mg IM
b. Lorazepam 2 mg PO
c. Chloral hydrate 500 mg PO
d. Benztropine mesylate 2 mg PO

SITUATION 6.2

Question:
Which two clinical signs observed in Mr. Brodeur justify the administration of benztropine?
a. Muscle stiffness in the neck and limbs
b. Elevated temperature and flushed skin
c. Inability to sit still or remain calm
d. Paranoia and social withdrawal

SITUATION 6.3

Scenario:
At 10:30 AM, Mr. Brodeur, 22 years old, hospitalized for paranoid schizophrenia, is visibly anxious and irritable. He is:

- Pacing rapidly, knocking objects over as he passes
- Holding his hands over his ears and mumbling unintelligibly
- Becoming increasingly aggressive: he threatens, shoves the nurse, and clenches his fists
- His face is flushed, and he appears very tense

Earlier at 08:30, Mr. Brodeur received lorazepam (Ativan) 2 mg PO for anxiety, with little effect.

His current PRN orders include:

- Haloperidol 5 mg PO or IM q4h PRN if agitated
- Lorazepam 2 mg PO or SL q4h PRN if anxious
- Benztropine mesylate 2 mg PO or IM PRN if extrapyramidal symptoms

Question:
What is the most appropriate medication to administer now?
a. Benztropine mesylate 2 mg PO
b. Lorazepam 2 mg PO
c. Haloperidol 5 mg IM
d. Chloral hydrate 500 mg PO

SITUATION 6.4

Question:
What is the most important action the nurse must take before administering the medication?
a. Attempt to reason with the patient one last time
b. Take the patient's vital signs
c. Ask for assistance from another staff member
d. Document the patient's behavior in the chart

SITUATION 6.5

Question:
What is the priority nursing intervention while you wait for the medication to begin working?
a. Ask him to go to his room
b. Encourage him to join a group activity for distraction
c. Continue to ask questions to assess orientation and cognition
d. Leave him alone so he doesn't feel provoked

SITUATION 6.6

Scenario:
"We don't understand why our son is acting like this. He's never been violent before. What is happening to him?"

Question:
Based on Mr. Brodeur's medical diagnosis, what is one appropriate explanation the nurse can give to help his parents understand his behavior?
a. He is likely acting out because of unresolved family issues
b. This is a side effect of his medication
c. This behavior is part of his illness, possibly due to hallucinations, delusions, or mistrust
d. He is trying to manipulate the staff and gain control

SITUATION 6.7

Scenario:
This afternoon, you observe a sudden change in his condition:

- He is diaphoretic (sweating profusely)
- His temperature is 39.8°C
- His muscles are rigid
- He appears confused and barely responsive
- His heart rate is elevated at 122 bpm
- His blood pressure is 150/100 mmHg

You notify the physician immediately.

Question:
Based on the clinical presentation, what do you suspect is happening to Mr. Brodeur?
a. Extrapyramidal side effects
b. Serotonin syndrome
c. Acute psychosis
d. Neuroleptic malignant syndrome

SITUATION 6.8

The physician has been notified.

Question:
What is the priority nursing intervention at this time?
a. Administer the next scheduled dose of haloperidol with close monitoring
b. Apply warm blankets and encourage fluid intake
c. Transfer the patient to a quiet room for observation
d. Hold haloperidol and prepare the patient for emergency care

SITUATION 6.9

Scenario:
Mr. Brodeur, 22 years old, remains hospitalized for paranoid schizophrenia. During a calm moment, he opens up about his past and shares that he occasionally uses cannabis and stimulants with friends when feeling "too low" or "wired." He says, "I don't think it's a big deal. It helps me get through the day."
As part of discharge planning, the team asks you to provide education on how illicit drug use may affect his mental health and recovery.

Question:
What should the nurse include when teaching Mr. Brodeur about the impact of illicit substance use on schizophrenia symptoms?
a. Occasional cannabis use has no effect on schizophrenia symptoms
b. Illicit substances may worsen psychotic symptoms and interfere with medication effectiveness
c. Using stimulants can help counteract the sedation caused by antipsychotics
d. Most people with schizophrenia can safely manage occasional recreational drug use

SITUATION 6.10

Scenario:
The care team wants to ensure he understands the importance of recognizing early warning signs of relapse to prevent future hospitalization.

You are reviewing this with him before discharge.

Question:
Which of the following should the nurse emphasize as early signs of relapse in schizophrenia?
a. Feeling more energetic and sociable than usual
b. Noticing increased mistrust, social withdrawal, or disrupted sleep patterns
c. Becoming tearful or sad while watching emotional movies
d. Feeling hungry and sleeping well after medication adjustment

SITUATION 7.1

Scenario:
Mr. Jérémie Paquette, 29 years old, has been hospitalized for treatment-resistant schizophrenia. He has had multiple failed trials with other antipsychotic medications. The psychiatrist has prescribed clozapine starting today.

Question:
The nurse is preparing to administer the first dose. What is the priority nursing intervention?
a. take a baseline EEG
b. evaluate creatinine clearance
c. evaluate suicidal tendencies
d. assess baseline white blood cell count and absolute neutrophil count

SITUATION 7.2

Scenario:
During his follow-up today, the nurse notices that Mr. Paquette appears pale, weak, and complains of a sore throat and fever (38.8°C). He mentions having mouth ulcers and says he feels "worse than usual." The nurse checks his latest lab results:

- WBC (White Blood Cell Count):
  - Patient value: 2,000 cells/ML
  - Normal values: (4,500 – 11,000 cells/ML)
- ANC (Absolute Neutrophil Count):
  - Patient value: 400 cells/ML
  - Normal value: > 1,500 cells/ML
    - Mild neutropenia: 1,000 – 1,500 cells/ML
    - Moderate neutropenia: 500 – 1,000 cells/ML
    - Severe neutropenia: < 500 cells/ML

Question:
What do you suspect is happening to the patient?
a. He has developed anemia related to poor nutrition.
b. He is experiencing the common side effects of antipsychotic medications.
c. He is showing signs of agranulocytosis induced by clozapine.
d. He has caught a common viral infection due to being in a shared unit.

SITUATION 7.3

Question:
What is your priority nursing intervention?
a. Encourage fluid intake and monitor temperature
b. Educate the patient about hand hygiene
c. Place the patient on neutropenic precautions and notify the prescriber
d. Administer acetaminophen for fever

SITUATION 8.1

Scenario:
Three days ago, Mrs. Brunet underwent an abdominal hysterectomy and bilateral salpingo-oophorectomy. The surgery was uncomplicated, and her physical recovery is progressing well.
Recent findings: The progress notes mention that Mrs. Brunet frequently cries, and her movements appear slow.

During your conversation, she reveals that she recently separated from her partner, feels guilty about the separation, and reports feeling very sad and exhausted for several weeks. She confides in you, saying:

"I don't know if I feel like going on with the struggle."
You suspect major depressive disorder.

Question:
What other sign or symptom would support your suspicion of major depressive disorder in Mrs. Brunet?
a. Loss of appetite and nausea
b. Loss of interest in activities
c. Anxiety about surgical recovery
d. Concern for her children's well-being

SITUATION 8.2

Scenario:
Mrs. Brunet's doctor diagnosed major depression and prescribed citalopram (Celexa), 20 mg PO qd. According to your assessment, Mrs. Brunet does not have a suicide plan.

Question:
Identify a priority problem and nursing directive that you must enter in the TNP to provide clinical follow-up for Mrs. Brunet?
a. Problem: Sleep disturbance
Directive: Assist with relaxation techniques before bedtime
b. Problem: Poor self-esteem
Directive: Encourage client to verbalize emotions
c. Problem: Low suicide risk
Directive: Notify nurse if client shows signs of suicide risk (dir. orderly's work plan)
d. Problem: Pain related to surgery
Directive: Administer analgesics PRN and reassess after 1 hour

SITUATION 8.3

Scenario:
For 2 days, Mrs. Brunet has been taking her daily antidepressant as prescribed. It is 9:00 and you bring her her medication. She says to you: "I don't want to take it anymore. I've been taking it for a few days and I don't feel any better, there's no point in taking it." The progress note indicates that the client has been reluctant to take the medication since treatment was started. Explanations have already been given to her to make her understand the importance of this pharmacological urcatment, in particular its beneficial effects, but she remains skeptical.

Question:
What priority information must you gue Mrs. Brunet to encourage her to keep taking her medication
a. Antidepressants begin to work within 24–48 hours for most people
b. The side effects of antidepressants disappear after 1 week
c. Antidepressants only work if taken with meals
d. It can take 2 to 4 weeks for antidepressants to produce their full therapeutic effect

SITUATION 8.4

Scenario:
It has now been one week since Mrs. Denise Brunet started taking citalopram (Celexa) 20 mg PO daily. This morning, the nurse notes that she is confused, agitated, and restless. She is diaphoretic, her temperature is 38.9°C, and her heart rate is 112 bpm. She also displays muscle rigidity and tremors in both arms. Her pupils appear dilated, and she keeps clenching her jaw.

Question:
What do you suspect is happening to Mrs. Brunet?
a. Neuroleptic malignant syndrome

b. Serotonin syndrome
c. Benzodiazepine withdrawal
d. Acute delirium from infection

SITUATION 8.5

Question:
What is your priority intervention?
a. Administer acetaminophen for fever
b. Place cold compresses to reduce agitation
c. Hold the citalopram and notify the physician immediately
d. Reorient the patient and monitor her closely for the next hour

SITUATION 9

Scenario:
Julien, a 28-year-old male, is hospitalized on the mental health unit with a diagnosis of Borderline Personality Disorder (BPD). He was admitted following a recent crisis involving impulsive behavior and emotional dysregulation.

This morning, during your one-on-one interaction with Julien, he tells you, "You're the only one who understands me. You actually care. All the other nurses here are rude, cold, and don't even look at me." He becomes visibly upset when another staff member enters the room and refuses to speak with them.

Clinical Signs:

- Mood swings and intense emotional reactions
- Strong attachment to the nurse
- Rejection and criticism of other staff
- No signs of psychosis, hallucinations, or delusions

Question:
What do you suspect the patient is likely exhibiting?
a. projection
b. splitting
c. denial
d. rationalization

SITUATION 9.2

Scenario:
During a team meeting, the nurses discuss that Julien frequently tells one nurse that she is the only one who understands him, then later complains to another nurse that the first is incompetent and doesn't care. This pattern has caused tension among staff and confusion about how to respond.

Question:
As a nursing team, what is the most appropriate approach to effectively manage Julien's behavior?
a. Avoid discussing Julien's behavior to prevent escalation.
b. Provide consistent responses and set clear boundaries.
c. Assign a single nurse to care for Julien to prevent confusion.
d. Encourage Julien to express all of his feelings openly to every staff member.

SITUATION 9.3

Scenario:
During an individual therapy session, he tells the nurse, "My doctor is amazing, but all the nurses here are incompetent." This reflects a pattern of idealizing one caregiver while devaluing others, a behavior previously observed by the care team.

Question:
How should the nurse respond to Julien's comment to maintain therapeutic communication and support emotional regulation?
a. "Your doctor might be great, but we nurses know what we're doing too."
b. "What makes your doctor amazing and the nurses incompetent?"
c. "I think you're overreacting; all the staff are qualified."
d. "It's important to see that everyone here is trying to help you."

SITUATION 9.4

Scenario:
Today, during a routine interaction, he suddenly says to the nurse, "You were so nice yesterday, but today you're just like everyone else — completely useless."

Question:
What is the most appropriate nursing response to support a therapeutic relationship with Julien?
a. "I'm sorry you feel that way, but I am here to help you just as I did yesterday."
b. "I was the same yesterday as I am today; maybe you're just in a bad mood."
c. "Why do you think I'm useless today? Can you explain?"
d. "You shouldn't say such things; it's not fair to compare people like that."

