# ♡ Hearts ♡

**Ace of Hearts** Option # 2 is correct. A perforated duodenal ulcer presents with sudden, sharp pain which can result in a very tender, rigid abdomen. This may result in a medical emergency. The gastro-duodenal contents empty into the peritoneal cavity which may result in peritonitis, septicemia, and shock. Option #1 is incorrect since this may present with later shock. Dizziness may be accompanied with symptoms such as tachycardia, tachypnea, oliguria, and being obtunded. The decrease pulse would not even be correct if the question presented with later complications. Option #3 may occur with later complications from peritonitis. Additional symptoms would include: nausea and vomiting, no bowel sounds, and shallow respirations. Option #4 may be seen with severe peritonitis.

**King of Hearts** Option # 3 is correct. This option indicates the client may be in shock. This is classified as a triage level I, mandating immediate care. Option #1 is a child with moderate trauma, level III, urgent and should be treated within 30 minutes. Options #2 and #4 are classified as level II (emergent) and can be transferred by the ambulance and arrive at the hospital within 15 minutes.

**Queen of Hearts** Option #4 is a clinical assessment for hypocalcemia. Carpal spasms may occur if the client's calcium levels are low. Other assessment findings that may occur from hypocalcemia as a result of the parathyroid involvement from the surgery may include tetany, Chvostek's or Trousseau's signs. Option #1 is a normal blood pressure and does not mandate immediate intervention. Option # 2 is correct positioning for this client to prevent flexion or hyperextension of the suture line. Other care may include having a tracheostomy set at the bedside, assessing for hemorrhage, respiratory obstruction and supporting neck, head and shoulders to prevent tension on the suture line. Option # 3 is not specific enough regarding the sore throat for this client. If the option read hoarseness, breathy voice or swallowing issues then this would be a concern due to the risk of obstruction.

**Jack of Hearts** Option # 1 is a priority since tinnitus is an assessment finding indicating toxicity for loop diuretics. Option # 2 may indicate that the client needs more medication, but it is not a priority to a complication with toxicity. Option # 3 is low and is a concern, but not a priority over toxicity. Option # 4 is not correct. The client may be receiving Lasix due to the hypertension and may need a change in the amount receiving, but still is not a priority over toxicity. Notice that options # 2 and # 4 are similar in that they are both assessment findings indicating the client may need the diuretic. Option # 3 is a concern, but not a priority to an actual assessment finding of toxicity.

**Ten of Hearts** Option # 3 is correct. This child has a medical condition with an expectable outcome. Option #1 is a child with an unpredictable outcome due to the entubation. Option #2 is unpredictable since child may be unstable and any outcome with poisoning from an overdose may also be unpredictable. Option #4 is also unpredictable due to the child's airway and may result in an unpredictable outcome.

**Nine of Hearts** Option # **2** is correct. This option is a nursing activity that involves a standard that involves a procedure that is unchanging. Option #1 cannot be delegated since it expects the nursing assistant to evaluate the client which is not appropriate for the nursing assistant. Option #3 is incorrect since it also involves evaluation. Option #4 cannot be delegated since the option evaluates a procedure and is out of the scope of practice for the UAP.

**Eight of Hearts** Option # 1 is correct due to the hyperkalemia . The normal potassium level if 3.5 to 5.0 mEq / L. If the client receives this medication with this level there is a risk for cardiac dysrhythmias. Option # 2 is not correct because the client should receive the drug due to the hypertension. The heart rate is within normal range for administering the drug. If the heart rate was below 60 then we would question this order since one of the actions of this drug category is to decrease contractility. Option # 3 is within normal range. There is not a reason to question this drug. Option # 4 is appropriate and there is no reason to question this.

