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Question: 1248

For central device, what prevents air embolism during removal?

A. Slow withdrawal
B. Valsalva maneuver
C. Trendelenburg position
D. Occlusive dressing

Answer: B
Explanation: Valsalva or occlusion during removal prevents air entry.

Question: 1249

A nurse is preparing to administer a unit of platelets. The patient asks, "I am O positive, but the bag says A positive. Is this a mistake?" The nurse understands the compatibility rules for platelets. What is the correct response/action?

A. "This is acceptable. Unlike red blood cells, ABO compatibility is preferred but not required for platelets, though we monitor for hemolysis."
B. "We will administer Benadryl first to prevent a reaction to the mismatched type."
C. "Stop! This is a critical error. I will return it to the blood bank immediately."
D. "Platelets do not have AB antigens, so blood type does not matter."

Answer: A
Explanation: While ABO-identical platelets are preferred, they are not strictly required because platelets possess ABO antigens but the concentrate contains very little plasma (antibodies). A-positive platelets can be given to an O-positive patient, though the small amount of plasma containing anti-B (in the A donor) is generally irrelevant, and anti-A (which the O patient has) might attack the platelets slightly but it is usually clinically acceptable in shortages or routine practice depending on facility policy. It is *not* a critical error requiring immediate return without context, provided the facility policy allows ABO-incompatible platelets (which most do). *Note: The most accurate general nursing answer is recognizing that ABO incompatibility is permitted for platelets, unlike RBCs.*

Question: 1250

Neonatal ECMO patient on heparin lock via add-on one-way stopcock. Bolus overruns during line reversal at 0.1 mL/hour. ACT 180 seconds (target 200). Add-on failure mode?

A. Slide clamp override
B. Priming volume deficit

C. Check valve fatigue
D. Luer lock reversal

Answer: C
Explanation: Repeated heparin boluses fatigue one-way stopcock check valves, permitting retrograde flow and dilution during low-rate infusions; replacement with competency-designed add-on prevents ACT fluctuations in ECMO. Luer reversal intentional; clamps/slide not overrunnable.

Question: 1251

Of the following medications, which should not be administered through a 0.2-micron filter?

A. cephalothin sodium (Keflin)
B. ampicillin sodium (Omnipen-N)
C. amphotericin B (Fungizone)
D. tobramycin sulfate (Nebcin)

Answer: C
Explanation: An amphotericin B molecule is too large to pass through a 0.2-micron filter. Because of its size, an amphotericin B molecule would need a filter size of at least 1.2 microns to allow passage (infusion). Ampicillin sodium (Omnipen-N), cephalothin sodium (Keflin), and tobramycin sulfate (Nebcin) will pass through a 0.2-micron filter without difficulty.

Question: 1252

TPN osmolarity 2200 mOsm/L peripheral. Switch central? Formula: 12.5% dextrose.

A. Use PPN only
B. Increase to 25% dextrose central
C. Add mannitol
D. Maintain peripheral limit

Answer: B
Explanation: Central access tolerates >1800 mOsm/L; 25% dextrose optimizes calories.

Question: 1253

In a cardiac cath lab, a 50-year-old patient with STEMI on heparin infusion at 12 units/kg/hour develops HIT with platelet count drop from 200,000 to 80,000/µL, and new DVT. PTT is 100 seconds.

A. Continue heparin and monitor platelets
B. Switch to low-molecular-weight heparin
C. Discontinue heparin and start argatroban
D. Reduce heparin dose to prevent bleeding

Answer: C
Explanation: Discontinuing heparin and starting argatroban is direct thrombin inhibitor therapy for HIT with thrombosis, per guidelines, avoiding further exposure. Continuing heparin and monitoring platelets risks progression. Reducing heparin dose to prevent bleeding does not address antibody reaction. Switching to low-molecular-weight heparin cross-reacts.

Question: 1254

Blood sampling order: CBC, CMP, troponin. Patient on TPN infusion. Which discard volume from PICC line ensures no infusate interference with electrolytes?

A. 3 mL
B. 10 times catheter dead space
C. 10 mL
D. 5 mL

Answer: B
Explanation: INS standards recommend discarding 10 times the catheter dead space (typically 4-5 mL for PICCs) before blood sampling from central lines on TPN to eliminate hyperalimentation nutrient/dextrose interference with CMP electrolytes; fixed 5-10 mL approximates but volume-specific calculation prevents dilutional errors precisely.

Question: 1255

A nurse is caring for a patient who has been on TPN for three days. The patient develops metabolic acidosis with a bicarbonate level of 15 mEq/L. Which of the following interventions is most appropriate?