SITUATION 10.1

Scenario:
Isabelle Martin, a 28-year-old woman diagnosed with Borderline Personality Disorder (BPD) at the age of 20, presents to the clinic for an urgent evaluation. She has a significant history of self-harm and two previous suicide attempts. At present, she is not taking any prescribed medications and has been inconsistently participating in therapy.

Upon arrival, Isabelle is tearful, visibly anxious, and pacing the room. She reports intense sadness and describes frequent arguments with her partner, expressing an overwhelming fear of abandonment. Her speech is rapid and pressured, and her mood shifts quickly, alternating between despair and a desperate need for reassurance. At one point, she says, "I don't know who I am anymore," in a broken, distressed tone. Isabelle admits to having thoughts of self-harm, but denies any current suicidal intent. However, the nurse observes superficial cuts on her forearm, consistent with recent non-suicidal self-injury.

Question:
Based on the initial assessment, which of the following nursing actions should the nurse prioritize? (Select 2 answers)
a. Assess Isabelle's self-harm wounds and provide wound care.
b. Initiate a suicide risk assessment immediately.
c. Offer reassurance to address her fears of abandonment.
d. Encourage her to attend regular therapy sessions.
e. Contact her partner to provide details about the conversation.

SITUATION 10.2

Scenario:
Following an episode of self-harm and suicidal ideation, Isabelle Martin has been admitted to the psychiatric unit for close monitoring and stabilization. During her hospitalization, she begins to develop complex interactions with staff that reflect the interpersonal challenges typical of Borderline Personality Disorder (BPD).

During a routine check-in with Nurse Sophie, Isabelle says,

"You are the only one who understands me. Nurse Claire is cold and doesn't care about me at all. I don't want her to be my nurse anymore. Can you please make sure that she doesn't come near me?"

Later that day, Nurse Claire enters the room to provide care. Isabelle immediately remarks,

"Nurse Sophie told me that you don't like me and that you think I'm just faking my problems. She's so much nicer than you are."

The two nurses later consult with each other and review their notes, confirming that Nurse Sophie never made such a statement, and both are concerned about the emotional volatility and pattern in Isabelle's responses.

Question:
What defense mechanism is Isabelle most likely exhibiting?
a. Projection
b. Denial
c. Rationalization
d. Splitting

SITUATION 1.1

A. Adjustment disorder (unspecified)

Mme. Morin is showing signs of significant emotional and behavioral response to a stressful life event (stillbirth), including physical complaints and social withdrawal, but without meeting full criteria for major depression or psychosis. Adjustment disorder is characterized by maladaptive reactions that occur within 3 months of a stressor and cause functional impairment, without the more severe or specific symptoms required for other psychiatric diagnoses.

- Option b is possible but is typically tied to live birth and hormonal shifts, and her symptoms appear directly related to grief.
- Option c requires more persistent and severe symptoms such as anhedonia, suicidal ideation, or hopelessness over at least 2 weeks.
- Option d involves neurological symptoms (e.g., paralysis, blindness), not general somatic complaints.

SITUATION 1.2

A. Encourage Mme. Morin to express her feelings and provide a supportive, non-judgmental presence.

In adjustment disorder, the nurse's primary role is to provide emotional support, validate the patient's feelings, and create a safe environment where the patient can process the stressful event. Therapeutic communication fosters trust and emotional release, which are essential in healing.

- Option b (structured exercise) may be helpful later but is not the first priority in early grief and adjustment.
- Option c (avoidance) is countertherapeutic and may prolong the disorder.
- Option d (return to work) may be too soon and can increase emotional burden without resolving the underlying grief.

SITUATION 2

D. Within 3 months of the event

For a diagnosis of adjustment disorder, emotional or behavioral symptoms must begin within 3 months of the identifiable stressor (e.g., traumatic loss, accident, breakup).

- Option a and b are too soon and may reflect an acute stress reaction.
- Option c is closer, but the accepted diagnostic timeframe is within 3 months.
- This timeline helps distinguish adjustment disorder from other mood or anxiety disorders that may not have a clear, recent trigger.

SITUATION 3.1

C. Risk of fall – Check blood pressure lying and standing twice daily (BID).

Mr. Robitaille is taking lorazepam and two central-acting antidepressants (citalopram and mirtazapine), which increase the risk of sedation, dizziness, and orthostatic hypotension, especially in the elderly. Monitoring orthostatic BP BID helps prevent falls. Option a is incorrect — he is at risk of weight loss, not gain.

Option b is less urgent — constipation should be treated if present, but Lax-A-Day does not need to be given regularly without symptoms.

SITUATION 3.2

A. Suicidal risk

In the early stages of antidepressant treatment, especially in elderly patients, energy and motivation may return before mood fully improves, increasing the risk that a patient with previous suicidal thoughts may now have the means and energy to act.

Hallucinations and delusions are less common with SSRIs and not described in this scenario.

Memory deficits may still exist but are not the priority compared to assessing safety and risk of self-harm.

SITUATION 4

D. Inspect all personal effects carefully before giving them to the patient

Patients under suicide risk may use ordinary items as means of self-harm. The nurse must inspect all belongings to ensure no dangerous objects (e.g., cords, sharp items, medications) are present. This balances patient safety with the need for emotional support from family.

- Option a risks introducing unsafe items.
- Option b is inappropriate, as the patient should not have unrestricted choice.
- Option c is too restrictive—patients can receive personal effects if they are first safely screened.

SITUATION 5.1

A. Substance use (alcohol)
B. Recent job loss and financial stress

- Substance use is a well-established individual risk factor for suicide. Alcohol lowers inhibition and increases impulsivity, especially during times of crisis.
- Job/financial stress is also listed by the CDC as a major individual stressor, especially when combined with emotional distress or relationship loss.
- Option C may actually be a protective factor, depending on the patient's relationship with the child.
- Option D is a demographic correlation, but not a specific, modifiable risk factor in this context.

Note: Loss of relationships or divorce can be a risk factor as well but is it not available in the option.

SITUATION 5.2

B. Having a pet cat named Felix
C. Attending weekly church services

- Pets are recognized as a reason for living and can provide emotional support and companionship, making them an individual protective factor.
- Regular religious involvement (such as church attendance) is considered a societal protective factor, especially when there are moral or spiritual objections to suicide or a sense of purpose and belonging.
- Option a (living alone) can be a risk, not a protective factor.
- Option d is supportive but too informal and occasional to qualify as a strong protective factor compared to more established relationships.
- Option e (being single) is not a protective factor—in fact, relationship loss can increase suicide risk.

SITUATION 6.1

D. Benztropine mesylate 2 mg PO

Mr. Brodeur is showing classic signs of extrapyramidal side effects (EPS), likely due to haloperidol, a high-potency typical antipsychotic. EPS symptoms include muscle rigidity, restlessness (akathisia), and stiffness.

- Benztropine, an anticholinergic, is used to counteract EPS.
- Haloperidol (a) would worsen his symptoms.
- Lorazepam (b) may calm anxiety but will not address the underlying motor symptoms.
- Chloral hydrate (c) is a sedative but inappropriate for EPS treatment.

SITUATION 6.2

A. Muscle stiffness in the neck and limbs
C. Inability to sit still or remain calm

- a. Stiffness in the neck and limbs indicates dystonia, a common type of EPS.
- c. Inability to sit still reflects akathisia, another form of EPS.
- These symptoms are both treated with benztropine, an anticholinergic agent used to manage EPS induced by antipsychotics.
- Option b refers more to anticholinergic toxicity or serotonin syndrome.
- Option d are psychiatric symptoms, not indicators of EPS.

SITUATION 6.3

C. Haloperidol 5 mg IM

Mr. Brodeur is exhibiting acute psychotic agitation with aggression, and lorazepam already failed to calm him earlier this morning. The presence of threats, physical aggression, flushed face, pacing, and psychotic behavior (mumbling, hands over ears) requires the use of a neuroleptic to manage severe behavioral dysregulation.

- Haloperidol IM is appropriate here due to the severity and potential for harm, and it acts faster via the intramuscular route.
- Lorazepam (b) has already been ineffective.
- Benztropine (a) is used for EPS, not agitation.
- Chloral hydrate (d) is a sedative-hypnotic, not used in acute aggressive psychosis.

SITUATION 6.4

C. Ask for assistance from another staff member

In a situation where the patient is agitated, threatening, or physically aggressive, it is essential to protect the safety of the nurse and the patient. Administering an IM injection to a volatile, potentially violent patient requires team support, both for de-escalation and physical safety.

- Option a is not wrong but should only be attempted if safe.
- Option b may not be feasible or safe in a volatile situation.
- Option d is important but comes after ensuring safety and medication administration.

Question:
What is the priority nursing intervention while you wait for the medication to begin working?
a. Ask him to go to his room or a quiet place to reduce external stimulation
b. Encourage him to join a group activity for distraction
c. Continue to ask questions to assess orientation and cognition
d. Leave him alone so he doesn't feel provoked

SITUATION 6.5

A. Ask him to go to his room or a quiet place to reduce external stimulation

When a patient is agitated, the priority is to reduce environmental stimuli that may escalate behavior. A quiet spaceallows the medication to take effect safely while minimizing triggers like noise, people, or light.

- Option b is inappropriate—group activities may worsen agitation.
- Option c is not the priority at this stage; it may provoke further stress.
- Option d could be unsafe if the patient deteriorates without supervision.

SITUATION 6.6

C. This behavior is part of his illness, possibly due to hallucinations, delusions, or mistrust

In paranoid schizophrenia, threatening or aggressive behavior can result from auditory hallucinations, delusional thinking, distorted perceptions, or excessive mistrust. Patients may feel threatened, misinterpret reality, or believe others intend to harm them, leading to defensive or hostile actions. Helping the family understand this reduces stigmaand encourages compassionate support.

- Option a and d are judgmental and incorrect.

- Option b is misleading—while medications can cause side effects, his symptoms are consistent with the illness itself.

SITUATION 6.7

D. Neuroleptic malignant syndrome

Neuroleptic Malignant Syndrome (NMS) is a rare but serious reaction to antipsychotic drugs, especially high-potency neuroleptics like haloperidol. It is characterized by:

- Hyperthermia
- Muscle rigidity
- Autonomic dysfunction (e.g., high BP, tachycardia, diaphoresis)
- Altered mental status
- It requires emergency medical intervention and immediate discontinuation of neuroleptics.
- Options a, b, and c may share some symptoms, but the combination of fever, rigidity, and altered consciousnessis most consistent with NMS.

SITUATION 6.8

D. Hold haloperidol and prepare the patient for emergency care

Mr. Brodeur is showing classic signs of Neuroleptic Malignant Syndrome (NMS), a life-threatening reaction to antipsychotic medications such as haloperidol. The nurse must immediately stop the causative agent, in this case haloperidol, and initiate emergency interventions (cooling, IV fluids, oxygen if needed, transfer to higher level of care).

- Option a would worsen the patient's condition.
- Option b is inappropriate and unsafe as a first response.
- Option c delays the urgent interventions required.

SITUATION 6.9

B. Illicit substances may worsen psychotic symptoms and interfere with medication effectiveness

Substance use—especially cannabis, stimulants, or hallucinogens—can significantly worsen schizophrenia symptoms, trigger psychotic episodes, and interfere with antipsychotic medication effectiveness.

- Option a is false—cannabis has been strongly linked to worsening psychosis, particularly in people with schizophrenia.
- Option c is dangerous and misinformed.
- Option d disregards the high risk of relapse and poor treatment adherence in patients who use substances.

