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Exam : **CCNS**

Title : Certified Clinical Nurse Specialist

Vendor : Medical Tests

Version : DEMO

NO.1 A clinical nurse specialist is monitoring the blood glucose level of a neonate who was born to a diabetic mother.
The nurse determined that the blood glucose level is 50 mg/dL. What would be the action of the nurse?
A. Feed the baby orally with 10% dextrose in water
B. Monitor the neonate continuously for the next twenty-four hours
C. Alert the physician and request an order of glucose 50%
D. Assess the cord serum glucose level
Answer: B
Explanation: The action of the nurse should be to monitor the neonate continuously for the next twenty-four hours. The blood glucose level is within the normal range for neonates, so it doesn't require
any measure aside from continuously monitoring the patient for the next twenty-four hours.

NO.2 Who among the following pediatric patients should be assessed first by the nurse?
A. A child with skin rashes on his face and trunk
B. A child with two episodes of inconsolable crying while the knees are drawn over the abdomen and then
plays between the episodes
C. A child with two episodes of soft stools during the shift
D. A child who had a cough for the past three days, with clear nasal discharge and is irritable
Answer: B
Explanation: The pediatric patient that the nurse should assess first is a child with two episodes of inconsolable crying while the knees are drawn over the abdomen and then plays between the episodes.
This indicates appendicitis. The pattern of abdominal pain in appendicitis is as follows: pain occurs for two
to three hours, pain is relieved in two to three hours, and then pain recurs and persists. During the time
that pain subsides, the rupture of appendicitis may occur unnoticed.

NO.3 A mother of a newborn baby Roger is asking the neonatal care nurse at what stage of development is
normal for when baby Roger is 2 months of age?
A. Oral
B. Anal
C. Phallic
D. Latency
Answer: A
Explanation: The neonatal care nurse should inform the stage of development that is normal for baby Roger when he is 2 months of age is oral. This is the first stage of development and can last up to 1 year
after birth.

NO.4 A nurse is coaching a group of student nurses about the anatomy and physiology of the head. The nurse
asks one of the students what to do if she observes that there is blood coming from a patient's ear

after a
head injury sustained following a motor vehicle collision. The correct response by the student nurse should be:
A. Cleanse the ear with sterile gauze
B. Put sterile cotton loosely in the external ear
C. Turn the patient to the unaffected side
D. Test the drainage with dextrostix
Answer: B
Explanation: The correct response by the student nurse should be to put sterile cotton loosely in the external ear. This will absorb the drainage without causing further trauma. Additionally, the nurse should
notify the attending physician immediately, as this could be a sign of a life threatening condition.

NO.5 Rudy is a 55-year-old patient who was diagnosed with Hepatitis A.
After three weeks, the patient developed hepatic cirrhosis and ascites with an elevated serum ammonia level. What would be the
priority nursing intervention, considering that the patient has high ammonia levels?
A. Oral fluid intake restrictions
B. Obtaining a daily weight
C. Observe for signs of increasing confusion
D. Measurement of urine specific gravity
Answer: C
Explanation: The priority nursing intervention considering that the patient has a high ammonia level is to
observe for any signs of increasing confusion. The patient's safety will be the priority since the patient has
altered level of consciousness caused by an increased serum ammonia level that impairs the cranial nerve system.

NO.6 A nursing care plan has been created for a term small-for-gestational-age neonate who was admitted to
the NICU. A priority nursing diagnosis was: Imbalance nutrition: Less than body requirements. The goal
was for the newborn to reach 4 pounds by a specified date. On the specified date, the infant weighs 3 pounds and 2 ounces. The nurse should:
A. Increase the daily number of calories
B. Reassess the problem before altering the plan
C. Postpone the evaluation date for another month
D. Change the goal to a more realistic number
Answer: B
Explanation: The nurse should reassess the problem before altering the plan. Before further intervention,
the reason for the inadequate weight gain must be evaluated. Evaluation should be done before changing
the plan or altering the goal.

NO.7 When teaching a mother how to prevent accidents while caring for her 6-month-old, the nurse

should
emphasize that this age child can usually:
A. Sit up
B. Roll over
C. Crawl lengthy distances
D. Stand while holding onto furniture
Answer: B
Explanation: Muscular coordination and perception are developed enough at 6 months so that infant can
roll over. If unaware of this ability of the infant, the mother could leave the child unattended for a moment
to reach for something and the child could roll off the crib.

