TEST BANK



Test Bank Pharmacology: A Patient-Centered Nursing Process Approach 11th Edition ISBN: 9780323793155 Jennifer Yeager, Kathleen DiMaggio, Linda McCuistion, Mary Winton

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Table of Content

1. Clinical Judgment Management Model (CIMM) and the Nursing Process 2. Drug Development and Ethical Considerations 3. Pharmacokinetics and Pharmacodynamics 4. Pharmacogenetics 5. Complementary and Alternative Therapies 6. Pediatric Considerations 7. Drug Therapy in Older Adults 8. Drugs in Substance Use Disorder 9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Addrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mod Stabilizers 24. Antiinflammatories 25. Malgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides	
3. Pharmacogenetics 4. Pharmacogenetics 5. Complementary and Alternative Therapies 6. Pediatric Considerations 7. Drug Therapy in Older Adults 8. Drugs in Substance Use Disorder 9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Anthelmintics, and Peptides 31. Antimalarials, Anthelmintics, and Peptides	1. Clinical Judgment Management Model (CJMM) and the Nursing Process
4. Pharmacogenetics 5. Complementary and Alternative Therapies 6. Pediatric Considerations 7. Drug Therapy in Older Adults 8. Drugs in Substance Use Disorder 9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Antifungals, and Antivirals 31. Antituberculars, Anthelmintics, and Peptides 32. HIV- and AlDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs	2. Drug Development and Ethical Considerations
5. Complementary and Alternative Therapies 6. Pediatric Considerations 7. Drug Therapy in Older Adults 8. Drugs in Substance Use Disorder 9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Anthelmintics, and Peptides 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant	3. Pharmacokinetics and Pharmacodynamics
6. Pediatric Considerations 7. Drug Therapy in Older Adults 8. Drugs in Substance Use Disorder 9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines	4. Pharmacogenetics
7. Drug Therapy in Older Adults 8. Drugs in Substance Use Disorder 9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs <	5. Complementary and Alternative Therapies
8. Drugs in Substance Use Disorder 9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers <td>6. Pediatric Considerations</td>	6. Pediatric Considerations
9. Safety and Quality 10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers <	7. Drug Therapy in Older Adults
10. Drug Administration 11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelminitics, and Peptides 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	8. Drugs in Substance Use Disorder
11. Drug Calculations 12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	9. Safety and Quality
12. Fluid Volume and Electrolytes 13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	10. Drug Administration
13. Vitamin and Mineral Replacement 14. Nutritional Support 15. Adrenergic Agonists and Antagonists 16. Cholinergic Agonists and Antagonists 17. Stimulants 18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AlDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	11. Drug Calculations
14. Nutritional Support15. Adrenergic Agonists and Antagonists16. Cholinergic Agonists and Antagonists17. Stimulants18. Depressants19. Antiseizure Drugs20. Drugs for Parkinsonism and Alzheimer Disease21. Drugs for Neuromuscular Disorders and Muscle Spasms22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	12. Fluid Volume and Electrolytes
15. Adrenergic Agonists and Antagonists16. Cholinergic Agonists and Antagonists17. Stimulants18. Depressants19. Antiseizure Drugs20. Drugs for Parkinsonism and Alzheimer Disease21. Drugs for Neuromuscular Disorders and Muscle Spasms22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	13. Vitamin and Mineral Replacement
16. Cholinergic Agonists and Antagonists17. Stimulants18. Depressants19. Antiseizure Drugs20. Drugs for Parkinsonism and Alzheimer Disease21. Drugs for Neuromuscular Disorders and Muscle Spasms22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	14. Nutritional Support
16. Cholinergic Agonists and Antagonists17. Stimulants18. Depressants19. Antiseizure Drugs20. Drugs for Parkinsonism and Alzheimer Disease21. Drugs for Neuromuscular Disorders and Muscle Spasms22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	15. Adrenergic Agonists and Antagonists
18. Depressants 19. Antiseizure Drugs 20. Drugs for Parkinsonism and Alzheimer Disease 21. Drugs for Neuromuscular Disorders and Muscle Spasms 22. Antipsychotics and Anxiolytics 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	
19. Antiseizure Drugs20. Drugs for Parkinsonism and Alzheimer Disease21. Drugs for Neuromuscular Disorders and Muscle Spasms22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	17. Stimulants
20. Drugs for Parkinsonism and Alzheimer Disease21. Drugs for Neuromuscular Disorders and Muscle Spasms22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	18. Depressants
21. Drugs for Neuromuscular Disorders and Muscle Spasms22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	19. Antiseizure Drugs
22. Antipsychotics and Anxiolytics23. Antidepressants and Mood Stabilizers24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	20. Drugs for Parkinsonism and Alzheimer Disease
 23. Antidepressants and Mood Stabilizers 24. Antiinflammatories 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers 	21. Drugs for Neuromuscular Disorders and Muscle Spasms
24. Antiinflammatories25. Analgesics26. Penicillins, Other Beta-Lactams, and Cephalosporins27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones29. Sulfonamides and Nitroimidazoles Antibiotics30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	22. Antipsychotics and Anxiolytics
 25. Analgesics 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers 	23. Antidepressants and Mood Stabilizers
 26. Penicillins, Other Beta-Lactams, and Cephalosporins 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers 	24. Antiinflammatories
 27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers 	25. Analgesics
 28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers 	26. Penicillins, Other Beta-Lactams, and Cephalosporins
 29. Sulfonamides and Nitroimidazoles Antibiotics 30. Antituberculars, Antifungals, and Antivirals 31. Antimalarials, Anthelmintics, and Peptides 32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers 	27. Macrolides, Oxazolidinones, Lincosamides, Glycopeptides, Ketolides, and Lipopeptides
30. Antituberculars, Antifungals, and Antivirals31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	28. Tetracyclines, Glycylcyclines, Aminoglycosides, and Fluoroquinolones
31. Antimalarials, Anthelmintics, and Peptides32. HIV- and AIDS-Related Drugs33. Transplant Drugs34. Vaccines35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	29. Sulfonamides and Nitroimidazoles Antibiotics
32. HIV- and AIDS-Related Drugs 33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	30. Antituberculars, Antifungals, and Antivirals
33. Transplant Drugs 34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	31. Antimalarials, Anthelmintics, and Peptides
34. Vaccines 35. Anticancer Drugs 36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	32. HIV- and AIDS-Related Drugs
35. Anticancer Drugs36. Targeted Therapies to Treat Cancer37. Biologic Response Modifiers	33. Transplant Drugs
36. Targeted Therapies to Treat Cancer 37. Biologic Response Modifiers	34. Vaccines
37. Biologic Response Modifiers	35. Anticancer Drugs
	36. Targeted Therapies to Treat Cancer
38. Upper Respiratory Disorders	37. Biologic Response Modifiers
	38. Upper Respiratory Disorders