SITUATION 6.10

B. Noticing increased mistrust, social withdrawal, or disrupted sleep patterns

Early signs of schizophrenia relapse often include:

- Social withdrawal
- Disturbed sleep patterns
- Increased suspiciousness or paranoia
- Reduced functioning or self-care
- Identifying these symptoms early allows for timely intervention, medication review, or support services to prevent full relapse.
- Option a may reflect manic symptoms, not typical relapse signs in schizophrenia.
- Option c and d are not concerning and may reflect normal emotional or physical responses.

SITUATION 7.1

D. assess baseline white blood cell count and absolute neutrophil count

Clozapine carries a high risk of agranulocytosis, a potentially fatal drop in white blood cells, particularly neutrophils. For this reason, it is mandatory to assess the WBC and ANC before initiating therapy and to monitor these values regularly during treatment. This ensures the patient's immune system can tolerate the medication and helps prevent life-threatening infections.

While suicide risk (choice c) is relevant in schizophrenia, it is not the priority specific to clozapine initiation. EEG (choice a) is not required unless there's a seizure history. Creatinine clearance (choice b) is useful for kidney function monitoring but not specific to clozapine's main risks.

SITUATION 7.2

C. He is showing signs of agranulocytosis induced by clozapine.

Mr. Paquette presents with fever, sore throat, weakness, and mouth ulcers—classic symptoms of agranulocytosis, especially in the context of a severely low ANC (<0.5 × 109/L).

This is a medical emergency requiring immediate discontinuation of clozapine, protective isolation if needed, and close monitoring. The care team may also consider hospitalization and administering granulocyte colony-stimulating factor (G-CSF) if appropriate.

This is a known and serious side effect of clozapine, which is why regular blood monitoring is essential. The nurse should immediately notify the prescriber and take infection-control precautions.

SITUATION 7.3

C. Place the patient on neutropenic precautions and notify the prescriber

The patient is experiencing agranulocytosis, a life-threatening adverse effect of clozapine characterized by severely low neutrophils (ANC < 500 cells/ML). This makes the patient extremely vulnerable to infection. Your priority nursing interventions include:

- Immediately initiating neutropenic precautions (e.g., private room, no fresh flowers or raw fruits/vegetables, strict hand hygiene).

- Notify the prescriber right away. Clozapine should be discontinued, and the patient may need antibiotics or even hospitalization depending on the severity of infection.

SITUATION 8.1

B. Loss of interest in activities

A loss of interest or pleasure in activities (anhedonia) is one of the core diagnostic criteria for major depressive disorder, along with persistent sadness, fatigue, feelings of worthlessness, and suicidal ideation.

- a may occur with depression but is not specific
- c and d can be normal emotional responses and do not confirm a diagnosis

SITUATION 8.2

C. Problem: Low suicide risk
Directive: Notify nurse if client shows signs of suicide risk (dir. orderly's work plan)

Even though Mrs. Brunet currently presents with low suicide risk, this remains a priority problem due to her diagnosis of major depression. It's essential to ensure ongoing clinical surveillance, especially by informing support staff to alert the nurse if any signs of suicide risk emerge.

SITUATION 8.3

D. It can take 2 to 4 weeks for antidepressants to produce their full therapeutic effect

It is important for patients like Mrs. Brunet to understand that antidepressants do not produce immediate results. Explaining that it may take 2 to 4 weeks to feel the full benefits can help manage expectations and improve adherence to the treatment plan.

SITUATION 8.4

B. Serotonin syndrome

The combination of fever, agitation, hyperreflexia, tremors, confusion, and autonomic instability (such as tachycardia and sweating) in a patient who recently started an SSRI like citalopram strongly suggests serotonin syndrome, a potentially life-threatening condition requiring immediate intervention.

SITUATION 8.5

C. Hold the citalopram and notify the physician immediately

Serotonin syndrome is a medical emergency. The priority action is to stop the serotonergic agent (citalopram) and notify the physician for further evaluation and possible supportive or pharmacologic management. Other interventions may be necessary, but the first step is discontinuing the causative agent.

SITUATION 9.1

B. splitting

Julien is displaying splitting, a defense mechanism commonly seen in Borderline Personality Disorder. It involves seeing others as either all good or all bad, which reflects an inability to integrate positive and negative aspects of self or others. His idealization of one nurse while devaluing the others is a classic sign.

SITUATION 9.2

B. provide consistent responses and set clear boundaries

The behavior described is consistent with splitting, a common defense mechanism in BPD, where the patient perceives individuals as either entirely good or entirely bad. To prevent manipulation or staff conflict, the nursing team should maintain a united, consistent approach and establish clear professional boundaries. This promotes emotional stability and prevents reinforcing maladaptive relational patterns.

SITUATION 9.3

D. "It's important to see that everyone here is trying to help you."

This response validates the therapeutic environment, avoids reinforcing splitting behavior, and promotes a balanced view of the healthcare team.

SITUATION 9.4

A. "I'm sorry you feel that way, but I am here to help you just as I did yesterday."

This response maintains a calm, consistent, and therapeutic stance. It avoids confrontation, supports emotional stability, and reinforces the nurse's role as a reliable caregiver despite Julien's emotional fluctuations.

SITUATION 10.1

A. Assess Isabelle's self-harm wounds and provide wound care.
B. Initiate a suicide risk assessment immediately.

The nurse's first priority is to ensure Isabelle's immediate physical and emotional safety. Even though she denies current suicidal intent, her history of suicide attempts, recent self-harm, and emotional instability warrant a thorough suicide risk assessment. At the same time, any visible wounds must be assessed and treated, as they present a risk of infection and may signal escalating self-harm behaviors.
Options c and d may be addressed later during therapeutic engagement, but are not immediate safety priorities. Option eviolates patient confidentiality and is not appropriate without consent or legal necessity.

SITUATION 10.2

D. Splitting

Splitting is a common defense mechanism in individuals with Borderline Personality Disorder, where they view people as all good or all bad, with no middle ground. This leads to idealizing one caregiver (e.g., Nurse Sophie) while devaluing another (e.g., Nurse Claire). It often causes interpersonal conflict and challenges in maintaining therapeutic relationships.

- Projection would involve attributing one's own thoughts or feelings to someone else.
- Denial involves refusing to accept reality or facts.
- Rationalization is giving logical-sounding excuses to justify irrational behavior.

In this case, the behavior strongly reflects splitting, a hallmark of the condition.

MATERNAL & CHILD

SITUATION 1.1

Scenario
Mrs. Jolicoeur, 35 years old, gave birth at 38 weeks of gestation to her second child under epidural anesthesia at 11:25 following a difficult labor. She sustained a third-degree perineal tear and was transferred to the postpartum unit at 13:00.

At the 16:00 report, the nurse informs you that the client's first void was 100 mL at 14:30; at that time, the uterine fundus (UF) was at 0/0, midline, and firm. The lochia is dark red and soaks one sanitary pad per hour. The client's vital signs at 15:30 were as follows: BP 110/60 mmHg, P 72/min (regular), R 20/min (regular, normal depth), and T 37.3°C. Her first time out of bed was well tolerated.

During your rounds at 16:25, you note that Mrs. Jolicoeur's uterine fundus is now at 1/0 and has deviated to the right. The client complains of "severe cramp-like" pain in her lower abdomen.

Question:
Based on your assessment of Mrs. Jolicoeur's clinical situation, what problem do you suspect?
a. Uterine atony
b. Bladder distention
c. Postpartum hemorrhage
d. Endometritis

SITUATION 1.2

Question:
What is your next priority intervention for Mrs. Jolicoeur?
a. Assist Mrs. Jolicoeur to void and reassess her fundus
b. Perform a bladder scan to assess for urinary retention
c. Perform an in-and-out catheterization to empty the bladder
d. Increase IV fluids and monitor for postpartum hemorrhage

SITUATION 1.3

Question:
Which two (2) signs and symptoms indicate that your interventions have resolved Mrs. Jolicoeur's problem?
a. Uterine fundus at 0/0 or at the level of the umbilicus
b. Relief of pain and cramps
c. Lochia changing to a lighter color
d. Increase in urine output

SITUATION 2.1

Scenario:
At 17:00, Mrs. Élise Dufresne, a 33-year-old postpartum client who delivered her second child at 38 weeks of gestationvia vaginal birth with epidural, reports moderate perineal edema and rates her pain as 4/10. She sustained a third-degree perineal tear and was transferred to the postpartum unit earlier in the day. To manage her discomfort, she has been given Acetaminophen (Tylenol) 325 mg, 2 tablets and Naproxen (Naprosyn) 250 mg, 1 tablet. While the medications provide some relief, Mrs. Dufresne expresses concern about taking too many analgesics and asks if there are alternative ways to manage her pain more naturally.

Question:
What is the best recommendation the nurse can give to Mrs. Dufresne to help her manage pain while minimizing the use of analgesics?
a. Apply a cold compress or ice pack to the perineum to reduce swelling and numb pain
b. Increase oral fluid intake and ambulate frequently to speed up postpartum recovery
c. Request a stronger analgesic from the physician if the current regimen is insufficient
d. Massage the perineal area to relieve discomfort and improve circulation

SITUATION 2.2

Mrs. Dufresne has anemia, and her doctor has prescribed an iron supplement to take until her next follow-up appointment. She wants to follow the medical prescription while continuing to consume dairy products.

Question:
What recommendation should the nurse give her?
a. Take the iron supplement with dairy products to reduce stomach irritation
b. Avoid dairy products completely until she no longer needs the iron supplement
c. Crush the iron supplement and mix it with milk to improve absorption
d. Take the iron supplement at least 1 hour before consuming dairy products

SITUATION 2.3

The following findings have already entered in Mrs. Dufresne's therapeutic nursing plan (TNP).

Priority problem:
- 1 - Vaginal delivery at 38 weeks
- 2 - 3rd-degree perineal tear

Question:
What new finding must you enter in the TNP to reflect the evolution of Mrs. Dufresne' clinical profile in connection with the clinical follow-up of her health situation?
a. Delayed postpartum hemorrhage
b. Postpartum depression
c. Anemia
d. Urinary retention

SITUATION 3.1

Scenario:
At 5:30 AM, Mrs. Lajoie, a 32-year-old primipara, gave birth vaginally, without anesthesia, to a healthy 3.4 kg boy after 8 hours of labor. During her first breastfeeding session, she asks you: "Apart from the fact that it doesn't hurt, how will I know if my baby has latched on properly?"

Question:
What should you tell her?
a. The baby's cheeks are dimpled with each suck.
b. You can hear or see your baby swallowing regularly.
c. The baby stays latched for no more than 5 minutes per breast.
d. The baby's lips are tucked inward around the nipple.

SITUATION 3.2

Twenty-four hours after giving birth, Mrs. Lajoie is getting ready to go home. While you are giving her the discharge information, she asks you:
"Apart from the fact that my baby is gaining weight, how will I know if he is getting enough milk after my milk comes in?"

Question:
Which of the following is the best response?
a. Your baby will sleep through the night without waking to feed.
b. Your baby will have at least 2 to 3 wet diapers per day.
c. Your baby will seem satisfied and relaxed after most feedings.
d. Your breasts will stay full and firm after each feeding.

SITUATION 4.1

Scenario:
While preparing her newborn for discharge, Mrs. Blunt tells you: "I've heard about Sudden Infant Death Syndrome. I know I should always put my baby to sleep on his back to help prevent it. Is there anything else I should do to reduce the risk?"

Question:
What other recommendation should you give Mrs. Blunt to help prevent SIDS?
a. Use soft pillows and stuffed animals to keep the baby cozy while sleeping.
b. Share your bed with the baby for easier nighttime feeding and bonding.
c. Place the baby on a firm mattress with no loose bedding or toys.
d. Dress the baby in several layers and keep the room very warm at night.

SITUATION 4.2

Scenario:
Two days after returning home with her newborn, Mrs. Blunt calls you. She is worried and says:
"I don't understand—my baby is so quiet, he's yellow, he sleeps more than usual, and he's been nursing poorly since yesterday. His behavior has really changed since we came home."