**Seven of Hearts** Option # 4 is correct since it can only be administered subcutaneous. Option # 1 is part of the correct procedure for administering, but questioning an inappropriate order is a priority. Before getting to the "Right way to administer", the nurse needs to have the "Right order with right route". Option # 2 is correct procedure, but not priority over option #4 because nurse should never get to the bedside with this question since the order is wrong due to route. While option # 3 should not be done, the priority is that the order is incorrect due to the route and if the nurse goes in the room and administers the way it is written, then the nurse missed that it should NEVER be administered IM. Read the stem carefully to be able to prioritize the care. Congratulate yourself for being successful on this question. If you were not, then congratulate yourself for LEARNING from your error. All of us have different ways to learn. You CAN do this!!!!!

**Six of Hearts** Option # 4 is correct**.** This is a priority due to the airway. This child may have epiglottitis and may need to be entubated, but definitely needs to be seen first out of these options. Option #1 is not a priority to airway. Option #2 is not a priority to airway. Option #3 is not a priority to airway.

**Five of Hearts** Option #2 is correct. This client is bleeding. Frequent swallowing is a sign of a complication of bleeding after a tonsillectomy. Option #1 is not a challenge; this is an expected outcome after this procedure. Option #3 is also an expected outcome. There is no information indicating a complication with this injury. Option # 4 is not a priority. These vital signs are normal.

**Four of Hearts** Option # 3 is correct due to tachycardia. The normal heart rate for a 3 day old is 120-160. Tachycardia at rest may indicate hypoxia which mandates immediate assessment to further evaluate the clinical findings for the neonate. If this neonate was crying loudly, then this option would not be correct, but since the neonate is resting the neonate needs to be further assessed. Option #1 may be an expected finding with crying. Option # 2 is an expected assessment for this neonate. The normal respiratory rate may be from 30-50. Option # 4 describes acrocyanosis and is not a priority to tachycardia. This may be assessed after delivery.

**Three of Hearts** Option # 1 is correct. This option indicates a complication with hypovolemia and needs IV fluid. The heart- rate is rapid and the blood pressure is low. Option # 2 may be an expected assessment finding. Option # 3 does not indicate any complications with the blood transfusion. If there was a febrile reaction, then the option would have included assessments such as fever, chills, nausea, headache, flushing, tachycardia, palpitations. If the client was experiencing a hemolytic reaction, then assessment findings would be tachycardia, nausea, vomiting, decreased urine output, flushed face, burning at site, fever, chills, chest pain, hypotension, back pain. If the client was experiencing an anaphylactic reaction, the assessment finding would include hives, itching, wheezing, stridor, pulmonary

edema, flushed face, urticaria, general discomfort, increased temperature, chills / chest pain, asthma, tachycardia. Option # 4 is an expected finding after this procedure.

**Two of Hearts** Option # 3 is correct since this may indicate some neurovascular complications. A decrease in sensation or tingling in the fingers may be a result of compartmental syndrome from swelling. Other assessment findings for this complication include changes in the pulse of the extremity with the cast due to swelling, pale extremity, pain may increase in the extremity that is in the cast, or paralysis may occur. Option # 1 may occur if the pregnant woman lies flat in bed. The nurse should recommend that she lie on her left side or in the upright position due to the pressure on the diaphragm from the baby. If the woman lies on the left side this will remove pressure off the inferior vena cava and assist with the blood flow or if the woman lies in the semi-Fowler's or Fowler's position, she will be able to breathe better due to less pressure on her lower lung fields. Option # 2 unfortunately does occur. The challenge occurs if there are assessment findings of fluid and electrolyte deficiency. Option # 4 is an expected finding and is not a priority to call over option #3.