NO.8 To communicate effectively with the parents of a hospitalized child, the nurse should:
A. Understand that non-verbal communication is meaningful
B. Have empathy with the parents, but realize that the nurse should be in control of the situation
C. Acknowledge positive comments and ignore negative comments
D. Present policy and procedures in detail upon admission
Answer: A
Explanation: To communicate effectively with the parents of a hospitalized child, the nurse should understand that non-verbal communication is meaningful. Observation of non-verbal behavior will assist
the nurse in determining who the decision-maker is; enable the nurse to assess readiness to learn and
provide guidelines to follow in communication of complex clinical information.

NO.9 Mr. Davids is admitted to the hospital with a diagnosis of left-sided congestive heart failure. During an
assessment, the nurse should expect to find:
A. Dyspnea on exertion
B. Peripheral edema
C. Crushing chest pain
D. Neck vein distention
Answer: A
Explanation: During an assessment, the nurse should expect to find dyspnea on exertion. Pulmonary congestion and edema occur because of fluid extravasations from the pulmonary capillary bed, resulting
in difficult breathing. Left-sided heart failure creates a backward effect on the pulmonary system that leads
to pulmonary congestion.

NO.10 A patient is scheduled to have a modified radical mastectomy. The physician orders to prepare two "units"
of blood in the event it is needed. The patient said to the nurse that she will only sign the consent for blood
transfusion if it will be coming from her relatives. The patient has type "A" negative blood. The nurse should advise the patient to have a relative whose blood is:

A. Type AB or A negative
B. Type O positive
C. Type A or O negative
D. Type AB positive
Answer: C
Explanation: The nurse should advise the patient to have a relative whose blood is type A or O negative
donate blood for a possible transfusion. These types are both compatible with the patient's blood type.

NO.11 On a visit to an older adult who has a chronic heart failure, the nurse observes that the infant lies quietly in
a crib and barely has basic needs attended. The older adult is the primary caregiver to the infant. The nurse should:
A. Advise purchasing appropriate toys designed for this age level
B. Inform the older adult that the infant will be retarded if not stimulated
C. Explain the need for the family to hire a mother's helper for the home
D. Initiate a referral to an appropriate agency to assess the need for a home health aide
Answer: D
Explanation: The nurse should initiate a referral to an appropriate agency to assess the need for a home
health aide. This will ensure that a thorough assessment of the family's needs is made and the appropriate assistance is initiated.

NO.12 Baby Boy Holiday was admitted to the unit due to cancer of the esophagus. The laboratory values show a
hemoglobin of 7g/dL, hematocrit of 25%, and RBC count of 2.5 million/mm3. Considering the data, an appropriate nursing diagnosis for the patient at this time would be:
A. Risk for injury related to possible metastasis and subsequent airway obstruction
B. Imbalanced nutrition; less than body requirements related to dysphagia
C. Ineffective airway clearance related to tumor growth and metastasis
D. Acute pain related to pressure of the tumor on surrounding tissues and nerves
Answer: B
Explanation: Considering the data, an appropriate nursing diagnosis for the patient at this time would be
imbalanced nutrition; less than body requirements related to dysphagia. The decreased hemoglobin and
hematocrit levels and RBC count may be a result of malnutrition; also, cancer of the esophagus can cause dysphagia and anorexia.

NO.13 During a nursing staff meeting, the nurses determine that they will make sure all vital signs are reported
and charted within 15 minutes following assessment. This is an example of:
A. Group Decision Making
B. Group Identity
C. Group patterns of interaction
D. Group leadership

Answer: B
Explanation: Ascertaining that the staff completes a task on time and that all members agree the task is
important is a characteristic of group identity.

NO.14 Which of the following findings, if identified in a patient who is being treated for hypovolemic shock, should
indicate to the nurse that the treatment is having the desired effect?
A. Pulse oximeter reading of 99%
B. Temperature of 98.4oF
C. Urine output of 30 mL/hr
D. CVP of 40 mmHg
Answer: C
Explanation: A finding, if identified in a patient who is being treated for hypovolemic shock, that should
indicate to the nurse that the treatment is having the desired effect, is a urine output of 30 mL/hr.
Management of hypovolemic shock includes monitoring of fluid balance. A diminished urinary output is
characteristic, thus fluid replacement therapy would adequately perfuse the kidneys and increase urine
output.