Question:
What will you recommend Mrs. Lajoie do to help resolve her baby's signs of jaundice?
a. Continue to breastfeed every 2–3 hours, even if you have to wake the baby.
b. Give the baby water between feedings to flush out the bilirubin.
c. Keep the baby swaddled and let him sleep as much as he wants.
d. Apply warm compresses to the baby's skin to help the yellow color fade.

SITUATION 5.1

Scenario:
At 9:30, Noémie Lessard, age 2½, was transferred from the emergency room to your unit following an episode of bronchospasm. This is her third admission for a similar issue.

On admission, she has moderate xiphoid, subcostal, and lower intercostal retractions, an occasional dry cough, and the following vital signs:

- P: 96/min., regular
- R: 46/min., regular
- T° (rectal): 37.7°C
- SpO2: 92% on room air
- You auscultate bilateral wheezing
- Her mother reports sleep disturbances and fatigue over the past few days

Question:
What other sign(s) must you check to complete your assessment of Noémie's respiratory condition?
a. Capillary refill time and skin color
b. Pupil size and reaction to light
c. Bowel sounds and abdominal distention
d. Grip strength and ability to walk unassisted

SITUATION 5.2

Scenario:
Noémie, age 2½ and weighing 12 kg, was hospitalized for bronchospasm and is receiving the following treatments:

- Prednisolone (Pediapred) 12 mg once daily
- Salbutamol (Ventolin) 0.4 mL in 3 mL NS every 2 hours by nebulizer
- Fluticasone (Flovent) 125 mcg, 2 puffs twice a day with a spacer and mask
- O2 via nasal prongs at 1.5 L/min

Before admission, she was not on regular medications. Treatment began upon arrival in the ER. At 22:00, her mother reports: "My daughter's breathing seems to have improved, but she is very restless and won't go to sleep. She's not usually like this."

Question:
Other than anxiety, what could explain the change in Noémie's behavior?
a. A side effect of salbutamol (Ventolin)
b. Mild hypoxia from low oxygen flow
c. Adverse reaction to fluticasone (Flovent)
d. A sugar rush from the corticosteroid suspension

SITUATION 6.1

Scenario:
Ellyn, a 3-year-old child diagnosed with asthma, is scheduled for discharge tomorrow. Her prescribed discharge medications include:

- Salbutamol (Ventolin) 100 mcg, 2 puffs every 4–6 hours as needed
- Fluticasone (Flovent) 125 mcg, 2 puffs twice daily for 14 days, then discontinue
- Prednisolone (Pediapred) 12 mg once daily in the morning for 4 days

While reviewing discharge instructions, Ellyn's mother asks you: "If Ellyn needs both inhalers at the same time, which one should I give first?"

Question:
Which inhaler should Ellyn's mother administer first, and why?
a. Fluticasone (Flovent) first, to reduce airway inflammation right away
b. Salbutamol (Ventolin) first, to open the airways before giving the corticosteroid
c. Either inhaler can be given first—it doesn't matter as long as both are taken
d. Alternate which one is given first each day to avoid dependence on one inhaler

SITUATION 6.2

Question:
When Ellyn needs both inhalers at the same time, how long should her mother wait between giving salbutamol (Ventolin) and fluticasone (Flovent)?
a. Administer both inhalers immediately, one after the other
b. Wait at least 3 to 5 minutes between the two inhalers
c. Wait 30 minutes to allow the bronchodilator to fully wear off
d. Give fluticasone first, then wait 10 minutes before giving salbutamol

SITUATION 7.1

Scenario:
Zoé, a 3-year-old girl, was hospitalized for an asthma flare-up and is being discharged with Fluticasone (Flovent), to be taken twice daily for 14 days.
Her mother tells you:
"Zoé is much better. But is it really that important to keep giving her the Flovent for the whole 14 days?"

Question:
What information will you give Zoé's mother to help her understand why it is important to continue the treatment as prescribed?
a. You can stop Flovent early if she's feeling better—it's mainly for emergencies.
b. Flovent must be continued to strengthen her immune system.
c. Stopping Flovent too soon may cause symptoms to return or worsen.
d. Flovent must be taken for life, even if she has no more asthma symptoms.

SITUATION 7.2

Zoé's mother expresses concern during discharge teaching: "I'm worried this inhaler medication might affect Zoé's growth. Is it safe to keep giving it to her?"

Question:
What is the best response to reassure Zoé's mother about the effect of the inhaler on her daughter's growth?
a. Inhalers always slow down growth a little, but it's not serious.
b. This medication won't affect Zoé's growth because it only works in the lungs.
c. Inhaler medications do not alter growth when used short-term and in controlled doses.
d. You can stop using the inhaler if you notice any change in Zoé's height.

SITUATION 8

Scenario:
At 19:30, Karine, a 4-year-old girl, is admitted for a fever of unknown cause and a fractured left humerus. She has a cast, is on IV antibiotics, and received an antipyretic analgesic.

During your physical exam, you notice multiple bruises of different shapes, sizes, and colors on various parts of her body (posterior right arm, front of both legs, between the shoulder blades, lower back).
Her mother says Karine tripped over a toy. Later, her father mentions that Karine is "always falling" and criticizes her. Karine avoids eye contact and stays physically distant.

Question:
What is your priority action in this situation of probable child abuse?
a. Question Karine's parents separately about their discipline methods.
b. Report your findings to the appropriate child protection authorities immediately.
c. Document the bruises and wait to see if more injuries develop before reporting.
d. Reassure the parents that accidents happen and continue observing the family dynamics.

SITUATION 9

Scenario:
You are caring for baby Florence, a 10-month-old patient admitted with parainfluenza virus, which requires droplet precautions. She is active, alert, and placed in a crib with side rails for safety. After completing your care tasks, you remove your PPE and exit the room. Once outside, you realize you forgot to raise the bedrails, placing the child at risk of falling. You intend to re-enter the room immediately but notice there are no clean gowns available nearby. A PAB is available but retrieving a gown would take time.

Question:
What is the most appropriate action to take next?
a. Ask the PAB to get more gowns.
b. Use your used gown again.
c. Wear a mask only and raise the bedrails.
d. Raise the bedrails without any PPE.

SITUATION 10

Scenario:
Émile, a 7-year-old boy, is admitted to the pediatric unit for dehydration and requires the insertion of an intravenous (IV) catheter for rehydration therapy. As the nurse prepares for the procedure, Émile begins to look anxious. He holds onto his favorite stuffed dinosaur and repeatedly asks if the needle will hurt.

Question:
Which technique is most appropriate for the nurse to use to distract Émile during the IV insertion?
a. blowing bubbles
b. giving him an iPad to play a simple game
c. offering a sucrose solution
d. sitting him on his parent's lap with his favorite toy

SITUATION 11.1

Scenario:
Sophie, a new mother, has just given birth to twin boys: Liam and Raphaël. Tragically, Liam was stillborn, while Raphaël survived. The couple had been aware during the pregnancy that Liam was unlikely to survive. They had prepared for both babies, even buying a car seat for each. Sophie has named both of her babies and has chosen to exclusively breastfeed Raphaël, which she has already begun.

Despite her bonding efforts, Sophie expresses emotional distress, saying,

"How will I feel taking care of Raphaël because I am constantly thinking about Liam?"

She also shared that she does not want to see Liam's body, and prefers to imagine that Liam looks like Raphaël.

Question:
What observation best indicates that Sophie is developing a healthy attachment bond with Raphaël?
a. The fact that she decided to exclusively breastfeed.
b. The fact that she has already named her babies.
c. The fact that she constantly thinks about Liam.
d. The fact that they bought the car seat.

SITUATION 11.2

Scenario:
A few hours after the birth of twins Liam (stillborn) and Raphaël (alive), Sophie is holding and breastfeeding Raphaël in her hospital bed. Her partner sits quietly beside her, occasionally glancing at the empty bassinet meant for Liam. A nurse gently reenters the room to check on them.
Sophie says softly,

"I don't want to see Liam. I want to remember him like Raphaël. I just want to focus on Raphaël now."

She appears emotionally fragile but not closed off. Her partner looks conflicted but doesn't speak.

Question:
What is the most therapeutic nursing action at this moment?
a. Explain to the mother the benefits of seeing Liam and how this could help her with the grieving process.
b. Give them time to discuss together and come back later.
c. Provide them with a leaflet on the stages of grief.

SITUATION 11.3

Scenario:
The nurse returns later in the evening and observes that Sophie remains tearful while feeding Raphaël. She speaks softly and seems emotionally distant, saying,

"I feel so torn. I love Raphaël, but every time I look at him, I wonder what Liam would have been like. I don't know how to be happy about this."

The nurse documents that Sophie has been preoccupied with grief, shows signs of emotional numbing, and has difficulty discussing her feelings openly. She remains attentive to Raphaël's feeding needs but is withdrawn.

Question:
What is the most appropriate new problem to add to the therapeutic nursing plan?
a. Persistent complex bereavement disorder
b. Difficulty adapting
c. Risk of neglect
d. Postpartum depression

SITUATION 12.1

Scenario:
Élise Bouchard, a first-time mother, brings her 2-day-old newborn, baby Olivier, to the maternity nurse during the postpartum hospital stay. Élise appears visibly anxious and says,

"My baby's hands and feet are bluish—what's wrong with him? Is he getting enough oxygen?"

You assess baby Olivier:
- He is awake and alert
- Skin on the trunk, face, and lips is pink
- Extremities (hands and feet) are bluish in color
- Respirations are regular at 42/min
- Oxygen saturation is 98% on room air
- Axillary temperature is 36.8°C

Question:
As the nurse, what is the most appropriate response or action?
a. Administer oxygen via nasal cannula at 1 L/min
b. Notify the physician immediately about possible central cyanosis
c. Reassure the parent that this is normal and monitor the baby
d. Place the baby in the radiant warmer and reassess in 1 hour

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Question:
As the nurse, what is the most appropriate response or action?
a. Administer oxygen via nasal cannula at 1 L/min
b. Notify the physician immediately about possible central cyanosis
c. Reassure the parent that this is normal and monitor the baby
d. Place the baby in the radiant warmer and reassess in 1 hour

Question:
What is the nurse's next best intervention?
a. Encourage skin-to-skin contact between the mother and baby
b. Apply a cold cloth to stimulate circulation in the extremities
c. Give the baby a warm bath to promote peripheral circulation
d. Adjust the room temperature to 22°C for better heat loss prevention

SITUATION 13

Scenario:
Baby Zoé was born at 39 weeks via spontaneous vaginal delivery with no complications. On the second day postpartum, the nurse observes several small, red blotchy spots with tiny white or yellowish pustules scattered across Zoé's trunk, face, and limbs. The lesions are non-vesicular, do not blanch completely, and are not causing the baby any discomfort. Zoé is feeding well, has stable vital signs, and is passing urine and meconium normally.

As the nurse prepares the discharge teaching, Zoé's mother, Sarah, looks worried and asks:

"She has this red rash all over her body. Are you sure it's safe for us to go home like this?"

Question:
What is the most appropriate nursing response?
a. "We'll keep you another day to monitor the rash."
b. "The rash is called erythema toxicum. It's common and harmless in newborns. You can absolutely go home."
c. "I'll ask the doctor to prescribe something to treat the rash before you leave."
d. "This rash might be a sign of an allergic reaction. Let's delay discharge just to be safe."

