1. A patient is admitted to the medical unit with possible Graves’ disease (hyperthyroidism). Which assessment finding supports this diagnosis?
   a. Periorbital edema
   b. Bradycardia
   c. Exophthalmos
   d. Hoarse voice

2. Which change in vital signs would you instruct a nursing assistant to report immediately for a patient with hyperthyroidism?
   a. Increased and rapid heart rate
   b. Decrease systolic blood pressure
   c. Increased respiratory rate
   d. Decreased oral temperature

3. For the patient with hyperthyroidism, what intervention should you delegate to the experienced certified nursing assistant?
   a. Instruct the patient to report palpitations, dyspnea, vertigo, or chest pain.
   b. Check the apical pulse, blood pressure, and temperature every 4 hours.
   c. Draw blood for thyroid-stimulating hormone, T3, and T4 levels.
   d. Explain the side effects of propylthiouracil (PTU) to the patient.

4. As the shift begins, you are assigned these patients. Which patient should you assess first?
   a. A 38-year-old patient with Graves’ disease and a heart rate of 94/minute
   b. A 63-year-old patient with type 2 diabetes and fingerstick glucose of 137 mg/dL
   c. A 58-year-old patient with hypothyroidism and heart rate of 48/minute
   d. A 49-year-old patient with Cushing’s disease and +1 dependent edema

5. A patient is hospitalized with adrenocortical insufficiency. Which nursing activity should you delegate to the nursing assistant?
   a. Remind patient to change positions slowly.
   b. Check the patient for muscle weakness
   c. Teach the patient how to collect 24-hour urine
   d. Plan nursing interventions to promote fluid balance

6. You assess a patient with Cushing’s disease. For which finding will you notify the physician immediately?
   a. Purple striae present on abdomen and thighs
   b. Weight gain of 1 pound since the previous day
   c. +1 dependent edema in ankles and calves
   d. Crackles bilaterally in lower lobes of lungs

7. The patient with pheochromocytoma had surgery to remove his adrenal glands. Which nursing intervention should you delegate to the nursing assistant?
a. Add strategies to provide a calm and restful environment post-operatively to the care plan.
b. Warm the patient to avoid smoking and drinking caffeinated beverages
c. Monitor the patient’s skin and mucous membranes for signs of adequate hydration.
d. Monitor lying and standing blood pressure every 4 hours with cuff placed on same arm

8. For the patient with pheochromocytoma, what physical assessment technique should you instruct the LPN/LVN to avoid?

9. The patient with adrenal insufficiency is to be discharged taking prednisone 10 mg orally each day. What will you be sure to teach the patient?
   a. Report excessive weight gain or swelling to the physician.
   b. Rapid changes of position may cause hypotension.
   c. A diet with foods high in potassium may be beneficial.
   d. Signs of hypoglycemia may occur while taking this drug.

10. You are caring for a patient who is post-hypophysectomy for hyperpituitarism. Which post-operative finding requires immediate intervention?
   a. Presence of glucose in nasal drainage
   b. Nasal packing present in nares
   c. Urine output of 40 – 50 mL per hour
   d. Patient complaints of thirst

11. Which patient’s nursing care would be most appropriate for the charge nurse to assign to the LPN, under the supervision of the RN team leader?
   a. A 51-year-old patient with bilateral adrenalectomy just returned from the post-anesthesia care unit
   b. An 83-year-old patient with type 2 diabetes and chronic obstructive pulmonary disease
   c. A 38-year-old patient with myocardial infarction who is preparing for discharge
   d. A 72-year-old patient admitted from long-term care with mental status changes

12. You are providing care for a patient who underwent thyroidectomy 2 days ago. Which laboratory value requires close monitoring?
   a. Calcium
   b. Sodium
   c. Potassium
   d. White blood cells

13. You are preparing to review a teaching plan for a patient with type 2 diabetes. What will you check to determine the patient’s level of compliance with his diabetic regimen?
   a. Patient’s fasting glucose level
   b. Patient’s oral glucose tolerance test results
   c. Patient’s glycosylated hemoglobin assay
d. Patient’s fingerstick glucose check for 24 hours

14. The patient has newly diagnosed type 2 diabetes. Which task should you delegate to the nursing assistant?
   a. Arrange consult with the dietician for patient.
   b. Verify patient’s insulin injection technique.
   c. Teach patient to use glucometer for monitoring glucose at home.
   d. Remind patient to check glucose level prior to each meal.

15. A nursing diagnosis for the newly diagnosed diabetic patient is risk for Injury related to sensory alterations. Which key points should you include in the teaching plan for this patient? (Choose all that apply).
   a. Clean and inspect your feet every day.
   b. Be sure that your shoes fit properly.
   c. Nylon socks are best to prevent friction between toes and shoes.
   d. Report any non-healing skin breaks to your doctor.