A. Increase protein intake
B. Reduce carbohydrate intake
C. Administer sodium bicarbonate
D. Monitor renal function

Answer: C
Explanation: In cases of metabolic acidosis, administering sodium bicarbonate can help to correct the acid-

base imbalance. However, it is essential to monitor the patient closely for any changes in their condition.

Question: 1256

The nurse is participating in a product evaluation for a new adhesive removal wipe. The primary safety concern that must be evaluated according to the Material Safety Data Sheet (MSDS/SDS) is:

A. Potential for skin sensitization or irritation
B. Shelf-life of the product
C. Recyclability of the packaging
D. Flammability of the solvent

Answer: A
Explanation: For a product applied directly to patient skin (adhesive remover), the primary clinical safety concern in the SDS is biocompatibility, specifically skin sensitization or irritation . While flammability is relevant for storage, patient skin safety is the priority in the clinical evaluation.

Question: 1257

Which midline catheter characteristic increases occlusion risk?

A. Polyurethane material
B. Single lumen
C. Tip in proximal basilic vein
D. Power-injectable

Answer: C
Explanation: Proximal termination increases stasis and thrombosis/occlusion; proper upper arm placement with tip near axillary fold reduces this.

Question: 1258

A nurse discusses safety administering bumetanide. The student understands side effects when stating which?

A. "The client may develop hypoglycemia during treatment."
B. "The client's PT and INR may be prolonged while taking this medication."
C. "I need to tell the client to avoid salt substitutes."
D. "Inverted T waves and a U wave may appear on the ECG."

Answer: D
Explanation: Bumetanide, a loop diuretic, causes hypokalemia, leading to ECG changes like inverted T waves, U waves, and dysrhythmias. "The client's PT and INR may be prolonged while taking this medication" relates to anticoagulants like warfarin. "The client may develop hypoglycemia during treatment" is from insulin/oral agents. "I need to tell the client to avoid salt substitutes" are avoided in hyperkalemia/ACE inhibitor use, not hypokalemia from diuretics.

Question: 1259

Which variable is a pre-analytical error that can specifically cause a false elevation in Ammonia levels?

A. Delay in transporting and separating the plasma
B. Transporting the specimen on ice
C. Fasting for 8 hours prior to the draw
D. Drawing the specimen without a tourniquet

Answer: A
Explanation: Ammonia is volatile. Blood cells continue to release ammonia after collection. If the separation of plasma is delayed, levels rise rapidly. Transporting on ice is required, not an error. Delay is the error.

Question: 1260

Patient with IgA deficiency receives washed RBCs; anaphylactoid reaction occurs (urticaria, bronchospasm). Next transfusion requires?

A. Standard leukocyte-reduced
B. IgA-deficient donor products
C. Premed antihistamine/steroid
D. Volume-depleted state avoidance

Answer: B
Explanation: IgA-deficient patients form anti-IgA causing anaphylaxis to trace plasma IgA in cellular components; IgA-deficient or washed products essential. Premedication insufficient; leukocyte reduction removes WBCs not plasma proteins.

Question: 1261

A patient on biologic therapy for rheumatoid arthritis develops dyspnea, hypotension of 85/50 mmHg, and urticaria 10 minutes into the infusion. Heart rate is 120 bpm, and oxygen saturation is 92%. How should

the nurse evaluate and respond to this acute reaction?

A. Monitor for 30 minutes without intervention
B. Switch to oral formulation
C. Administer epinephrine and stop infusion
D. Continue infusion at reduced rate

Answer: C
Explanation: The rapid onset of dyspnea, hypotension, tachycardia, urticaria, and decreased oxygen saturation points to an anaphylactic response to the biologic agent. Administer epinephrine and stop infusion is the immediate action to reverse symptoms and prevent progression. Continue infusion at reduced rate risks escalation. Monitor for 30 minutes without intervention delays critical care. Switch to oral formulation is not feasible during an acute event.

Question: 1262

An 81-year-old woman with osteoporosis, on bisphosphonates, and history of falls needs iron infusion for anemia. Labs: ferritin 10 ng/mL, TSH 5.2 mIU/L, calcium 8.2 mg/dL. She has cold intolerance and dry skin. To minimize hypersensitivity and bone pain risks during infusion in this older adult, what premedication and monitoring are essential?

A. Acetaminophen and diphenhydramine pre-infusion, monitor vital signs every 15 minutes
B. Hydrocortisone IV push if reaction occurs, assess for fractures daily
C. Calcium gluconate standby and check electrolytes post-infusion
D. Ondansetron for nausea and monitor thyroid function weekly

Answer: A
Explanation: Acetaminophen and diphenhydramine pre-infusion, monitor vital signs every 15 minutes prevent and detect anaphylactoid reactions common with iron in older adults with comorbidities. Calcium gluconate standby and check electrolytes post-infusion addresses hypocalcemia but not primary risks. Hydrocortisone IV push if reaction occurs, assess for fractures daily is reactive, not preventive. Ondansetron for nausea and monitor thyroid function weekly targets secondary symptoms.