SITUATION 14.1

Scenario:
Maïna, a 3-month-old girl, was admitted to the pediatric surgery unit yesterday following a surgical repair of an anal fissure. She currently weighs 4.9 kg. This morning, her vital signs are:

- BP: 86/40 mmHg
- P: 110 bpm, regular rhythm
- R: 36 breaths/min., regular and normal depth
- T: 38.6°C

You decide to administer an antipyretic based on the collective prescription:
Acetaminophen (Tylenol®) oral solution, 80 mg/mL
Dose: 15 mg/kg PO, single dose

Question:
What medical device will you use to prepare Maïna's medication?
a. 1 mL syringe
b. 1 mL dropper
c. 3 mL syringe
d. 5 mL graduated spoon

SITUATION 14.2

Rationale:
You inform the physician about Maïna's condition and he postpones her discharge from hospi- tal. Maïna's mother says that her daughter has a fever for the first time. She asks you how she should take Maïna's temperature at home.

Question:
What temperature measurement method will you recommend to Maïna's mother?
a. Rectal method.
b. Tympanic method.
c. Axillary method.
d. Oral method.

SITUATION 14.3

Scenario:
The nurse notices that Maïna is unable to latch properly to the breast despite 15 minutes of attempts. The baby appears calm but shows signs of hunger.

Question:
What is the most appropriate nursing intervention at this point?

a. Perform manual expression and feed the baby with a medication cup.
b. Use a breastfeeding aid (e.g., nipple shield).
c. Place the baby skin-to-skin.

SITUATION 15.1

Scenario:
Ms. Papin, a 28-year-old mother, gave birth to her son Samuel two days ago. The delivery was vaginal at 39 weeks of gestation. Samuel's medical record indicates that Ms. Papin's blood group is O+, while Samuel's blood group is At. There was a prolonged premature rupture of membranes (PROM) lasting 16 hours before delivery. Post-delivery, Samuel has been diagnosed with neonatal jaundice and has a cephalhematoma. In the first 24 hours, Ms. Papin successfully breastfed Samuel six times.

During your morning assessment, you observe that Samuel appears slightly lethargic, and his skin has a yellowish tint. Concerned about his feeding and the potential for hypoglycemia due to jaundice, you decide to discuss feeding recommendations with Ms. Papin.

Question:
What recommendation will you give Samuel's mother regarding her son's feeding?
a. Increase the frequency of nursing to a minimum of 8 feeds in 24 hours.
b. Practice skin-to-skin contact to promote milk production for 24 hours.
c. Supplement every feed with a commercial infant formula for 24 hours to prevent hypoglycemia.
d. Nurse every two hours for 24 hours to promote an adequate milk supply.

SITUATION 15.2

Scenario:
Samuel, who has been diagnosed with neonatal jaundice and is currently undergoing phototherapy. At 14:00, you enter the room and find Ms. Papin sitting in a chair with Samuel sleeping peacefully in her arms. He is wrapped in a warm blanket but is not wearing a hat.

Question:
What priority intervention will you carry out?
a. Give the teaching on how to put the phototherapy eyewear on.
b. Put the hat back on Samuel's head to retain his heat.
c. Put Samuel in skin-to-skin contact with his mother for his well-being.
d. Put Samuel back under the phototherapy lights.

SITUATION 15.3

Scenario:
Ms. Papin's newborn son is currently receiving phototherapy for neonatal jaundice. She expresses concern about interrupting breastfeeding sessions because the baby needs to stay under the phototherapy lights.

Question:
What other recommendation will you give to Ms. Papin regarding her son's feeding during phototherapy?
a. Limit feedings to ensure the baby remains under the light as long as possible.
b. Offer expressed breast milk by bottle while phototherapy continues.
c. Suggest using a phototherapy blanket (Biliblanket).
d. Wait to breastfeed until the phototherapy session is complete.

SITUATION 15.4

Scenario:
Samuel was placed under phototherapy for neonatal jaundice, but he still requires at least 24 more hours of treatment. Ms. Papin is feeling overwhelmed and discouraged, as her partner needs to return to work this evening, leaving her unsure of how she will manage with her other children at home and Samuel still in the hospital. She expresses her concerns to you, seeking guidance on how to handle the situation.

Question:
What is the best solution to suggest to Ms. Papin?
a. Offer to request a consultation with the social worker to get help for the children at home.
b. Explore the possibility of Ms. Papin having a room at the hospital while Samuel is in hospital.
c. Check whether it is possible to get a breast pump to use at home so that she can continue to express her milk while Samuel is in hospital.
d. Check with the physician whether it is possible to return home with community follow-up and home phototherapy.

SITUATION 16.1

Scenario:
Julie Gagnon, a 32-year-old woman, has just delivered her third child — a healthy baby girl weighing 4250 grams — via spontaneous vaginal delivery. Due to the size of the baby, a second- to third-degree episiotomy was performed.

One hour postpartum, you perform a routine assessment:

- Her abdomen is soft, and the uterus is deviated to the right.
- There is noticeable swelling in the perineal area.
- Her sanitary pad is 50% saturated with lochia rubra.

Question:
What is your initial nursing intervention?
a. Perform a uterine massage.
b. Assist Julie to urinate using a bedpan.
c. Perform a straight catheterization.
d. Encourage her to take a cold sitz bath for the perineal swelling.

SITUATION 16.2

Scenario:
Despite initial efforts to assist Julie Gagnon with voiding postpartum, she remains unable to urinate. Upon reassessment, you palpate a firm suprapubic mass, and her abdomen remains distended. A bladder scan reveals 350 mL of retained urine.

You proceed with a straight catheterization to relieve bladder distension.

Question:
What best justifies your intervention?
a. Due to the bladder scan result.
b. Due to the patient's discomfort.
c. Due to the palpable suprapubic mass.
d. To promote uterine contraction and prevent postpartum hemorrhage.

SITUATION 17.1

Scenario:
Yoon-Ji, a 24-year-old Korean mother, has just given birth to her first child. She is preparing to breastfeed for the first time. Yoon-Ji is eager to learn but only speaks Korean, while the nurse assisting her only speaks French. Yoon-Ji appears anxious and confused about how to properly position her baby and initiate breastfeeding. There is no one immediately available who speaks both languages, and the nurse needs to ensure that Yoon-Ji receives the necessary instruction.

Question:
What should the nurse do to effectively communicate and teach Yoon-Ji about breastfeeding?
a. Speak to the French-speaking spouse
b. Call the translation service
c. Use a fake breast and a doll to demonstrate breastfeeding
d. Call the lactation consultant

SITUATION 17.2

Scenario:
Yoon-Ji appears uncertain about breastfeeding and asks if it's really necessary to feed her baby right away since "the milk hasn't come in yet." With the help of the translator, you begin teaching her about colostrum, the first secretion produced by the breasts after delivery.

Question:
How will you explain the importance of the baby receiving colostrum?
a. Colostrum is rich in antibodies and helps protect the baby from infections.
b. Colostrum is high in water content and mainly keeps the baby hydrated.
c. Colostrum contains only small amounts of nutrients and should be discarded.
d. Colostrum increases milk production for the mother, so it must be expressed and stored.

SITUATION 18.1

Scenario:
Elliot, a 10-year-old boy with a medical history of inflammatory bowel disease (IBD), returns for a follow-up visit at the pediatric clinic. His parents express concern that he hasn't grown much since his last visit six months ago. Upon assessment, the nurse notes suboptimal growth and low weight gain. Elliot has been having intermittent diarrhea and reduced appetite.

Question:
Which recommendation should the nurse provide to Elliot's parents to best support his growth and nutritional needs?
a. Add daily probiotic supplements like yogurt or kefir.
b. Offer nutritional drinks such as Pediasure® or Boost® Kid Essentials.
c. Increase intake of high-fiber foods like whole wheat bread, beans, and raw vegetables.
d. Limit fluids like juice and water to reduce diarrhea episodes.

SITUATION 18.2

Scenario:
The nurse continues the education session and discusses long-term management. Elliot's parents ask, "Are there specific vitamins or minerals he's at risk of losing?"

Question:
Which mineral should the nurse emphasize to prevent future complications related to inflammatory bowel disease?
a. Magnesium
b. Sodium
c. Calcium
d. Potassium

SITUATION 18.3

Scenario:
During today's clinic visit, Elliot's mother expresses concern. "He refuses to eat anything. I've tried giving him his favorite food, but he just pushes the plate away. I'm getting frustrated—he's already losing weight."

Question:
Which response is most appropriate for the nurse to give to Elliot's parent?
a. "It is important for the child to eat. Make foods that they like."
b. "Be firm. The child will eat when hungry."
c. "I'll let the healthcare provider know about your concerns."
d. "I'll arrange for a consult with a nutritionist to get more ideas for mealtime."

SITUATION 18.4

Scenario:
Elliot has been prescribed oral corticosteroids to manage his inflammatory bowel disease. His parent expresses concern about possible side effects and how to give the medication safely.

Question:
Which TWO pieces of information should the nurse provide about corticosteroid therapy?
a. "Take with food or at mealtimes."
b. "Expect weight loss."
c. "It may cause low blood pressure."
d. "Take medication consistently and do not stop abruptly."

SITUATION 18.5

Scenario:
Elliot has been admitted to the pediatric unit with complaints of severe diarrhea over the past 24 hours. He appears fatigued and pale. His mother reports that he has had more than 8 loose stools today and hasn't been eating well. His most recent vitals show a heart rate of 122 bpm, BP 94/60 mmHg, and his mucous membranes appear dry. His weight has dropped by 1.5 kg since his last outpatient visit last week.
As the nurse working with Illiot today, you are preparing the initial care plan.

Question:
What is the priority nursing goal for Illiot at this time?
a. The child maintains adequate hydration.
b. The child demonstrates healthy coping skills.
c. The child reports improved sleep.
d. The child self-administers prescribed medication.

SITUATION 19

Scenario:
Marie, a 28-year-old woman recently confirmed to be 8 weeks pregnant, has a known history of inflammatory bowel disease (IBD), diagnosed in her early 20s. During her first prenatal visit, she expresses concern and asks, "Will my IBD affect my pregnancy or the baby?"

Question:
Which response by the nurse is most accurate?
a. "You will need to be on bedrest throughout the entire

pregnancy."
b. "Your disease may increase the risk for some pregnancy complications."
c. "The medications used to treat your disease are safe to use during your pregnancy."
d. "IBD should have no effect on pregnancy or the baby. We'll watch you closely."

SITUATION 20.1

Scenario:
You are caring for Amari, an 11-month-old infant diagnosed with bronchiolitis caused by respiratory syncytial virus (RSV). He is being admitted for oxygen therapy and close respiratory monitoring. His mother appears upset and concerned when she finds out that Amari will be placed in a semi-private room with another pediatric patient.

She asks, "Why isn't he in a private room? Isn't RSV contagious?"

Question:
Which explanation by the nurse is most appropriate regarding this room assignment?
a. "RSV is only contagious in adults, so room sharing is safe for children."
b. "Children with the same infection can safely be placed in the same room using proper precautions."
c. "We ran out of private rooms, but we'll do our best to monitor your child closely."
d. "Placing your child in a shared room is more cost-effective for the hospital."

SITUATION 20.2

Scenario:
During your shift, a newly hired nurse asks you why Amari is on both contact and droplet precautions.

Question:
What is the most appropriate infection control measure for this client?
a. Place the client in airborne isolation and use an N95 respirator
b. Wear a gown, gloves, and a surgical mask when within 2 meters of the client
c. Use only standard precautions unless the child is actively coughing
d. Allow the client to stay in the playroom while wearing a mask

SITUATION 20.3

Scenario:
During your shift, you notice that Amari appears more fatigued, with increased work of breathing. You check his oxygen saturation and find it has dropped to 88% on room air.

Medical orders:
- Initiate oxygen therapy via nasal cannula if SpO2 < 90%
- Maintain SpO2 ≥ 92%
- Notify the physician if respiratory rate exceeds 60 or signs of respiratory distress worsen

Question:
What is the most appropriate nursing intervention at this time?
a. Reassess in 15 minutes to confirm the low oxygen reading
b. Notify the physician immediately without taking further action
c. Apply oxygen via nasal cannula as ordered and reassess the response
d. Suction the nares and wait to see if SpO2 improves spontaneously

SITUATION 20.4

Scenario:
Amari is now stable and preparing for discharge. His mother asks what she can do at home to help him breathe better, especially when he's congested.