# ♦ Diamonds ♦

**Ace of Diamonds** Option #4 is correct since the drug is a diuretic. The desired outcome is a decrease in the fluid resulting in a decrease in the rales. (Refer to the book: *Nursing Made Insanely Easy, Rayfield & Manning* for the memory technique for Respiratory Acidosis and Alkalosis.) Since the pH is below 7.35 and the $pCO_2$ is above 45, then the client is experiencing respiratory acidosis. The diuretic will facilitate the removal of the fluid in the lungs resulting in the pH and $pCO_2$ returning to normal range. Option # 1 is a desired outcome, but does not answer the question regarding the specific clinical findings (rales and labs indicating respiratory acidosis). Option # 2 is not correct. The respirations are decreasing which could result with an increase in respiratory acidosis since the client may retain $CO_2$ with this respiratory rate. Option # 3 is an expected outcome, but does not answer the question regarding the assessment findings. The client could diurese urine , but not have an improvement in the clinical findings.

**King of Diamonds** Option # 3 is correct since MAO inhibitors are contraindicated with the use of Pseudoephedrine due to the risk with hypertension. Option #1 does not indicate a need for further teaching since Pseudoephedrine may cause rebound edema if used for too long. Option # 2 is a desired outcome; decreased swelling of the nasal passages is an expected result of this drug. Option #4 is a correct statement and does not indicate a need for further teaching. Other sympathomimetics that are often found in cough/cold preparations can cause excess side effects when given with this drug.

**Queen of Diamonds** Option # 3 is correct due to this drug being an angiotensin II receptor blocker which may result in tall T waves which is an increase in the potassium level. Option # 1 is not a priority over a complication with T wave changes on the ECG. Option # 2 is not a priority over option # 3. This does not indicate a complication. Options # 4 are within normal limits and do not indicate any complications. Range for BUN – 10-20. Range for creatinine -0.5- 1.5.

**Jack of Diamonds** Option #2 is correct due to the risk of infection. (Refer to *Pharmacology Made Insanely Easy* by Manning, Loretta and Rayfield, Sylvia for the memory technique.) Option # 1 would be appropriate if it was a steroid inhaler. Option # 3 is not correct. Option # 4 is not correct since steroids may actually result in hyperglycemia mandating the insulin to be increased versus decreased.

**Ten of Diamonds** Options #2, 3, and 4 are correct. These represent the universal / standard precautions that must be followed when suctioning a client. Option #1 is not included in this standard. This should not be necessary if the gloves are not damaged. Option # 5 is not included in this standard and is not necessary when suctioning a client in universal / standard precautions.

**Nine of Diamonds** Options # 4 and 5 are correct for Contact Isolation Precautions. Option # 1 is not correct for Clostridium Difficile. Alcohol is not sporicidal. Clostridium Difficile requires contact isolation precautions. Option # 2 is incorrect for this isolation precaution. Equipment and tables should not be shared between clients. Option # 3 is not a part of this standard. This would be necessary if the client was in droplet, airborne, or protective isolation (neutropenic precautions).

**Eight of Diamonds** Options # 2, 3, 4, and 1 reflect the correct chronological order for this procedure.

**Seven of Diamonds** Option #4 is correct. Wear a mask when 3 feet from the client when a client has this infection. This is necessary to minimize the transfer of the organism. Option # 1 is not necessary for this client when entering the room. If the client were suctioning, responding to an emergency involving blood, cleaning an incontinent client with diarrhea, or irrigating a wound, then the gown would definitely be necessary. Option # 2 is not necessary for this client. This would be important if the client needed contact isolation such as if they had MRSA, VRE, a major abscess, or a decubitus. Option # 3 is incorrect for this client. The nurse needs to wear a mask if at least 3 feet of the client.

**Six of Diamonds** Option#1 and #2 are correct. Option #1 is important in case the parathyroid gland has been accidentally removed during surgery. Option # 2 is important due to a possible airway obstruction that may be a result of swelling. Option # 3 and #4 are not standard equipment that must be at the bedside for all of these clients. Option # 5 is not appropriate for this client. It may be more appropriate if the client had a chest tube.