16. The diabetic patient has all of these assessment bindings. Which will you instruct the LPN/LVN to report immediately?
   a. Fingerstick glucose of 185 mg/dL
   b. Numbness and tingling in both feet
   c. Profuse perspiration
   d. Bunion on left great toe

17. The plan of care for the diabetic patient includes all of the following interventions. Which intervention could you delegate to the nursing assistant?
   a. Check to make sure that the patient’s bath water is not too hot.
   b. Discuss community resources for diabetic outpatient care.
   c. Instruct the patient to perform daily foot inspections.
   d. Check the patient’s technique for drawing insulin into a syringe.

18. You are precepting a nurse who has recently graduated and passes the NCLEX examination. The new nurse has been on the unit for only 2 days. Which patient should you assign to the new nurse?
   a. A 68-year-old diabetic who is experiencing signs of hyperglycemia including rapid, deep breathing and mental status changes
   b. A 58-year-old diabetic with peripheral neuropathy and cellulitis of the left ankle.
   c. A 49-year-old diabetic who has just returned from post-anesthesia care unit (PACU) after a below-the-knee amputation (BKA)
   d. A 72-year-old diabetic with diabetic ketoacidosis (DKA) on an IV insulin drip

19. In the emergency department, during initial assessment of a new admission with diabetes, you discover all of the following. Which information should you immediately report to the physician?
   a. Hammertoe of the left second metatarsophalangeal joint
   b. Rapid respiratory rate with deep inspirations
   c. Numbness and tingling bilaterally in the feet and hands
   d. Decreased sensitivity and swelling of the abdomen
20. You are caring for a diabetic patient who is developing DKA. Which delegated task is most appropriate?
   a. Ask the unit clerk to page the physician to come to the unit.
   b. Ask the LPN/LVN to administer IV insulin according to the sliding scale.
   c. Ask the nursing assistant to check the patient’s level of consciousness.
   d. Ask the nursing assistant to get the patient a cup of orange juice.

21. A diabetic patient presents with hot and dry skin, rapid and deep respirations, and a fruity odor to his breath. As charge nurse, you observe the new graduate RN accomplishing all these patient tasks. Which one requires that you intervene immediately?
   a. The RN checks the patient’s fingerstick glucose.
   b. The RN encourages the patient to drink orange juice.
   c. The RN checks the patient’s order for sliding scale insulin.
   d. The RN assess the patient’s vital signs every 15 minutes.

22. You are preparing a 24-year-old patient with diabetes insipidus (DI) for discharge from the hospital. Which statement indicates that the patient needs additional teaching?
   a. “I will drink fluids equal to the amount of my urine output.”
   b. “I will weigh myself every day using the same scale.”
   c. “I will wear my medical alert bracelet at all times.”
   d. “I will gradually wean myself off the vasopressin.”
RATIONALE
ENDOCRINE PROBLEMS

1. **ANSWER C** – Exophthalmos (abnormal protrusion of the eye) is characteristic of patients with hyperthyroidism due to Graves’ disease. Periorbital edema, bradycardia, and hoarse voice are all characteristics of patients with hypothyroidism. Focus: Prioritization

2. **ANSWER A** – The cardiac problems associated with hyperthyroidism include tachycardia, increased systolic blood pressure, and decreased diastolic blood pressure. Patients with hyperthyroidism also may have increased body temperature related to increased metabolic rate. Focus: Delegation/supervision

3. **ANSWER B** – Monitoring and recording vital signs are within the education scope of nursing assistants. An experienced nursing assistant should have been taught how to monitor the apical pulse. However, the nurse should observe the nursing assistant to be sure that she has mastered this skill. Instructing and teaching patients, as well as performing venipuncture for laboratory samples, are more suited to the educational scope of licensed nurses. In some facilities, an experienced nursing assistant may perform venipuncture, but only after special training. Focus: Delegation/supervision

4. **ANSWER C** – Although patients with hypothyroidism often have cardiac problems that include bradycardia, a heart rate of 48/minute may have significant implications for cardiac output and hemodynamic stability. Patients with Graves’ disease usually have a rapid heart rate, but 94/minute is within limits. The diabetic patient may need sliding scale insulin. This is important but not urgent. Patients with Cushing’s disease frequently have dependent edema. Focus: Prioritization

5. **ANSWER A** – Patients with hypofunction of the adrenal glands often have hypotension and should be instructed to change positions slowly. Once a patient has been instructed, it is appropriate for the nursing assistant to remind the patient of those instructions. Assessing, teaching, and planning nursing care require more education and should be done by licensed nurses. Focus: Delegation/supervision

6. **ANSWER D** – The presence of crackles in the patient’s lungs indicate excess fluid volume due to excess water and sodium reabsorption and may be a symptom of pulmonary edema, which must be treated rapidly. Striae (stretch marks), weight gain, and dependent edema are common findings in patients Cushing’s disease. These findings should be monitored, but are not urgent. Focus: Prioritization