Question:
What should the nurse teach the parent to do at home to help keep Amari's airway clear?
a. Use a warm compress on the chest twice daily
b. Offer water every 15 minutes to thin secretions
c. Administer over-the-counter decongestants for relief
d. Use a bulb syringe to suction the nose, especially before feedings and sleep

SITUATION 20.5

Scenario:
Amari's mother expresses concern about his reduced feeding and fewer wet diapers since being diagnosed with RSV. You decide to review signs of dehydration with her.

Question:
Which manifestation should the nurse include to watch for at home?
a. Sunken posterior fontanel
b. Moist mucous membranes
c. Sunken anterior fontanel
d. Excessive drooling

SITUATION 21

Scenario:
Samantha Langford, a 29-year-old G2T0P1A0L1, has just delivered a preterm infant at 32 weeks gestation following premature rupture of membranes (PROM). During your initial postpartum assessment, you note that her vital signs are abnormal, and she appears diaphoretic. Samantha reports seeing black spots and feeling unwell. She also brought Naproxen from home, which she uses occasionally for joint pain. You suspect pre-eclampsia based on her symptoms.

Question:
What is your immediate nursing action?
a. Apply a cold cloth to her forehead
b. Dim the lights and minimize stimuli
c. Remind her not to take the Naproxen
d. Maintain the patient in a supine position

SITUATION 1.1

B. Bladder distention

A full bladder is the most likely cause of the deviation of the uterine fundus to the right and the severe cramp-like pain in Mrs. Jolicouer's lower abdomen. After childbirth, a full bladder can prevent the uterus from contracting effectively, leading to discomfort and an increased risk of postpartum hemorrhage.

- At 14:30, Mrs. Jolicouer voided only 100 mL, which is a small amount considering postpartum diuresis. This suggests that she may have urinary retention or incomplete bladder emptying.
- At 16:25, the fundus is now 1/0 and deviated to the right, which indicates bladder distension. Normally, the fundus should remain midline if the bladder is empty.
- Her vital signs are stable, and her lochia (bleeding) pattern is within normal limits (one pad per hour), making postpartum hemorrhage (C) less likely at this stage.
- Uterine atony (A) would typically present with a soft or boggy uterus, but in this case, the fundus was initially firm and midline at 14:30.
- Endometritis (D), an infection of the uterine lining, is unlikely at this early postpartum stage. It usually presents with fever, foul-smelling lochia, and uterine tenderness rather than fundal deviation.

SITUATION 1.2

A. Assist Mrs. Jolicoeur to void and reassess her fundus

The priority intervention is to assist Mrs. Jolicoeur to void and then reassess her uterine fundus. A full bladder can displace the uterus and interfere with its ability to contract properly, increasing the risk of postpartum hemorrhage. Encouraging spontaneous voiding is the least invasive and most appropriate first step.

If she is unable to void, then the next step would be:

- B. Perform a bladder scan to assess for urinary retention and determine the volume of retained urine. This helps confirm whether her symptoms are due to bladder distension.
- C. Perform an in-and-out catheterization if the bladder scan confirms significant retention or if she remains unable to void. This will relieve bladder distension and allow the uterus to contract properly.
- D. Increasing IV fluids and monitoring for postpartum hemorrhage is not the immediate priority because her vital signs are stable, and her bleeding is within normal limits (one pad per hour). However, unresolved bladder distension could lead to further complications, making early intervention crucial.

SITUATION 1.3

A. Uterine fundus at 0/0 or at the level of the umbilicus
B. Relief of pain and cramps

Uterine fundus at 0/0 or at the level of the umbilicus: A displaced or elevated fundus was a key indicator of bladder distension. After voiding, the fundus should return to its midline position and remain firm at the umbilical level, confirming that the bladder is no longer interfering with uterine contraction.

Relief of pain and cramps: The cramp-like pain Mrs. Jolicoeur experienced was likely due to bladder distension and its impact on uterine contraction. Once the bladder is emptied, the uterus can contract properly, relieving discomfort.

- C. Lochia changing to a lighter color: Lochia progression (rubra → serosa → alba) occurs naturally over days to weeks and is not an immediate sign of bladder relief.
- D. Increase in urine output: While urination confirms bladder emptying, the key indicators of resolution are fundal position and pain relief, as these directly address the original problem.

SITUATION 2.1

A. Apply a cold compress or ice pack to the perineum to reduce swelling and numb pain

Applying a cold compress or ice pack is an effective and evidence-based non-pharmacological intervention for perineal pain relief postpartum. Cold therapy helps by reducing inflammation, decreasing edema, and numbing the perineal area, which leads to pain relief without the need for additional medications.

- B. Increasing fluid intake and ambulation is important for overall postpartum recovery, but it does not directly target perineal pain relief.
- C. Requesting a stronger analgesic should only be considered if other pain relief measures fail and the pain becomes severe. It is not the first-line recommendation.
- D. Massaging the perineal area is contraindicated in a third-degree perineal tear, as it may cause further irritation, pain, or trauma to the healing tissues.

SITUATION 2.2

D. Take the iron supplement at least 1 hour before consuming dairy products

Dairy products contain calcium, which can interfere with iron absorption by binding to the iron in the gastrointestinal tract, making it less available for the body to use. To ensure optimal absorption, iron supplements should be taken at least 1 hour before or 2 hours after consuming dairy products.

- A. Taking iron with dairy products is incorrect because calcium inhibits iron absorption, reducing the supplement's effectiveness.
- B. Avoiding dairy products completely is unnecessary. Mrs. Dufresne can still consume dairy as long as she separates it from iron intake.
- C. Crushing the iron supplement and mixing it with milk is incorrect, as milk further reduces iron absorption and may cause stomach irritation.

SITUATION 2.3

C. Anemia

Anemia is the new clinical finding that must be added to Mrs. Dufresne's therapeutic nursing plan (TNP), as it directly impacts her postpartum recovery and requires ongoing follow-up. Postpartum anemia is common due to blood loss during delivery and can lead to fatigue, dizziness, and delayed healing. Since her doctor has already prescribed an iron supplement, it is essential to document this condition in the TNP for proper monitoring and intervention.

- A. Delayed postpartum hemorrhage is incorrect because there is no indication that Mrs. Dufresne is experiencing excessive bleeding beyond the normal postpartum period.
- B. Postpartum depression is not supported by the current clinical data. While it is an important condition to monitor, there is no mention of mood changes, sadness, or other depressive symptoms in her case.
- D. Urinary retention is incorrect because there is no evidence suggesting difficulty in voiding or abnormal bladder function.

SITUATION 3.1

B. You can hear or see your baby swallowing regularly.

Audible or visible swallowing is a key sign of effective milk transfer, which strongly suggests a proper latch. It also indicates that the baby is getting enough milk and feeding well.

- A. The baby's cheeks are dimpled with each suck. Dimpling cheeks may indicate poor suction and that the baby is using facial muscles more than the tongue to draw milk, which can be a sign of an ineffective latch.
- C. The baby stays latched for no more than 5 minutes per breast. Duration is not a reliable indicator of latch quality. Some babies feed efficiently in 5 minutes, others take longer. The quality of the latch and milk transfer matters more than time.
- D. The baby's lips are tucked inward around the nipple. In a proper latch, the baby's lips should be flanged outward like a fish, not tucked in. Inward lips can reduce milk transfer and cause nipple pain or damage.

SITUATION 3.2

C. Your baby will seem satisfied and relaxed after most feedings.

A well-fed baby typically appears calm, content, and relaxed after feeding. This is a reliable behavioral sign that the baby has taken in enough milk.

- A. Your baby will sleep through the night without waking to feed. Newborns typically wake frequently (every 2–3 hours) to feed, even at night. Sleeping long stretches can be a sign of lethargy or inadequate intake, not necessarily a well-fed baby.
- B. Your baby will have at least 2 to 3 wet diapers per day. After the milk comes in (usually around day 3–5), a well-fed baby should have at least 6 wet diapers and 3 or more stools per day. 2–3 is too low for this stage.
- C. Your baby will seem satisfied and relaxed after most feedings. A well-fed baby typically appears calm, content, and relaxed after feeding. This is a reliable behavioral sign that the baby has taken in enough milk.
- D. Your breasts will stay full and firm after each feeding. Breasts should feel softer and lighter after a good feeding. If they remain full and firm, it could mean the baby didn't transfer enough milk.

SITUATION 4.1

C. Place the baby on a firm mattress with no loose bedding or toys.

This is a key recommendation from pediatric guidelines. A firm sleep surface with no loose or soft items helps maintain a safe environment and reduces the risk of SIDS and suffocation.

A. Use soft pillows and stuffed animals to keep the baby cozy while sleeping. Soft bedding and objects in the crib increase the risk of suffocation and SIDS. The sleep surface should be free of pillows, stuffed animals, bumper pads, and blankets.
B. Share your bed with the baby for easier nighttime feeding and bonding. Bed-sharing is associated with a higher risk of SIDS, especially in the first few months. Room-sharing (having the baby sleep in a crib or bassinet in the same room) is safer.
D. Dress the baby in several layers and keep the room very warm at night. Overheating increases the risk of SIDS. It's better to dress the baby in light sleep clothing and maintain a comfortable room temperature (around 20–22°C or 68–72°F).

SITUATION 4.2

A. Continue to breastfeed every 2–3 hours, even if you have to wake the baby.

Frequent feeding helps promote regular bowel movements, which is how bilirubin is excreted. It also keeps the baby well-hydrated and reduces the risk of worsening jaundice. Babies with jaundice often become sleepy and must be gently stimulated to feed.

B. Give the baby water between feedings to flush out the bilirubin. Giving water is not recommended for newborns and can interfere with breastfeeding. It offers no benefit in reducing bilirubin and may lead to electrolyte imbalances.
C. Keep the baby swaddled and let him sleep as much as he wants. While rest is important, excessive sleepiness in a jaundiced newborn is concerning. Babies need to be woken regularly to feed, especially if they are showing signs of jaundice.

D. Apply warm compresses to the baby's skin to help the yellow color fade. Jaundice is a systemic condition caused by elevated bilirubin levels in the blood. Warm compresses have no therapeutic effect and delay proper intervention.

SITUATION 5.1

A. Capillary refill time and skin color

These are essential indicators of tissue perfusion and oxygenation. In respiratory distress, inadequate oxygen exchange can lead to cyanosis, delayed capillary refill, and pale or mottled skin. These signs help determine the severity of hypoxia and overall circulatory status.

B. Pupil size and reaction to light. While neurological signs are important in general, they are not a primary focus in the assessment of acute respiratory distress or bronchospasm unless other neuro signs are present.
C. Bowel sounds and abdominal distention These are more relevant for gastrointestinal concerns. While abdominal distention can sometimes occur with severe air trapping, it's not a priority sign in this context.
D. Grip strength and ability to walk unassisted Not appropriate for a 2½-year-old in respiratory distress. Her fatigue is likely related to increased work of breathing, not muscle weakness.

SITUATION 5.2

A. A side effect of salbutamol (Ventolin)

Restlessness, irritability, and insomnia are common side effects of salbutamol, especially when given frequently (every 2 hours). It is a beta-2 agonist that can stimulate the nervous system, leading to excitability, tremors, and increased heart rate in children.

B. Mild hypoxia from low oxygen flow. Her oxygen saturation was 92% on room air earlier, and she's receiving 1.5 L/min O2, which is an appropriate flow for a child her age. If her breathing has improved, hypoxia is unlikely to be the cause of her restlessness.
C. Adverse reaction to fluticasone (Flovent).
Fluticasone is a long-acting inhaled corticosteroid that is not known to cause restlessness when used properly via inhalation. Its systemic absorption is minimal.
D. A sugar rush from the corticosteroid suspension.
Although Pediapred is sweetened for children, it doesn't contain enough sugar to cause a behavioral reaction. The restlessness is more likely due to medication effects (especially salbutamol), not sugar content.