Question: 1263

For a patient self-administering octreotide SQ for variceal bleed prophylaxis, education includes rotation. Patient has BMI 18, reports bruising. What modifies therapy education for adherence?

A. Pre-warm vial to 37°C
B. Use 32G insulin needle, gentle pinch technique
C. Limit sites to abdomen only

D. Apply pressure 5 min post-injection

Answer: B
Explanation: Low BMI increases bruising; 32G thinners skin trauma, pinch lifts SQ space reducing IM risk. Pressure standard, abdomen preferred but rotate quadrants, warming unnecessary.

Question: 1264

Therapeutic phlebotomy patient develops chest pain at 400 mL removal, ECG shows ST depression. Baseline CA**D.** What fluid replacement formula guides post-procedure repletion?

A. No replacement if asymptomatic
B. 3 mL crystalloid per 1 mL removed
C. Oral fluids 1 L over 4 hours
D. Isotonic volume equal to removed

Answer: B
Explanation: Standard replacement for therapeutic phlebotomy in CAD patients is 3 mL normal saline per 1 mL whole blood removed to restore oncotic pressure and prevent hypovolemia precipitating ischemia; equal volume under-replaces colloids, oral slow, always replace prophylactically.

Question: 1265

A patient with nasogastric suctioning presents with metabolic alkalosis. Which electrolyte disorder is most commonly associated with this acid-base imbalance and requires replacement?

A. Hypercalcemia
B. Hyponatremia
C. Hyperkalemia
D. Hypokalemia

Answer: D
Explanation: Metabolic alkalosis often co-exists with hypokalemia. Gastric suction removes hydrogen ions (acid) and potassium. Furthermore, in alkalosis, hydrogen ions shift out of cells to buffer the blood, while potassium shifts *into* cells to maintain electroneutrality, worsening serum hypokalemia.

Question: 1266

A patient completing antibiotic therapy via PICC has stable vitals and resolved infection per labs (CRP 5 mg/L). What is the next step for discontinuation?

A. Taper infusion rate over 2 hours
B. Continue flush for 24 hours post-last dose
C. Clamp line, flush with saline, and remove
D. Confirm tip position via X-ray first

Answer: C
Explanation: With therapy complete and resolution, clamp line, flush with saline, and remove to discontinue safely. Confirm tip position via X-ray first unnecessary if no issues. Continue flush for 24 hours post-last dose not required. Taper infusion rate over 2 hours for hyperosmolar but not antibiotics.

Question: 1267

During CAR-T cell therapy infusion, cytokine release syndrome emerges (fever 39.5°C, HR 140 bpm). Inline filter occludes after 50 mL of cellular product at 50 mL/hour. Labs: CRP 150 mg/L, ferritin 2500 ng/mL. Correct filter for resuming?

A. 260-micron large-pore
B. 0.22-micron sterile
C. 1.2-micron standard
D. 5-micron cell-sparing

Answer: A
Explanation: CAR-T cellular suspensions contain clusters >100 microns requiring 170-260 micron cell-sparing filters to preserve viability without lysing cells causing worsened CRS; standard 1.2-micron destroys cells; 0.22/5-micron cause total occlusion. This ensures therapeutic cell delivery amid inflammatory surge.

Question: 1268

TPN with lipids 20% at 125 mL/hr, patient triglycerides 450 mg/dL day 2. Action?

A. Increase rate to clear
B. Switch to 10% lipids
C. Add L-carnitine
D. Hold lipids, monitor q6h, resume <400

Answer: D

Explanation: Hypertriglyceridemia (>400) pauses lipids, non-lipid TPN continues; resume threshold per INS. 10% alternative long-term, no increase, carnitine investigational.

Question: 1269

A patient on home infusion therapy for pulmonary hypertension is receiving Epoprostenol (Flolan). The pump alarms "occlusion" and the patient immediately reports feeling dizzy and chest tightness. What is the critical half-life property of this drug that dictates the nurse's emergency response?

A. Half-life is 30 seconds; risk of rapid hypotension
B. Half-life is 3-5 minutes; immediate interruption causes rebound hypertension and death
C. Half-life is 4 hours; there is time to troubleshoot the pump
D. Half-life is 12 hours; the main risk is drug accumulation

Answer: B
Explanation: Epoprostenol has an extremely short half-life (approx 3-6 minutes). Continuous infusion is critical. Any interruption (pump failure, occlusion) leads to a rapid loss of drug effect, causing severe rebound pulmonary hypertension, cardiovascular collapse, and potential death within minutes. The nurse must immediately restore flow or have a backup line/pump ready.

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