**Five of Diamonds** Option # 3 is the correct answer. It is inappropriate to teach the client regarding the incorrect information. Green vegetables are high in vitamin K and this is the antidote to Coumadin. While teaching is in the scope of practice for nurses, teaching must reflect accurate information. This action definitely needs to be questioned. Option # 1 is appropriate nursing action. It does not indicate the nurse is going to do the entubation. It only indicates the nurse is setting up the equipment. Option # 2 not a correct answer since it is within the scope of practice to interpret assessment findings indicating drug toxicity and notify the provider of care to adjust the plan of care. (Refer to the book *Pharmacology Made Insanely Easy* by Manning, Loretta & Rayfield, Sylvia for memory techniques). Nausea and vomiting are signs of digitalis toxicity, and it is the RN's responsibility to recognize this and intervene. Part of safe medication administration is to assess for both adverse effects as well as expected outcomes. Option # 4 is correct nursing practice. This medication is a potassium sparing diuretic which may increase the potassium level even higher. The nurse indicates an understanding of the legal scope of practice regarding the need to intervene after assessing lab values prior to medication administration.

**Four of Diamonds** Option # 4 is correct. It defines the standard of care which will assist the nurse with the steps for this procedure. Option # 1 is not correct for this situation. The nurse needs to verify the procedure from the written standard due to accountability. Option # 2 outlines the policies for the employees in the organization. Option # 3 is incorrect since there is a manual to assist with the learning process.

**Three of Diamonds** Option # 1 is the correct answer. This option is not within the scope of practice for the nurse. This is the responsibility of the medical staff. Option #2 is appropriate for the nurse to implement. Option #3 is appropriate for the nurse too implement. Option #4 is true regarding the responsibility of the nurse. The nurse is only responsible for witnessing the signature, not the teaching regarding the medical intervention.

**Two of Diamonds** Option #1 is correct. Massaging could result in a dislodged clot. Option # 2 is not correct. There is not a need to intervene immediately. This is within the scope of practice for the UAP. Actually a family member could do this as well. Option # 3 is appropriate for the UAP and does not mandate immediate intervention. Option #4 is appropriate for the UAP to implement.

# ♣ Clubs ♣

**Ace of Clubs** Option #1 is correct. This drug is a coronary vasodilator. Blood pressure may decrease and result in the risk of falling from hypotension and syncope. Option #2 is incorrect. Peripheral pulses are not the priority to blood pressure. Option # 3 is not correct since the drug is a coronary vasodilator versus a bronchodilator. Option # 4 is incorrect. Temperature would be appropriate if this were an antibiotic.

**King of Clubs** Option # 3 is correct. Norepinephrine may cause tissue necrosis if it goes outside of the IV line due to vasoconstriction. The key to answering this successful is noting the stem of the question reads "Prior to beginning a norepinephrine (Levophed) infusion". Option #1 is not a priority over #3 due to the safety prior to beginning the infusion. This option would be a priority if the question asked what should be monitored hourly after initiating the infusion. Urine output should be monitored hourly when taking this medication. Option # 2 is not the correct answer over #3. Option #4 should be monitored every 5 – 15 minutes after infusion is started. Once again, the key to answering this question was the word "prior".

**Queen of Clubs** Option #3 is correct due to potential constipation when taking Procardia. Option #1 is not correct since grapefruit juice and grapefruit can cause increase levels and effects of the medication. Option #2 is not a priority over option #3. Procardia and calcium channel blockers may cause bradycardia due to the physiological effects on the heart of decreasing contractility by inhibiting the calcium transport into the myocardial and vascular smooth muscle cells. The provider of care will typically order the parameters of when to hold the medication. This typically is with a heart rate below 50 or 60 BPM. Of course, if the client is symptomatic due to bradycardia then the medication should also be held and provider of care notified. Option #4 is incorrect. If a client is in heart failure, this medication can create more complications with the failure due to the action of the drug.