39. Lower Respiratory Disorders

40. Cardiac Glycosides, Antianginals, and Antidysrhythmics

41. Diuretics

42. Antihypertensives

43. Anticoagulants, Antiplatelets, and Thrombolytics

44. Antihyperlipidemics and Drugs to Improve Peripheral Blood Flow

45. Gastrointestinal Tract Disorders

46. Antiulcer Drugs

47. Eye and Ear Disorders

48. Dermatologic Disorders

49. Pituitary, Thyroid, Parathyroid, and Adrenal Disorders

50. Antidiabetics

51. Urinary Disorders

52. Pregnancy and Preterm Labor

53. Labor, Delivery, and Postpartum

54. Neonatal and Newborn

55. Women's Reproductive Health

56. Men's Reproductive Health

57. Sexually Transmitted Infections

58. Adult and Pediatric Emergency Drugs

MULTIPLE CHOICE

- 1. All of the following would be considered subjective data, EXCEPT:
 - a. Patient-reported health history
 - b. Patient-reported signs and symptoms of their illness
 - c. Financial barriers reported by the patient's caregiver
 - d. Vital signs obtained from the medical record

ANS: D

Subjective data is based on what patients or family members communicate to the nurse. Patientreported health history, signs and symptoms, and caregiver reported financial barriers would be considered subjective data. Vital signs obtained from the medical record would be considered objective data.