SITUATION 6.1

B. Salbutamol (Ventolin) first, to open the airways before giving the corticosteroid

Salbutamol (Ventolin) first, to open the airways before giving the corticosteroid. Salbutamol is a short-acting beta-agonist (SABA) that works quickly to dilate the bronchial passages. Administering it first allows the airways to open, so the corticosteroid (Fluticasone) can then be more effectively delivered deeper into the lungs.

A. Fluticasone (Flovent) first, to reduce airway inflammation right away. Fluticasone is an inhaled corticosteroid that works over time to reduce inflammation. However, if the airways are narrowed or constricted, it won't be delivered effectively.
C. Either inhaler can be given first—it doesn't matter as long as both are taken. The order does matter. Bronchodilators should always be given before anti-inflammatory inhalers for maximum effectiveness.
D. Alternate which one is given first each day to avoid dependence on one inhaler. There is no clinical basis for alternating inhaler order. Treatment should be based on pharmacologic action, not on rotating routines.

SITUATION 6.2

B. Wait at least 3 to 5 minutes between the two inhalers

This allows salbutamol to relax and open the airway muscles, improving the effectiveness of fluticasone, which works by reducing inflammation in the lungs.

A. Administer both inhalers immediately, one after the other. Salbutamol needs time to dilate the airways so the steroid can be more effectively delivered. Immediate use of both limits fluticasone's absorption.
C. Wait 30 minutes to allow the bronchodilator to fully wear off. There is no need to wait this long. Salbutamol starts working within minutes. Waiting 30 minutes delays needed anti-inflammatory treatment unnecessarily.
D. Give fluticasone first, then wait 10 minutes before giving salbutamol. The order is reversed. Bronchodilators (like salbutamol) must be given before inhaled corticosteroids (like fluticasone) to ensure proper delivery and effectiveness.

SITUATION 7.1

C. Stopping Flovent too soon may cause symptoms to return or worsen.

Even if Zoé appears better, the underlying inflammation in her airways may still be present. Completing the full 14-day course helps ensure the inflammation is fully treated, reducing the risk of recurrence.

A. You can stop Flovent early if she's feeling better—it's mainly for emergencies. Fluticasone is not for emergency use—it's a controller medication meant to reduce airway inflammation over time. Stopping early puts the child at risk for another asthma episode.
B. Flovent must be continued to strengthen her immune system. Fluticasone does not boost immunity. It's a corticosteroid that reduces inflammation in the lungs, helping prevent asthma symptoms.
D. Flovent must be taken for life, even if she has no more asthma symptoms. Fluticasone can be used

short-term or long-term depending on the child's condition. In Zoé's case, it's prescribed for 14 days only, not for life.

SITUATION 7.2

C. Inhaler medications do not alter growth when used short-term and in controlled doses.

Research shows that short-term, well-controlled use of inhaled corticosteroids like Fluticasone does not affect growth. It's safe and effective when used as prescribed, especially for short treatment plans like Zoé's.

A. Inhalers always slow down growth a little, but it's not serious. This overgeneralizes the risk and can cause unnecessary fear. Growth effects, when they occur, are more likely with long-term or high-dose use, and even then, they are usually minimal and well-monitored.
B. This medication won't affect Zoé's growth because it only works in the lungs. Although fluticasone mainly acts locally in the lungs, a small amount can be absorbed systemically. That's why the dose and duration are carefully controlled, not because there's no risk at all.
D. You can stop using the inhaler if you notice any change in Zoé's height. Parents should not stop medications on their own. If there are concerns, they should speak with the healthcare provider, but sudden discontinuation may worsen symptoms.

SITUATION 8

B. Report your findings to the appropriate child protection authorities immediately.

In all suspected child abuse cases, the nurse is legally obligated to report the suspicion immediately to child protection services. Protecting the child's safety is the top priority.

A. Question Karine's parents separately about their discipline methods. While further information can be collected, investigating is not the nurse's role. If abuse is suspected, the nurse's duty is to report, not to interrogate.
C. Document the bruises and wait to see if more injuries develop before reporting. Delaying a report can put the child at further risk. Documentation is necessary, but reporting must be done immediately based on the current findings.
D. Reassure the parents that accidents happen and continue observing the family dynamics. Minimizing the situation is dangerous. It may delay intervention needed to protect the child.

SITUATION 9

C. Wear a mask only and raise the bedrails.

Droplet precautions require wearing a surgical mask within 2 meters (6 feet) of the patient to protect against infectious respiratory droplets. A gown is not required unless there will be close physical contact with the patient or their secretions. In this case, the safety risk (fall) outweighs the minimal risk of infection transmission since you are only interacting with the bedrails, not the patient directly.

- Option a delays action and increases fall risk.
- Option b is unsafe; reusing contaminated PPE increases cross-contamination risk.
- Option d violates basic infection control protocols—even if minimal PPE is needed, some PPE (a mask) is still required for droplet precautions.

SITUATION 10

A. blowing bubbles

- a. Blowing bubbles – This technique engages school-age children in active participation. It encourages slow, deep breathing, which naturally calms the nervous system and reduces pain perception. It's developmentally appropriate, simple, and effective during short, painful procedures like IV starts.
- b. Giving him an iPad to play a simple game. While using a tablet or digital distraction can be effective, it is passive and may not promote the same breathing control as bubble-blowing. It can be helpful before or after the procedure, but during the procedure, it may not hold the child's attention in the same focused way that interactive, physically engaging distraction does.
- c. Offering a sucrose solution. This is not appropriate for a 7-year-old. Sucrose solutions are used primarily for infants under 12 months as a sweet taste can release natural opioids to soothe pain. For school-age children, more age-appropriate distraction techniques are preferred.
- d. Sitting him on his parent's lap with his favorite toy. This is comforting but not as effective as a distraction strategy. Emotional support is important, but pairing it with a cognitive distraction (like blowing bubbles) is more effective at decreasing pain perception in school-age children who are more cognitively developed.

SITUATION 11.1

A. The fact that she decided to exclusively breastfeed.

- a. The fact that she decided to exclusively breastfeed. Choosing to breastfeed — especially after experiencing the trauma of a stillbirth — is a significant sign of emotional connection and active engagement in the surviving infant's care. It reflects maternal investment, physical closeness, and attachment.
- b. The fact that she has already named her babies. Naming a baby (even a stillborn one) is part of grief acknowledgment and healthy mourning, but does not alone reflect ongoing bonding with the living baby.
- c. The fact that she constantly thinks about Liam. Persistent thoughts of the deceased twin are expected during grief, but if they interfere with

- caregiving, it may reflect unresolved grief rather than healthy bonding with Raphaël.
- d. The fact that they bought the car seat. Buying a car seat is part of prenatal preparation, not a sign of postnatal attachment. It shows planning, not necessarily bonding.

SITUATION 11.2

B. Give them time to discuss together and come back later.

This approach shows empathy, respect for their process, and allows for autonomy in grief. Many parents change their minds after processing their emotions. Reoffering support later is therapeutic and supportive.

- a. Explain to the mother the benefits of seeing Liam and how this could help her with the grieving process. This may feel pressuring or intrusive in a highly emotional moment. Even if well-intentioned, pushing the idea of viewing the stillborn infant too early may cause distress or guilt. It's better to allow space and revisit later with consent.
- c. Provide them with a leaflet on the stages of grief. While educational materials are useful, handing a generic pamphlet during an acute emotional moment may come off as impersonal and may not address their immediate emotional needs.

SITUATION 11.3

C. Difficulty adapting

Sophie is experiencing normal but intense grief with some functional emotional struggles. She's showing signs of emotional conflict and disorganization, but not neglecting care. This label reflects early maladaptation to a traumatic event and helps guide support interventions like grief counseling and psychoeducation.

- a. Persistent complex bereavement disorder. This diagnosis requires prolonged and impairing grief lasting beyond 12 months (per DSM-5-TR). Sophie's grief is intense but still within the expected early rangepostpartum. It's too soon to label it as a persistent disorder.
- d. Risk of neglect. There is no indication that Sophie is neglecting Raphaël. She continues breastfeeding and holding him. Emotional withdrawal does not equal neglect unless there's a consistent failure to meet the child's physical or emotional needs.
- e. Postpartum depression. This diagnosis requires a cluster of depressive symptoms such as persistent low mood, fatigue, irritability, guilt, disinterest in baby, etc., sustained over at least 2 weeks. Sophie's emotional reaction appears situationally appropriate and centered on grief, not classic PPD.

Risk of depression - Acceptable answer, but not the best fit based on current observations. While Sophie is tearful, she remains emotionally responsive and is caring for Raphaël. There's no clear evidence yet of clinical depressive symptoms (anhedonia, sleep changes, suicidal ideation, etc.).

SITUATION 12.1

C. Reassure the parent that this is normal and monitor the baby

Acrocyanosis is a common and normal finding in newborns due to immature circulation. It often resolves in the first few days. No medical intervention is required unless other signs of distress are present.

- a. Administer oxygen via nasal cannula. Unnecessary. Oxygenation is adequate (SpO2 98%), and baby is not in respiratory distress. This may cause harm or over-treatment.
- b. Notify the physician about central cyanosis. This is acrocyanosis, not central cyanosis. Central cyanosis affects lips, tongue, and mucosa, which are pink in this case.
- d. Place the baby in the radiant warmer and reassess. While warmth supports circulation, the baby's temperature is normal. This intervention is not necessary unless hypothermia is present.

SITUATION 12.2

A. Encourage skin-to-skin contact between the mother and baby

This is the gold standard to promote thermoregulation and bonding. It helps stabilize temperature, heart rate, and circulation, which can reduce acrocyanosis.

- b. Apply a cold cloth. Incorrect and harmful. This may worsen acrocyanosis and lower the baby's body temperature.
- c. Warm bath . Contraindicated. Newborns should not be bathed until their temperature is stable. A bath may cause heat loss and worsen acrocyanosis.
- d. Room temperature to 22°C. Too low for a newborn. Recommended room temperature for newborns is around 24–26°C. Cooler rooms may increase peripheral vasoconstriction and worsen acrocyanosis.

SITUATION 13

B. "The rash is called erythema toxicum. It's common and harmless in newborns. You can absolutely go home."

Erythema toxicum neonatorum is a normal newborn finding in over 50% of full-term babies. It does not require treatment or delay discharge.

- a. Erythema toxicum is benign and self-limiting, typically resolving within the first 1–2 weeks of life.
- c. No medications are needed. The rash is self-resolving.
- d. Erythema toxicum is not an allergic reaction and should not delay discharge.

SITUATION 14.1

A. 1 mL syringe

- Calculated dose:
  - 15 mg/kg × 4.9 kg = 73.5 mg
  - Volume to administer:
  - 73.5 mg ÷ 80 mg/mL = 0.92 mL

- Since the amount is less than 1 mL, a 1 mL syringe offers the highest level of precision, which is essential for infant medication safety.
- A 3 mL syringe may be less accurate for volumes under 1 mL.
- A dropper or spoon is not suitable due to risk of dosing errors.

SITUATION 14.2

C. Axillary method.

Given that Maïna just had an anal fissure repair, the rectal method should be avoided to prevent discomfort and potential injury to the healing area. Although the rectal method is typically the most accurate for infants, it is contraindicated in this situation.

The axillary (underarm) method, while slightly less accurate, is non-invasive and safe for infants. It is the best alternative in this case, considering Maïna's recent surgery. This method is easy for parents to perform at home and minimizes the risk of exacerbating any pain or complications related to her surgical site.