**Jack of Clubs** Option #1 is correct. Acute confusion is one of the earliest symptoms of toxicity for the elderly client. Clients can also present with anorexia and / or nausea and vomiting. Option #2 is not a priority over option #1. Bradycardia may definitely be an undesirable effect, and it is imperative to assess the heart rate prior to administering the drug, but it is not the earliest assessment finding indicating a complication with toxicity. Options # 3 and #4 are also undesirable effects, but these are similar to option #2 since they are not the earliest assessment findings indicating a complication with this medication.

**Ten of Clubs** Option #1 is correct. It is a nonselective beta blocker and may result in bronchoconstriction. (Refer to *Pharmacology Made Insanely Easy*, by Manning, Loretta and Rayfield , Sylvia for memory technique.) Option # 2 does not need questioned. This would be appropriate for this client since this does not reflect bradycardia. Option #3 is appropriate for this client. There is not a need to question this order for this client. Ace Inhibitors are appropriate for clients after a myocardial infarction since these drugs suppress rennin-angiotensin-aldosterone system by blocking the conversion of angiotensin 1 to angiotensin 2 (a potent vasoconstrictor). This will result in a decrease in the systemic and peripheral vascular resistance and will decrease left ventricular dilation after an MI. Option #4 does not need to be questioned since this diuretic will be therapeutic for this client.

**Nine of Clubs** Option #2 is correct. Grapefruit juice can result in a peaked concentration of carbamazepine (Tegretol) and should be questioned. Option #1 is not correct since it does not need to be questioned. This is appropriate for client with seizures. This medication inhibits nerve impulses by limiting influx of sodium ions into the motor cortex from across the cell membrane. Option #3 is appropriate to reduce GI irritation, so there is no need to question the order. Option #4 is not correct since this in within the therapeutic level for this drug which is 4 – 12 micrograms / ml and does not need to be questioned.

**Eight of Clubs** Option #1 is correct since it may cause infection. Prednisone (Deltasone) may cause immuno-suppression, so it would be inappropriate to administer this vaccine to the client. Option #2 is appropriate practice, so does not need to be questioned. Option #3 does not need to be questioned since a sore throat may indicate an infection and does need to be reported. Option #4 does not need to be questioned because the client's sodium may increase when taking prednisone (Deltasone). This elevation in sodium could result in an increase in the client's BP. Sodium level must be monitored.

**Seven of Clubs CHANGE IN ANSWER!!!!!!!** Option #1 is correct since it can result in tachycardia. Since tachycardia is a potential complication from brethine (Terbutaline), the client must not have any tachycardia prior to taking the drug. Action of this drug is relatively selective for beta 2 (pulmonary) – adrenergic receptor sites, with less effect on beta 1 (cardiac) adrenergic receptors. The therapeutic effects from this drug is bronchodilation. **Option # 2 and # 3 are also important to assess. So these are also acceptable answers for your game and your NCLEX**. Option # 2 may increase from the physiological action of this drug. Option # 3 is the reason the client is receiving the medication. The respirations are important to assess and to reevaluate, but the desired outcome from this medication will be an improvement in the breathing and a potential complication will be with tachycardia, hypertension and tremors. Respirations are important to assess to evaluate the desired outcome, but also the client can experience paradoxical bronchospasms from excessive use of inhalers . **Options # 1, #2, #3 are all acceptable answers.** Option # 4 is not correct for this medication.

**Six of Clubs** Option #3 is correct. An undesirable effect from this medication is BP changes. It stimulates contraction of uterine muscle fibers. Option #1 is incorrect. This would be an appropriate assessment finding for a client with a neurological complication such as head injury, meningitis, etc. The motor movement, eye opening, and verbal skills are evaluated with the Glasgow Coma Scale. Option #2 would be a priority for a client receiving a bronchodilator or narcotic. The baseline assessments for a client receiving methylergonovine (Methergine) would include maternal HR and BP, (FHR) fetal heart rate and I and O every 2 hours. Option # 4 is not a priority for this medication.