DIF: Cognitive Level: Understanding (Comprehension) MSC: NCLEX: Management of Client Care TOP: Nursing Process: Planning

- 2. The nurse is using data collected to define a set of interventions to achieve the most desirable outcomes. Which of the following steps is the nurse applying?
 - a. Recognizing cues (assessment)
 - b. Analyze cues & prioritize hypothesis (analysis)
 - c. Generate solutions (planning)
 - d. Take action (nursing interventions)

ANS: C

When generating solutions (planning), the nurse identifies expected outcomes and uses the patient's problem(s) to define a set of interventions to achieve the most desirable outcomes. Recognizing cues (assessment) involves the gathering of cues (information) from the patient about their health and lifestyle practices, which are important facts that aid the nurse in making clinical care decisions. Prioritizing hypothesis is used to organize and rank the patient problem(s) identified. Finally, taking action involves implementation of nursing interventions to accomplish the expected outcomes.

DIF: Cognitive Level: Understanding (Comprehension) TOP: Nursing Process: Nursing Intervention MSC: NCLEX: Management of Client Care

- 3. A 5-year-old child with type 1 diabetes mellitus has had repeated hospitalizations for episodes of hyperglycemia. The parents tell the nurse that they can't keep track of everything that has to be done to care for their child. The nurse reviews medications, diet, and symptom management with the parents and draws up a daily checklist for the family to use. These activities are completed in which step of the nursing process?
 - a. Recognizing cues (assessment)
 - b. Analyze cues & prioritize hypothesis (analysis)

- c. Generate solutions (planning)
- d. Take action (nursing interventions)

ANS: D

Taking action through nursing interventions is where the nurse provides patient health teaching, drug administration, patient care, and other interventions necessary to assist the patient in accomplishing expected outcomes.

DIF: Cognitive Level: Understanding (Comprehension) TOP: Nursing Process: Nursing Intervention MSC: NCLEX: Management of Client Care

- 4. The nurse is preparing to administer a medication and reviews the patient's chart for drug allergies, serum creatinine, and blood urea nitrogen (BUN) levels. The nurse's actions are reflective of which of the following?
 - a. Recognizing cues (assessment)
 - b. Analyze cues & prioritize hypothesis (analysis)
 - c. Take action (nursing interventions)
 - d. Generate solutions (planning)

ANS: A

Recognizing cues (assessment) involves gathering subjective and objective information about the patient and the medication. Laboratory values from the patient's chart would be considered collection of objective data.

DIF: Cognitive Level: Understanding (Comprehension)

TOP: Nursing Process: Assessment MSC: NCLEX: Management of Client Care

- 5. Which of the following would be correctly categorized as objective data?
 - a. A list of herbal supplements regularly used provided by the patient.
 - b. Lab values associated with the drugs the patient is taking.
 - c. The ages and relationship of all household members to the patient.
 - d. Usual dietary patterns and food intake.

ANS: B

Objective data are measured and detected by another person and would include lab values. The other examples are subjective data.

DIF:Cognitive Level: Understanding (Comprehension)TOP:Nursing Process: AssessmentMSC: NCLEX: Management of Client Care

- 6. The nurse reviews a patient's database and learns that the patient lives alone, is forgetful, and does not have an established routine. The patient will be sent home with three new medications to be taken at different times of the day. The nurse develops a daily medication chart and enlists a family member to put the patient's pills in a pill organizer. This is an example of which element of the nursing process?
 - a. Recognizing cues (assessment)
 - b. Analyze cues & prioritize hypothesis (analysis)
 - c. Take action (nursing interventions)

d. Generate solutions (planning)

ANS: C

Taking action (nursing interventions) involves education and patient care in order to assist the patient to accomplish the goals of treatment.