SITUATION 14.3

A. Perform manual expression and feed the baby with a medication cup.

- Manual expression followed by cup feeding ensures that the baby receives nutrition and maintains sucking reflex while avoiding the risk of nipple confusion, which is especially important in breastfed infants.
- Using a medication cup for expressed breast milk helps support breastfeeding continuity and prevents reliance on artificial nipples.
- While skin-to-skin (option c) is beneficial for bonding and encouraging feeding, in this case, the baby needs effective intake after multiple failed latch attempts.
- Breastfeeding aids (option b) may sometimes help, but they can interfere with latch learning or increase nipple confusion in young infants.

SITUATION 15.1

A. Increase the frequency of nursing to a minimum of 8 feeds in 24 hours.

Increasing the frequency of nursing to a minimum of eight feeds in 24 hours is crucial for several reasons. Preventing Hypoglycemia: Frequent feeding helps to ensure that the newborn receives adequate calories, which is vital in preventing hypoglycemia, especially in infants with jaundice.

Promoting Effective Breastfeeding: Increasing the frequency of feeds encourages better stimulation of the breast, which can enhance milk production and ensure that the infant receives enough colostrum and mature milk.

Managing Jaundice: Frequent feeding is beneficial for newborns with jaundice as it promotes hydration and helps with the elimination of bilirubin through stool. While nursing every two hours also promotes milk supply, the correct option is more specific to the situation of increasing total feeds within the 24-hour period. Supplementing with formula, is not necessary unless there are signs of inadequate feeding, and skin-to-skin, while beneficial for bonding and milk production, does not directly address the immediate feeding needs of Samuel.

SITUATION 15.2

D. Put Samuel back under the phototherapy lights.

The priority intervention in this scenario is to put Samuel back under the phototherapy lights. Effectiveness of Treatment: Phototherapy is essential for treating neonatal jaundice by breaking down excess bilirubin in the blood. Prolonged exposure to the lights is necessary to effectively lower his bilirubin levels.

Safety and Monitoring: While skin-to-skin contact is important for bonding and comfort, it is crucial that Samuel receives uninterrupted phototherapy treatment during this critical time to manage his jaundice effectively.

Eye Protection: Although teaching about eyewear is necessary, the immediate priority is to ensure Samuel receives the treatment he needs.
Temperature Regulation: While maintaining body temperature is important, Samuel is already wrapped warmly in a blanket. However, he still requires phototherapy treatment, which is more critical at this moment.

SITUATION 15.3

C. Suggest using a phototherapy blanket (Biliblanket).

- A Biliblanket allows for continuous phototherapy while the baby remains in close contact with the mother, enabling breastfeeding without interruption.
- This approach promotes frequent feeding, which enhances bilirubin excretion through stool and urine.
- Options a and d could delay feeding and reduce hydration, potentially worsening jaundice.
- While option b may provide some benefits, it is less ideal than direct breastfeeding, especially when phototherapy can continue with a blanket device.

SITUATION 15.4

D. Check with the physician whether it is possible to return home with community follow-up and home phototherapy.

The best solution in this scenario is to explore the possibility of Samuel continuing his phototherapy treatment at home with community follow-up.
Continuity of Care: Home phototherapy, when appropriately managed with community follow-up, allows the baby to receive the necessary treatment while being in a familiar environment. This can reduce stress for Ms. Papin and provide her with the opportunity to care for her other children.
Family-Centered Care: This option supports the family's needs by enabling Ms. Papin to stay home and maintain her role in caring for her other children, reducing the logistical challenges she faces.
Patient Comfort and Convenience: This approach allows Ms. Papin to remain close to her newborn while also being able to manage household responsibilities. It also reduces the emotional strain that might arise from prolonged separation from her baby.

The other options offer some support but do not directly address the primary concern of managing Samuel's treatment while meeting the family's needs. Consulting with a social worker could be helpful, but ensuring Samuel's medical needs are met in the least disruptive manner for the family is more urgent. Exploring home phototherapy provides a practical solution that aligns with Ms. Papin's concerns.

SITUATION 16.1

B. Assist Julie to urinate using a bedpan.

A deviated uterus in the immediate postpartum period often indicates a full bladder, which can hinder uterine contraction, increase bleeding, and lead to uterine atony. The least invasive and most appropriate first step is to assist the patient to void.

- a. Uterine massage is useful if the uterus is boggy, but not when deviation is the main concern.
- c. Catheterization is only considered if the patient cannot void on her own after assistance.
- d. A cold sitz bath is appropriate for perineal swelling but does not address the priority issue — the uterine deviation likely caused by bladder distension.

SITUATION 16.2

D. To promote uterine contraction and prevent postpartum hemorrhage.

In the immediate postpartum period, a full bladder can displace the uterus, prevent it from contracting effectively, and lead to increased vaginal bleeding and postpartum hemorrhage. Catheterizing the bladder allows the uterus to return to the midline and contract properly, which is essential for controlling bleeding.

- a. The bladder scan is informative but not the main justification.
- b. Discomfort is a symptom, not the clinical reason for action.
- c. The palpable mass supports the diagnosis of bladder distension but does not address the urgency of preventing complications.

SITUATION 17.1

B. Call the translation service

Effective communication is critical in healthcare, especially in situations where language barriers exist. Using a professional translation service ensures that Yoon-Ji receives accurate information in her native language, reducing the risk of miscommunication. This approach respects the patient's cultural and linguistic needs and allows for a clear understanding of breastfeeding techniques. While options like speaking to the French-speaking spouse or using visual aids might seem helpful, they do not guarantee accurate communication and may lead to misunderstandings. Involving a translation service is the best way to ensure that Yoon-Ji can learn and practice breastfeeding effectively.

SITUATION 17.2

A. Colostrum is rich in antibodies and helps protect the baby from infections.

Colostrum is the first milk produced by the breasts, usually yellowish in color and thick in consistency. It is highly concentrated with immunoglobulins, especially IgA, which coat the baby's intestines and provide passive immunity. It also contains nutrients, white blood cells, and growth factors essential for a newborn's first days of life. Teaching this to the mother —even through a translator—is crucial to encourage early breastfeeding and mother-baby bonding.

SITUATION 18.1

B. Offer nutritional drinks such as Pediasure® or Boost® Kid Essentials.

Children with IBD are at risk for malnutrition and poor growth due to malabsorption, chronic inflammation, and decreased intake. Nutritional drinks like Pediasure® or Boost® Kid Essentials are high in calories, protein, and essential nutrients, and are easier to digest than solid foods. They help meet daily nutritional requirements, especially when appetite is low.

- Option a (probiotics like yogurt or kefir) may support gut health but do not provide sufficient calories for catch-up growth.
- Option c (high-fiber foods like whole grains, beans, and raw veggies) may worsen symptoms like diarrhea or abdominal cramping in IBD flares.
- Option d (reducing fluids) is not appropriate — hydration is essential, especially with ongoing diarrhea.

SITUATION 18.2

C. Calcium

Children with IBD are at increased risk for calcium deficiency, especially if they are taking corticosteroids (which reduce calcium absorption and increase bone loss). Poor calcium intake, malabsorption, and inflammation can lead to low bone mineral density, increasing the risk for osteopenia and fractures.

- Magnesium and potassium may also be lost with diarrhea, but deficiencies are usually corrected during acute careand not the primary concern for long-term complications.
- Sodium loss can occur with dehydration, but again, it's more relevant in acute episodes.
- Calcium is essential for long-term bone health, especially during the growth years.

SITUATION 18.3

D. "I'll arrange for a consult with a nutritionist to get more ideas for mealtime."

Children with IBD often experience appetite loss during flares. Forcing them to eat may lead to mealtime conflict, which can worsen the problem. A nutritionist can provide individualized strategies, such as nutrient-dense, high-calorie small meals, meal replacements, or bland food options during flares.

- Option a implies the burden is entirely on the parent, without offering support.
- Option b is dismissive and may lead to nutritional compromise.
- Option c delays action and doesn't address the parent's need for immediate support.
- Option d connects the parent to a resource who can help create a sustainable nutrition plan tailored to IBD.

SITUATION 18.4

A. "Take with food or at mealtimes."
D. "Take medication consistently and do not stop abruptly."

- a. Corticosteroids can irritate the stomach lining. Taking them with food helps prevent gastric upset or ulcers.
- d. Abruptly stopping corticosteroids can cause adrenal insufficiency. It is crucial to taper off under medical supervision.
- b. Corticosteroids are more likely to cause weight gain, not loss, due to increased appetite and fluid retention.
- c. They often lead to hypertension (high blood pressure), not low.

Note: A client taking corticosteroids tends to retain fluid, and sodium tends to exacerbate the retention. Therefore, the client should reduce the intake of foods that are high in sodium.

SITUATION 18.5

A. The child maintains adequate hydration.

Illiot is showing signs of dehydration—tachycardia, dry mucous membranes, weight loss, and fatigue—due to excessive fluid loss from diarrhea. Preventing further fluid imbalance and maintaining adequate hydration is the top priority at this stage. The other goals are also part of holistic care, but they do not take precedence over a physiological safety need.

SITUATION 19

B. "Your disease may increase the risk for some pregnancy complications."

- Inflammatory bowel disease can increase the risk of pregnancy complications such as preterm birth, low birth weight, or small-for-gestational-age infants—especially if the disease is active during pregnancy. Disease control is key. While some medications are safe during pregnancy, not all are, so a blanket reassurance (as in option c or d) is inaccurate. Bedrest is not standard care unless medically indicated.

SITUATION 20.1

B. "Children with the same infection can safely be placed in the same room using proper precautions."

In hospital settings, it is common and acceptable to cohort children who have the same confirmed infection (in this case, RSV). This helps manage room availability while maintaining infection control through contact precautions. The other options are incorrect or inappropriate because they either dismiss valid infection concerns, focus on cost, or contain inaccurate clinical information.

SITUATION 20.2

B. Wear a gown, gloves, and a surgical mask when within 2 meters of the client

RSV spreads through contact and respiratory droplets, not airborne particles. Infection control measures include using contact and droplet precautions: wearing gloves, a gown, and a surgical mask when within 2 meters of the child. Children with RSV should not access common areas like playrooms due to the risk of transmission to others.

SITUATION 20.3

C. Apply oxygen via nasal cannula as ordered and reassess the response

Because Amari's SpO2 is below 90%, the nurse must follow the standing order to initiate oxygen therapy immediately to prevent hypoxia. Delaying intervention or waiting without applying oxygen may worsen the child's condition. After applying oxygen, reassessment and physician notification may follow based on clinical response.

SITUATION 20.4

D. Use a bulb syringe to suction the nose, especially

before feedings and sleep

Infants with RSV often have difficulty breathing due to nasal congestion. Teaching the parent to use a bulb syringe to gently suction the nose — especially before feedings and sleep — can help maintain a clear airway, improve feeding, and promote comfort.

SITUATION 20.5

C. Sunken anterior fontanel

The anterior fontanel normally remains open until 12 to 18 months of age, making it a useful clinical indicator of hydration status in infants. A sunken anterior fontanel suggests moderate to severe dehydration due to fluid volume deficit.

In contrast, the posterior fontanel usually closes by 2 to 3 months, so by 11 months of age, it is typically no longer palpable and not a reliable sign.

Other signs of dehydration include dry mucous membranes, lethargy, decreased tear production, and decreased urine output.

SITUATION 21

B. Dim the lights and minimize stimuli

Samantha is exhibiting early signs of pre-eclampsia with neurologic involvement (visual changes, diaphoresis, abnormal vitals). Minimizing stimuli helps prevent seizure activity, which is a priority after the physician is informed.

Option d (Maintain in a supine position) is incorrect and contraindicated in pregnancy/postpartum because it can compress the inferior vena cava and reduce placental perfusion or venous return. The left lateral position is preferred.

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