**Five of Clubs** Option #2 is correct. Mobic decreases pain and inflammation associated with osteoarthritis. Options # 1, #3, and #4 are incorrect. Option #4 would be a result of allopurinol (Zyloprim).

**Four of Clubs** Option #1 is correct. Aricept increases acetylcholine concentrations in the cerebral cortex by slowing degradation of acetylcholine released in cholinergic neurons. The desired outcome will be that client will experience decrease in confusion and present with a mood improvement. This option indicates awareness and hope in the future. Option #2 is behavior a client will present with who does have Alzheimer's Disease and does not indicate a desired outcome from this medication. Option #

3 does not indicate a desired outcome from the drug. This actually indicates confusion if trying to go to bed in AM. Option #4 is not correct. This is not a desired outcome.

**Three of Clubs** Option #4 is correct. Mannitol increases osmotic pressure of glomerular filtrate, preventing reabsorption of water. Intracranial pressure should be reduced resulting in client being more oriented. Option #1 may be an expected assessment, but it does not indicate there has been an improvement in the intracranial pressure. Option #2 is normal serum sodium and should always be in the normal range even if client is not receiving Mannitol. Option # 3 is a level that needs to be monitored while receiving this medication due to the risk of dehydration. If the serum osmolality is > 310 – 320 mOsm / kg, then Mannitol is contraindicated due to the risk of circulatory overload.

**Two of Clubs** Option #4 is correct. The key in answering this question successfully is to know that the antacid should be administered approximately 1 hour after meals and typically no meds should be administered with the antacid due to drug – drug interaction. The other key to answering this is to know that cimetidine (Tagamet) can be given prior to meals. If the antacid is administered with meals, then there is no benefit to giving the antacid. Options # 1, #2, and #3 are incorrect due to these facts.

# ♠ Spades ♠

**Ace of Spades** Option #3 is correct. Client may be bleeding. Warfarin (Coumadin) is an anticoagulant. The action of the drug is that it interferes with the hepatic synthesis of vitamin K – clotting factors (II, VII, IX, and X). Undesirable effects may be signs of bleeding such as an elevated heart rate, paleness in color, and not less alert. Option #1 is incorrect due to the fact that these green leafy vegetables are high in vitamin K which is the antidote to warfarin (Coumadin). Option #2 is incorrect since garlic and Coumadin can result in bleeding from the drug-drug interaction. Option #4 is incorrect since PTT is evaluated with Heparin and PT is evaluated with warfarin (Coumadin).

Ki **ng of Spades** Option #4 since these assessment findings indicate a complication with hypokalemia. Option #1 would be correct if the medication was being given for pulmonary edema. Option #2 may occur as a result of diuresing, but is not a priority to report. Meticulous mouth care can resolve the dry mouth, but signs of hypokalemia may result in cardiac complications. Option #3 does not need to be reported since this is a desirable outcome.

**Queen of Spades** Option #4 is correct due to decrease respirations. The action of the drug is that it combines with opiates receptors in the CNS. This reduces the stimuli from sensory nerve endings and can also reduce the respirations. Option #4 is showing a trend in respiratory depression. Option #1 may occur if client was to change positions quickly, but is not a priority over option #4. Option #2 is not a priority to #4. Option #3 indicates the respirations are increasing versus decreasing. The client may need additional medication if the respirations are increasing as a result of pain, but this still is not a priority over #4 which is trending to respiratory depression,

**Jace of Spades** Option #2 is correct. This may be an indication of potential toxicity. Ototoxicity may result from high levels for extended periods of time. Option #1 is not a priority to Option #2. Option #3 is a desired outcome from the antibiotic. If the medication is effective the temperature will continue to decrease. If the temperature has increased from 98.6 degrees F, then this still would not be a priority since this is the reason the client is taking the medication. Toxic signs would still be the priority. Option #4 is within the normal limits and does not need to be reported. This indicates the medication is working appropriately.