DIF: Cognitive Level: Applying (Application) TOP: Nursing Process: Nursing Intervention MSC: NCLEX: Management of Client Care

- 7. A patient who is hospitalized for chronic obstructive pulmonary disease (COPD) wants to go home. The nurse and the patient discuss the patient's situation and decide that the patient may go home when able to perform self-care without dyspnea and hypoxia. This is an example of which phase of the nursing process?
 - a. Recognizing cues (assessment)
 - b. Analyze cues & prioritize hypothesis (analysis)
 - c. Take action (nursing interventions)
 - d. Generate solutions (planning)

ANS: D

Generating solutions (planning) involves defining a set of interventions to achieve the most desirable outcomes, which, for this patient, means being able to perform self-care activities without dyspnea and hypoxia.

DIF: Cognitive Level: Understanding (Comprehension) TOP: Nursing Process: Planning MSC: NCLEX: Management of Client Care

- 8. A patient will be sent home with a metered-dose inhaler, and the nurse is providing teaching. Which is a correctly written expected outcome for this process?
 - a. The nurse will demonstrate the correct use of a metered-dose inhaler to the patient.
 - b. The nurse will teach the patient how to administer medication with a metered-dose inhaler.
 - c. The patient will know how to self-administer the medication using the metered-dose inhaler.
 - d. The patient will independently administer the medication using the metered-dose inhaler at the end of the session.

ANS: D

Expected outcomes must be patient-centered and clearly state the outcome with a reasonable deadline and should identify components for evaluation.

DIF: Cognitive Level: Applying (Application) MSC: NCLEX: Management of Client Care TOP: Nursing Process: Planning

- 9. The nurse is generating solutions (planning) for a patient who has chronic lung disease and hypoxia. The patient has been admitted for increased oxygen needs above a baseline of 2 L/min. The nurse generates an expected outcomes stating, "The patient will have oxygen saturations of >95% on room air at the time of discharge from the hospital." What is wrong with this goal?
 - a. It cannot be evaluated.

- b. It is not measurable.
- c. It is not patient-centered.
- d. It is not realistic.

ANS: D

The expected outcome is not realistic because the patient is not usually on room air and should not be expected to attain that expected outcome by discharge from this hospitalization.

DIF: Cognitive Level: Applying (Application) MSC: NCLEX: Management of Client Care TOP: Nursing Process: Planning

- 10. The nurse is developing a teaching plan for an elderly patient who will begin taking an antihypertensive drug that causes dizziness and orthostatic hypotension. Which hypothesis (problem) documented by the nurse is appropriate for this patient?
 - a. Deficient knowledge related to drug side effects.
 - b. Ineffective health maintenance related to age.
 - c. Readiness for enhanced knowledge related to medication side effects.
 - d. Risk for injury related to side effects of the medication.

ANS: D

This patient has an increased risk for injury because of drug side effects, so this is an appropriate hypothesis (problem) to direct the type of care and follow-up the patient will receive.

DIF: Cognitive Level: Applying (Application) TOP: Nursing Process: Nursing Diagnosis MSC: NCLEX: Management of Client Care

- 11. An older patient must learn to administer a medication using a device that requires manual dexterity. The patient becomes frustrated and expresses lack of self-confidence in performing this task. Which action will the nurse perform next?
 - a. Ask the patient to keep trying until the skill is learned.
 - b. Provide written instructions with illustrations showing each step of the skill.
 - c. Schedule multiple sessions and practice each step separately.
 - d. Teach the procedure to family members who can administer the medication for the patient.

ANS: C

Nurses should be sensitive to patient's level of frustration when teaching skills. In this case, breaking the steps down into individual parts will help with this patient's frustration level.

DIF:Cognitive Level: Applying (Application)TOP: Nursing Process: PlanningMSC:NCLEX: Management of Client CareTOP: Nursing Process: Planning

- 12. A school-age child will begin taking a medication to be administered at 5 mL three times daily. The child's parent tells the nurse that, with a previous use of the drug, the child repeatedly forgot to bring the medication home from school, resulting in missed evening doses. What will the nurse recommend?
 - a. Encourage the child to be more responsible and that it is important to take the medication as prescribed.