NO.15 A 20-year-old patient was diagnosed with neutropenia. When teaching the patient and his family, the
nurse should include the avoidance of:
A. Using suppositories or enemas
B. Using a filter mask
C. Performing oral hygiene after every meal
D. Performing perineal hygiene after each bowel movement
Answer: A
Explanation: When teaching the patient and his family, the nurse should include the avoidance of using
suppositories or enemas. A neutropenic patient is at high risk for infection, especially from bacterial
infection of the gastrointestinal and respiratory tract.

NO.16 A nurse is caring for patient who is scheduled for nephrectomy due to a renal cell carcinoma of the right
kidney. It appears that the left kidney is normal. The nurse observes that the patient is anxious and in
doubt whether dialysis will ultimately be a necessity. The nurse should plan to use which information in
discussing this with the patient?
A. Dialysis could become likely, but it depends on how the patient complies with restrictions after the surgery
B. One kidney is adequate to meet the needs of the body, so long as it has a normal function
C. There is likelihood that the patient will need dialysis within the next 3-10 years
D. There is no need for dialysis because of the nature of the surgery
Answer: B

Explanation: When discussing this with the patient, the nurse should explain that one kidney is adequate
to meet the needs of the body, so long as it has a normal function. This patient needs emotional support
and reassurance that the remaining kidney should be able to fully meet the body's metabolic needs.

NO.17 A seventeen-year-old female patient is receiving furosemide, 40 mg P.O. twice daily. In the plan of care,
the nurse should emphasize teaching the patient about the importance of consuming:
A. Lean red meat
B. Bananas and oranges
C. Fresh, green vegetables
D. Creamed corn
Answer: B
Explanation: In the plan of care, the nurse should emphasize teaching the patient about the importance of
consuming bananas and oranges. Because furosemide is a potassium-wasting diuretic, the nurse should
plan to teach the patient to increase intake of potassium-rich foods, such as bananas and oranges. Fresh,
green vegetables; lean red meat; and creamed corn are not good sources of potassium.

NO.18 When planning discharge teaching for an adolescent patient who had an ileostomy, the nurse should
place primary emphasis on:
A. Informing the patient about the ileostomy association
B. Telling the patient whom to contact if assistance is needed
C. Encouraging the patient to return to school or work as soon as possible
D. Teaching the patient the importance of irrigations to regulate bowel movements
Answer: B
Explanation: When planning discharge teaching for an adolescent patient who had an ileostomy, the nurse should place primary emphasis on telling the patient whom to contact if assistance is needed. The
patient should know there is help available, even though direct supervision is no longer provided.

NO.19 Mr. Collins is placed on digitalis on discharge from the hospital. The nurse planning with him for his
discharge should educate him as to the purpose and actions of his new medication. What should the nurse teach the patient to do at home to monitor his reaction to this medication?
A. Check his serum potassium (K) level
B. Weigh himself daily
C. Take his radial pulse for one full minute
D. Obtain his blood pressure
Answer: C
Explanation: What a nurse teaches the patient to do at home to monitor his reaction to this medication is
to take his radial pulse for one full minute. All other choices have some validity; however, option C

relates
best to the action of the medication. If the pulse rate drops below 60 or is markedly irregular, the digitalis
should be held and the physician consulted.

NO.20 A sixteen-year-old patient who speaks a little English has emergency gallbladder surgery. During
discharge preparation, which nursing action would best help this patient understand wound care instruction?
A. Demonstrating the procedure and having the patient return the demonstration
B. Asking an interpreter to relay the instructions to the patient
C. Asking frequently if the patient understands the instruction
D. Writing out the instructions and having a family member read them to the patient
Answer: A
Explanation: During discharge preparation, the nursing action that would best help this patient understand
wound care instruction is demonstrating the procedure and having the patient return the demonstration.
This ensures that the patient can perform wound care correctly. The patient may claim to understand discharge instructions when they do not. An interpreter or family member may communicate verbal or
written instructions inaccurately.