7. **ANSWER D** – Monitoring vital signs is within the educational scope of the nursing assistant. The nurse should be sure to instruct the nursing assistant that blood pressure measurements are to be done with the cuff on the same arm. Revising the care plan and instructing and assessing patients are beyond the scope of nursing assistants and fall within the purview of licensed nurses. Focus: Delegation/supervision
8. **ANSWER: PALPATION OF THE ABDOMEN** – Palpating the abdomen can cause sudden release of catecholamines and severe hypertension. Focus: Delegation/supervision

9. **ANSWER A** – Rapid weight gain and edema are signs of excessive drug therapy, and the dose of the drug needs to be adjusted. Hypertension, hyperkalemia, and hyperglycemia are common in patients with adrenal hypofunction. Focus: Prioritization

10. **ANSWER A** – The presence of glucose in nasal drainage indicates that the fluid is CSF (cerebrospinal fluid) and suggests a CSF leak. Packing is normally inserted in the nares after the surgical incision is closed. Forty to 50 mL per hour is adequate urine output and patients may experience thirst post-operatively. When patients are thirsty, nursing staff should encourage fluid intake. Thirst may be a sign of hypokalemia. The nurse should assess the patient's thirst and check the patient's potassium level. This is not as urgent as the CSF leak. Focus: Prioritization

11. **ANSWER B** – The 83-year-old patient has no complicating factors at the moment. Providing care for stable and uncomplicated patients is within the LPN’s educational preparation and scope of practice, with the care always being provided under the supervision and direction of the RN. The RN should assess the newly post-operative patient and the new admission. The patient who is preparing for discharge after MI may need some complex teaching. Focus: Delegation/supervision, assignment

12. **ANSWER A** – The parathyroid glands are located on the back of the thyroid gland. The parathyroids are important in maintaining calcium and phosphorus balance. The nurse should be attentive to all patient laboratory values, but calcium and phosphorus are important to monitor after thyroidectomy. Focus: Prioritization

13. **ANSWER C** – The higher the blood glucose level is over time, the more elevated the glycosylated hemoglobin becomes. Glycosylated hemoglobin is a good indicator of average blood glucose level over the previous 120 days. Fasting glucose and oral glucose tolerance tests are important diagnostic tests. Fingerstick blood glucose monitoring provides information that allows for adjustment of patients’ therapeutic regimen. Focus: Prioritization

14. **ANSWER D** – The nursing assistant’s role includes reminding patients about interventions that are already part of the plan of care. Arranging for a diet consult is appropriate to delegate to the unit clerk. Teaching and assessing require additional education and should be completed by licensed nurses. Focus: Delegation/supervision, assignment

15. **ANSWER A, B & E** – Sensory alterations are the major cause of foot complications in diabetic patients, and patients should be taught to examine their feet on a daily basis. Properly fitted shoes protect the patient from foot complications. Broken skin increases the risk of infection. Cotton socks are recommended to absorb moisture. Patients, family, or health care providers may trim toenails. Focus: Prioritization

16. **ANSWER C** – Profuse perspiration is a symptom of hypoglycemia, a complication of diabetes that needs urgent treatment. A glucose level of 185 will need
coverage with sliding-scale insulin, but this is not urgent. Numbness, tingling, and bunions are related to the chronic nature of diabetes and are not urgent. Focus: Prioritization

17. ANSWER A – Checking the bath water temperature is part of assisting with activities of daily living and is within the educational scope of the nursing assistant. Discussion of community resources and teaching and assessing require a higher level of education and are appropriate to the scope of practice of licensed nurses. Focus: Delegation

18. ANSWER B – The new nurse is still orienting to the unit. Appropriate patient assignments at this time include those who are stable and not complex. Focus: Assignment

19. ANSWER B – Rapid, deep respirations (Kussmaul) are symptomatic of DKA. Hammertoe, as well as numbness and tingling, are chronic complications associated with diabetes. Decreased sensitivity and swelling (lipohypertrophy) occur at a site of repeated insulin injections, and treatment involves teaching the patient to rotate injection sites. Focus: Prioritization

20. ANSWER A – The nurse should not leave the patient. The scope of the unit clerk’s job includes calling and paging physicians. LPN/LVNs generally do not administer IV push medication. IV fluid administration is not within the scope of nursing assistants. Patients with DKA already have a high glucose level and do not need orange juice. Focus: Delegation/supervision

21. ANSWER B – The signs and symptoms the patient is exhibiting are consistent with hyperglycemia. The RN should not give the patient additional glucose. All of the other interventions are appropriate for this patient. The RN should also notify the physician at this time. Focus: Prioritization

22. ANSWER D – The patient with permanent DI requires life-long vasopressin therapy. All of the other statements are appropriate to the home care of this patient. Focus: Prioritization