**Ten of Spades** Option #1 is correct. These assessments are indicative of minor toxicity and if continues can result in dehydration leading to further toxicity since Lithium is a salt. Option #2 is not unusual for a client who is manic. This is one of the reasons the client is taking Lithium. Option #3 is an appropriate intervention. There is no need to report this action since it is necessary for this client to be well hydrated. Option #4 does not need to be reported. It is necessary to maintain the normal level of sodium.

**Nine of Spades** Option #1 is correct. If client is experiencing a delusion, safety is a priority. Appropriate verification of client is a priority. Option #2, Notify provider of care is important but is not a priority to option #1. Option #3 is also important to do, but if the client is given the wrong medication due to inappropriate identity since client is having a delusion, client could die from medication. Option #4 is never done. Client is brought back to reality, but is never confronted.

**Eight of Spades** Option #2 is a priority of care due to safety with blood administration. The word "PRIOR" to is the key to successfully answering this question. Option #1 is not prior to the administration; it is during the administration. Option #3 is appropriate care for during the administration. This indicates a blood reaction and does require immediate intervention, but this still does not answer the question. The question is asking about care prior to beginning the blood. Option #4 is always inappropriate since the only IV fluid that should be administered with blood is normal saline.

**Seven of Spades** Option #3 is correct. Insulin is a high alert drug, and the dose must be checked by 2 nurses to ensure safety and proper dose. Option #1 is incorrect due to abbreviation. There is a list of "*Do Not Use Abbreviations",* and this is on the list. U must be spelled out to units. Refer to *Pharmacology Made Insanely Easy* for the frequently used abbreviations that are unsafe or go to www.ismp.org (Institute for Safe Medication Practices) for additional information. Option #2 is not following the appropriate standard of care for administering insulin, so is incorrect. Option #4 is incorrect since it should only be administered daily.

**Six of Spades** Option #1 is correct since this is on the ISMP (Institute for Safe Medication Practices) list of "*Do Not Use Abbreviations".* This drug should be spelled out "Magnesium Sulfate". Option #2 is incorrect since it is not consistent with standard of care. Option #3 is always a good thing to look up unknown information, but this option is still incorrect because the order is not written appropriately and needs to be revised by the provider of care. Option #4 is incorrect since the order should not be accepted until the drug is clearly spelled out. If the nurse is getting ready to administer and is verifying client identity, then there is a lack of understanding about safe medication administration.

**Five of Spades** Option #2 is correct. These are "*Sound Alike Drugs*" and could result in an error! Safety is ALWAYS the best policy. Options #1, #3, and #4 are ignoring the challenge with the "*Sound Alike Drugs*".

**Four of Spades** Option #3 is correct. Lasix is a diuretic and should not be routinely administered at night. The client will be up all night diuresing and not get any sleep. This is currently written as a daily dose and does need questioning. Options # 1, #2, and #4 are not priority to #3 due to the order. It is important to assess along with the potassium level, calcium level, Magnesium level, Serum glucose, and uric acid level, daily weight, I & O when taking Lasix. It is also important to assess any symptoms of ototoxicity, muscle cramps, lightheadedness, or signs of dehydration when a client is taking Lasix.

**Three of Spades** Option #2 is correct. Vitamin K should never be administered IVP. It should be administered SubQ or IM. Options # 1, #3, and #4 are all important when administering this medication, but are not the answers since the order is written incorrectly and could lead to death if administered IVP. In other words, these options do not answer the question as it is written.

**Two of Spades** Option #4 is correct. QD must be spelled out to be an acceptable order. QD is recognized as one of the "*Do Not Use Abbreviations*". Option #1 is an appropriate nursing intervention, but does not address the inappropriate abbreviation. Option #2 is appropriate to do, but is not a priority over #4. Option #3 is important, but is not a priority over #4 due to incorrect order.